DEPARTMENT OF LABOR

Employment Standards Administration

20 CFR Parts 718, 722, 725, 726, and 727

RIN 1215–AA99

Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, as Amended

AGENCY: Employment Standards Administration, Labor.

ACTION: Proposed rule.

SUMMARY: On January 22, 1997, the Department issued a proposed rule to amend the regulations implementing the Black Lung Benefits Act. The Department initially allowed interested parties until March 24, 1997 to file comments, but extended that deadline twice. When the comment period finally closed on August 21, 1997, the Department had received almost 200 written submissions from coal miners, coal mine operators, insurers, physicians, and attorneys. In addition, the Department held two hearings, one on June 19, 1997 in Charleston, West Virginia, and another on July 22–23, 1997 in Washington, D.C. Over 50 people testified at the Department's hearings. In total, the Department heard from over 100 former coal miners and members of their families, over 50 coal mine operators and insurance companies that provide black lung benefits insurance, eight physicians, eight attorneys representing both claimants and coal mine operators, nine legislators at the federal and state levels, and groups as diverse as the United Mine Workers of America, the National Black Lung Association, the National Mining Association, the American Insurance Association, and the American Bar Association.

The Department has reviewed all of the comments and testimony, and has decided to issue a second proposal, revising a number of the most important regulations contained in the earlier proposal. In some cases, the Department has proposed additional changes to these regulations. In other cases, the Department has explained its decision not to alter its proposal based on the comments received to date. Finally, the Department has prepared an initial regulatory flexibility analysis. The Department's second proposal is intended to accomplish two purposes. First, it will provide notice to all interested parties of the proposed revisions, as well as of the initial regulatory flexibility analysis set forth in this document. Second, the re-proposal will allow small entities that may have been unaware of the Department's earlier proposal to submit comments on the entire proposed rule.

DATES: Comments must be submitted on or before December 7, 1999.

ADDRESSES: All comments concerning these proposed regulations should be addressed to James L. DeMarce, Director, Division of Coal Mine Workers' Compensation, Room C–3520, Frances Perkins Building, 200 Constitution Ave., NW., Washington, DC 20210.

FOR FURTHER INFORMATION CONTACT: James L. DeMarce, (202) 693–0046.

SUPPLEMENTARY INFORMATION:

This notice reprints 20 CFR Parts 718, 722, 725, and 726 in their entirety for the convenience of interested parties. This notice thus necessarily includes proposed revisions contained in the Department's original notice of proposed rulemaking. 62 FR 3338 (Jan. 22, 1997). The Department intends this notice to supplement the original notice, however, and not to replace it. To the extent that previously proposed regulatory changes have not been altered by the revisions contained in this notice, the explanation of those changes contained in the Department's initial notice remains valid. Where the Department has proposed additional changes, those changes are explained below.

Summary of Noteworthy Proposed Regulations

Evidentiary Development

Documentary Medical Evidence

The Department's initial proposal governing evidentiary development in black lung claims resulted in the greatest volume of public comment, from coal mine operators, their insurers, claims servicing organizations and miners. Many commenters were critical of the Department's proposal that all documentary medical evidence was to be submitted to the district director in the absence of extraordinary circumstances. Numerous commenters, expressing widely varying points of view, also addressed the proposed limitation on the amount of documentary medical evidence that each side could submit in a given claim.

After carefully considering the many valid objections to the required submission of documentary medical evidence to the district director, the Department now proposes to retain the current process for submitting documentary medical evidence into the record. Under this process, parties may submit documentary medical evidence either to the district director or to an administrative law judge (ALJ) up to 20 days before an ALJ hearing, or even thereafter, if good cause is shown. This proposal does retain, however, the Department's original limitation on the amount of documentary medical evidence which may be submitted in each claim. To clarify its intent, the Department has defined differently the applicable evidentiary limitations. These limitations are now expressed in terms of the types of evidence most commonly used to establish or refute entitlement to benefits under §§ 718.202 and 718.204. Thus, rather than describing the evidentiary limitations in terms of two pulmonary evaluations or consultative reports, the revised § 725.414 speaks in terms of two chest X-ray interpretations, the results of two pulmonary function tests, two arterial blood gas studies, and two medical reports.

The revised § 725.414 also would make explicit the amount of evidence which each side may submit in rebuttal of its opponent's case. A party may submit no more than one physician's interpretation of each chest X-ray, pulmonary function test, or arterial blood gas study submitted by its opponent. In addition, the Department proposes to permit a party to rehabilitate evidence that has been the subject of rebuttal. For example, where a party submits a physician's interpretation in rebuttal of a chest X-ray interpretation or objective test, the party that originally submitted the chest X-ray or test into evidence may introduce a contrary statement from the physician who originally interpreted it.

This proposal would alter in one significant way the limitations on the amount of medical evidence admissible in each claim. In order to allow for a more careful consideration of the unique facts and circumstances of each case, and to provide an additional procedural safeguard, this proposal would permit an administrative law judge to admit medical evidence into the record in excess of the limits outlined in § 725.414 upon a showing of good cause. The Department's prior proposal would have permitted the admission of such evidence only if a moving party could demonstrate extraordinary circumstances.

Complete Pulmonary Evaluation

The Department also proposes a change in the manner in which it administers the complete pulmonary evaluation required by the Black Lung Benefits Act. Under the Department's original proposal, a miner could be examined either by a physician selected

by the Department or by a physician of his choosing. If the miner selected the physician, however, the report of that examination would have counted as one of the two pulmonary evaluations the miner was entitled to submit into evidence. The Department now proposes to allow the miner to choose the physician or facility to perform the complete pulmonary evaluation from a list of providers maintained by the Department. The authorized list of physicians and facilities in a given case would include all those in the state of the miner's residence and contiguous states. If, however, a miner chose a provider more than one hundred miles from his residence to administer the 413(b) evaluation, the designated responsible operator could choose to send the miner a comparable distance for its examination. The 413(b) examination results would not count against the miner's quota. § 725.406.

The Department believes that this proposal would benefit all parties to a claim. It would make possible the best quality respiratory and pulmonary evaluation and would insure each miner a thorough examination, performed in compliance with the applicable quality standards. Such a pulmonary evaluation would therefore give the Department a sound evidentiary basis upon which to make an initial finding, a finding which both the claimant and the operator may find credible. The Department intends to develop more rigorous standards for physicians and facilities that perform pulmonary evaluations and to reevaluate the fees it pays physicians to perform and explain the results of these examinations. The Department has discussed in the preamble to § 725.406 several possible criteria that the Office might use in selecting appropriate physicians and facilities, and invites comment on these and other possible criteria.

Developing medical evidence relevant to the claimant's respiratory and pulmonary condition, including the objective medical testing required by the Department's quality standards, may involve costs beyond the reach of some claimants. Thus, this proposal would require a district director to inform the claimant that he may have the results of the Department's initial objective testing sent to his treating physician for use in the preparation of a medical report that complies with the Department's quality standards. The district director's notice would also inform the claimant that, if submitted, a report from his treating physician would count as one of the two reports he is entitled to submit under § 725.414, and that he may wish to seek advice, from a lawyer or other qualified representative, before requesting his treating physician to supply such a report. In this way, the Department hopes to assist claimants who may not be able to afford the necessary objective testing.

Documentary Evidence Pertaining to the Liability of a Potentially Liable Operator or the Responsible Operator

Although the Department now proposes to allow the submission of new documentary medical evidence while a case is pending before the Office of Administrative Law Judges, it has not altered the proposal with respect to the required submission to the district director of all documentary evidence relevant to potentially liable operators and the responsible operator. Proposed §§ 725.408, 725.414 and 725.456 would continue to require that such evidence be submitted to the district director and that an administrative law judge may admit additional evidence on such issues only if the party seeking to submit the evidence demonstrates extraordinary circumstances justifying its admission. The Department has revised proposed § 725.408, however, in response to operators' comments. That section would now allow an operator, notified of its potential liability under proposed § 725.407, 90 days, rather than 60, to submit documentary evidence challenging the district director's determination that it meets the requirements in § 725.408(a)(2). In addition, the 90 day period could be extended for good cause pursuant to § 725.423.

Witnesses

This proposal alters the provisions governing witnesses testimony. §§ 725.414, 725.456, 725.457. The revisions would allow a physician to testify, either at a hearing or pursuant to deposition, if he authored a ''medical report'' admitted into the record pursuant to § 725.414. Alternatively, if a party has submitted fewer than the two medical reports allowed as an affirmative case, a physician who did not prepare a medical report could testify in lieu of such a report. No party would be allowed to offer the testimony of more than two physicians, however, unless the administrative law judge found good cause to allow evidence in excess of the § 725.414 limitations. The Department also has proposed altering its original limitation on the scope of a physician's testimony. If a physician is permitted to testify, he may testify as to any medical evidence of record, and not solely with respect to the contents of the report he prepared.

The regulations governing witnesses testimony would continue to require that the parties notify the district director of any potential witness whose testimony pertains to the liability of a potentially liable operator or the responsible operator. Absent such notice, the testimony of such a witness may not be admitted into a hearing record absent an administrative law judge's finding of extraordinary circumstances. §§ 725.414, 725.457.

Witnesses' Fees

The Department received comments from both miners and coal mine operators criticizing its initial proposal, which would have assessed liability for witnesses' fees on the party seeking to cross-examine a witness if the witness's proponent did not intend to call the witness to appear at the hearing. In response to these objections, the Department now proposes to assess the costs of cross-examination of a witness on the party relying on that witness's affirmative testimony. This change will make the regulation more consistent with the manner in which witnesses' fees are paid in general litigation. Under the proposal, the party whose witness is to be cross-examined may request the administrative law judge to authorize a less burdensome method of cross-examination than an actual appearance at a hearing, provided that the alternative method authorized will produce a full and true disclosure of the facts.

The only exception to this general rule would be in the case of an indigent claimant. If a claimant is the proponent of the witness whose cross-examination is sought, and the claimant demonstrates that he would be deprived of ordinary and necessary living expenses if required to pay the witness's fee and mileage necessary to produce the witness for cross-examination, the administrative law judge may apportion the costs of the cross-examination between the parties, up to and including the assessment of the total cost against the party opposing claimant's entitlement. A claimant shall be considered deprived of funds required for ordinary and necessary living expenses under the standards set forth at 20 CFR 404.508. The Black Lung Disability Trust Fund may not be held liable for such witness's fee in any case in which the district director has designated a responsible operator, except that the fund may be assessed the cost associated with the cross-examination of the physician who performed the miner's complete pulmonary evaluation.

Subsequent Claims

Subsequent applications for benefits are filed more than one year after the denial of a previous claim and may be adjudicated only if the claimant demonstrates that an applicable condition of entitlement has changed in the interim. In its initial notice of proposed rulemaking, the Department attempted to clarify the regulation governing subsequent claims by summarizing and incorporating into the regulation's language the outcome of considerable appellate litigation. 62 FR 3351–3353 (Jan. 22, 1997). Because the courts of appeals have issued additional decisions since the Department's initial proposal, the proposal now merely codifies caselaw that is already applicable to more than 90 percent of the claimants who apply for black lung benefits. The Department's complete discussion of the numerous comments received in response to the first notice of proposed rulemaking is found under § 725.309.

This second proposal contains two changes to § 725.309 as initially proposed. Both changes affect § 725.309(d)(3). The Department now proposes elimination of the rebuttable presumption that the miner's physical condition has changed if the miner proves with new medical evidence one of the applicable conditions of entitlement. Commenters responded that the proposal was confusing and would lead to considerable litigation. The Department agrees that the presumption is unnecessary and suggests its deletion. Under the new proposal, a subsequent claim will be denied unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. Section 725.309(d)(3) of this proposal also clarifies the Department's original intent with respect to subsequent survivors' claims. In order to avoid an automatic denial, the applicant in a subsequent survivor's claim must demonstrate that at least one of the applicable conditions of entitlement is unrelated to the miner's physical condition at the time of his death. Thus, if the prior denial was based solely on the survivor's failure to establish that the miner had pneumoconiosis, that the miner's pneumoconiosis was caused by coal mine employment, or that the pneumoconiosis contributed to the miner's death, any subsequent claim must also be denied, absent waiver by the liable party.

By allowing the filing of a subsequent claim for benefits which alleges a worsening of the miner's condition, the Department merely recognizes the progressive nature of pneumoconiosis. The proposed regulation does not allow the reopening of any prior claim which was denied more than one year before the filing of the subsequent claim. It also prohibits any award of benefits for a period of time covered by that prior denial. Responsible operators have argued to the circuit courts of appeals that the Department's regulatory scheme allows the ''recycling'' of an old claim in violation of the Supreme Court's holding that a black lung claimant may not ''seek[] to avoid the bar of res judicata [finality] on the ground that the decision was wrong.'' *Pittston Coal Group* v. *Sebben,* 488 U.S. 105, 123 (1988). The courts have uniformly rejected this argument, see *Lovilia Coal Co.* v. *Harvey,* 109 F.3d 445, 449–450 (8th Cir. 1997), *cert. denied,* 118 S. Ct. 1385 (1998). Thus, the Department's proposal is fully consistent with the Supreme Court's holding in *Sebben,* and gives appropriate finality to prior denials.

The Department's experience with subsequent claims also demonstrates the need for such filings. During the period between January 1, 1982, when the Black Lung Benefits Amendments of 1981 took effect, and July 16, 1998, 10.56 percent of the subsequent claims filed by living miners were ultimately awarded as opposed to only 7.47 percent of first-time claims. To prevent a miner who has previously been denied benefits from filing a subsequent claim would force each miner to ''guess'' correctly when he has become totally disabled due to pneumoconiosis arising out of coal mine employment because a premature and unsuccessful filing would forever bar an award. In addition, the total number of subsequent claims filed by miners during that same time period, 30,964, as compared to the total number of claims filed, approximately 107,000, indicates that the provision is not abused. Of the total number of claims filed, only approximately 1,400, or 1.3 percent, were from individuals who had been denied benefits three or more times. Thus, in general, only an individual who believes his condition has truly worsened files a subsequent claim.

Although the Department's proposal would allow the filing of subsequent claims, the Department also intends to take steps to better educate claimants with respect to the requirements for entitlement. The Department intends to provide better initial pulmonary evaluations and better reasoned, more detailed explanations of denials of claims. By providing claimants with a more realistic view of their possible entitlement, the Department expects that the number of nonmeritorious applications will be reduced.

Attorneys' Fees

In its first notice of proposed rulemaking, the Department attempted to clarify an operator's liability for a claimant's attorney's fees and the dates on which the operator's liability commenced. The Department also recognized the Trust Fund's liability for attorneys' fees and made it coextensive with a liable operator's. In general, the Department used the date of the event which created an adversarial relationship between the claimant and either the operator or the fund as the date on which liability for a claimant's attorney's fees commenced. The Department used this date based on the theory that it was the creation of an adversarial relationship which required employment of an attorney. Thus, for example, a successful claimant's attorney could only collect a fee from an operator or the fund for necessary work performed after the liable operator first contested the claimant's eligibility or the fund first denied the claim. *See* 62 FR 3354, 3399 (Jan. 22, 1997).

Upon further reflection and consideration of the comments received, however, the Department now proposes to allow successful claimants' attorneys to collect fees from an operator or the fund for all necessary work they perform in a case rather than only the work performed after creation of an adversarial relationship. Although the creation of an adversarial relationship and the ultimately successful prosecution of a claim are still necessary to trigger employer or fund liability for attorneys' fees, the date on which the adversarial relationship commenced will no longer serve as the starting point of liability. The Department believes this change may be appropriate in light of the evidentiary limitations present in the proposal. These limitations significantly alter the consequences of an early submission of evidence and make the quality of each piece of evidence submitted significantly more important. Thus, in an attempt to avoid setting a trap for the unwary claimant and to encourage early attorney involvement in these claims, the Department proposes allowing successful attorneys to collect fees for all of the necessary work they perform.

Treating Physicians' Opinions

In the preamble accompanying its initial proposal, the Department noted that its proposal to allow a fact-finder to give controlling weight to the opinion of

a treating physician attempted to codify principles embodied in case law and also drew on a similar regulation adopted by the Social Security Administration, 20 CFR 404.1527(d)(2). See 62 Fed. Reg. 3338, 3342 (Jan. 22, 1997). The Department's proposal elicited widely divergent comment from numerous sources. The Department now invites comment on alternative ways to determine when a treating physician's opinion may be entitled to controlling weight.

The purpose of this proposal is not to limit a factfinder's consideration of any properly admitted medical or other relevant evidence. Rather, this regulation would mandate only that the factfinder recognize that a treating physician may possess additional insight into the miner's respiratory or pulmonary condition by virtue of his extended treatment. The Department has proposed two changes to § 718.104(d). In the absence of contrary probative evidence, the adjudication officer would be required to accept the physician's statement with regard to the nature and duration of the doctor's treatment relationship with the miner, and the frequency and extent of that treatment. § 718.104(d)(5). The Department has also added language to § 718.104(d) to make explicit its intent that a treating physician's opinion may establish all of the medical elements of entitlement. Finally, the Department has retained the language in the original proposal that whether controlling weight is given to the opinion of a treating physician shall also be based on the credibility of that opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

Waiver of Overpayments

In its previous notice of proposed rulemaking, the Department extended the right to seek waiver of recovery of an overpayment to all claimants, without regard to whether recovery was sought by a responsible operator or the Black Lung Disability Trust Fund. 62 FR 3366–3367 (Jan. 22, 1997). The Department received numerous comments in response, many urging adoption of a more generous waiver provision fashioned after the Longshore and Harbor Workers' Compensation Act. Many other comments opposed the extension of waiver rights to all claimants as an unconstitutional deprivation of responsible operators' property rights and right to appeal. Thus far, these comments have not provided the Department with a sufficient basis for altering its original proposal. *See* the discussion under § 725.547.

The Department also heard testimony from a number of witnesses generally critical of the application of the criteria used to determine whether recoupment of an overpayment would defeat the purposes of title IV of the Federal Coal Mine Health and Safety Act or would be against equity and good conscience. These waiver criteria are incorporated into the Black Lung Benefits Act from the Social Security Act, 30 U.S.C. 923(b), 940, incorporating 42 U.S.C. 404(b), and the Social Security Administration uses them in its adjudication of overpayments arising under title II of the Social Security Act. Thus, Social Security's current interpretation of these criteria is found in Social Security regulations governing title II claims, 20 CFR 404.506 through 404.512, not in their regulations governing Part B claims filed under the Black Lung Benefits Act, 20 CFR 410.561 through 410.561h. In order to make the standards for waiver of recovery of a black lung overpayment more current, the Department proposes to amend section 725.543 to incorporate Social Security's title II standards, rather than its Part B regulations.

Definition of Pneumoconiosis and Establishing Total Disability Due to Pneumoconiosis

The Department has suggested no further change to its initial proposal defining pneumoconiosis, § 718.201, and no significant change to its regulation defining total disability and disability causation, § 718.204. The miner retains the burden of proving each of these required elements of entitlement.

The Department received widely divergent comments from medical professionals on its proposed definition of pneumoconiosis. Some commenters argued that the proposal lacked a sound medical basis and would therefore unjustifiably increase the number of claims approved. Other physicians, also with expertise in pulmonary medicine, supported the proposal. As a result, the Department sought additional guidance on this issue from the National Institute for Occupational Safety and Health (NIOSH). The Department forwarded to NIOSH all of the comments and testimony it had received relevant to § 718.201 and requested that NIOSH advise the Department whether any of the material altered that agency's original opinion, submitted during the comment period, which supported the Department's proposal. NIOSH concluded that the unfavorable comments and testimony did not alter its previous position: NIOSH scientific analysis supports the proposed definitional changes.

The Department also received numerous comments on its proposed regulation defining total disability and disability causation, and setting out the criteria for establishing total disability. The Department has proposed no significant change to § 718.204. It has proposed, however, a change in the methodology by which pulmonary function tests are administered. § 718.103(a) and Appendix B to Part 718. This proposal would require that pulmonary function testing be administered by means of a flow-volume loop, a more reliable method of ensuring valid, verifiable results in pulmonary function testing. The Department invites comment on these proposed changes.

True Doubt

The ''true doubt'' rule was an evidentiary weighing principle under which an issue was resolved in favor of the claimant if the probative evidence for and against the claimant was in equipoise. In its first notice of proposed rulemaking, the Department proposed deleting subsection (c) of the current regulation at § 718.3, because the Supreme Court held that this language failed to define the ''true doubt'' rule effectively. 62 FR 3341 (Jan. 22, 1997). Although the Department received a number of comments urging the proposal of a ''true doubt'' rule, the Department has not done so in this second notice of proposed rulemaking.

The Department believes that evaluation of conflicting medical evidence requires careful consideration of a wide variety of disparate factors, making the applicability of any true doubt rule extremely limited. The availability of these factors makes it unlikely that a factfinder will be able to conclude that the evidence, although in conflict, is equally probative. Thus, the Department does not believe that promulgation of a true doubt rule will enhance decision-making under the Act.

Federal Coal Mine Health and Safety Act Endorsement

Section 726.203 was not among the regulations the Department opened for comment in its previous notice of proposed rulemaking. Representatives of the insurance industry commented, however, that a different version of the endorsement contained in § 726.203(a) has been in use since 1984, with the Department's knowledge and consent. The Department is now opening § 726.203 for comment. Although this proposal does not suggest alternative language for the endorsement, the

preamble does contain the version of the endorsement which the industry provided. The Department invites comment on its possible use, but urges commenters to bear in mind the requirement in § 726.205 that endorsements other than those provided by § 726.203 may be used only if they do not ''materially alter or attempt [] to alter an operator's liability for the payment of any benefits under the Act.* * *'' The Department also requests that the insurance industry submit for the record any document it might possess from the Department authorizing use of the different endorsement.

Medical Benefits

Since the Department's initial proposal, the U.S. Court of Appeals for the Sixth Circuit has issued a decision addressing the compensability of medical expenses incurred as a result of treatment for totally disabling pneumoconiosis. *Glen Coal Co.* v. *Seals,* 147 F.3d 502 (6th Cir. 1998). A majority of that panel held that the Benefits Review Board had erred by applying the Fourth Circuit's presumption to a miner whose coal mine employment took place within the jurisdiction of the Sixth Circuit. In the Fourth Circuit, if a miner entitled to monthly black lung benefits receives treatment for a pulmonary disorder, it is presumed that that disorder is caused or aggravated by the miner's pneumoconiosis. *Doris Coal Co.* v. *Director, OWCP,* 938 F.2d 492 (4th Cir. 1991); *Gulf & Western Indus.* v. *Ling,* __ F.3d __, 1999 WL 148851 (4th Cir. Mar. 19, 1999).

The Department believes that black lung benefit claims adjudication should vary as little as possible from circuit to circuit, and consequently continues to propose a regulatory presumption, based on the Fourth Circuit's approach, that would apply nationwide. The Sixth Circuit's opinion would allow such a result, given the separate views expressed by each of the three judges sitting on that panel. The Department also believes that a regulatory presumption governing the compensability of medical expenses for the treatment of totally disabling pneumoconiosis is appropriate given the rational connection between the facts proven and the facts presumed.

Explanation of Proposed Changes

Open Regulations

The Department invites comments from interested parties on the following regulations: § 718.3, § 718.101, § 718.102, § 718.103, § 718.104, § 718.105, § 718.106, § 718.107, § 718.201, § 718.202, § 718.204, § 718.205, § 718.301, § 718.307, § 718.401, § 718.402, § 718.403, § 718.404, Appendix B to part 718, Appendix C to Part 718, part 722 (entire), § 725.1, § 725.2, § 725.4, § 725.101, § 725.103, § 725.202, § 725.203, § 725.204, § 725.209, § 725.212, § 725.213, § 725.214, § 725.215, § 725.219, § 725.221, § 725.222, § 725.223, § 725.306, § 725.309, § 725.310, § 725.311, § 725.351, § 725.362, § 725.367, § 725.403, § 725.405, § 725.406, § 725.407, § 725.408, § 725.409, § 725.410, § 725.411, § 725.412, § 725.413, § 725.414, § 725.415, § 725.416, § 725.417, § 725.418, § 725.421, § 725.423, § 725.452, § 725.454, § 725.456, § 725.457, § 725.458, § 725.459, § 725.465, § 725.478, § 725.479, § 725.490, § 725.491, § 725.492, § 725.493, § 725.494, § 725.495, § 725.502, § 725.503, § 725.515, § 725.522, § 725.530, § 725.533, § 725.537, § 725.543, § 725.544, § 725.547, § 725.548, § 725.606, § 725.608, § 725.609, § 725.620, § 725.621, § 725.701, § 725.706, § 726.2, § 726.8, § 726.101, § 726.104, § 726.105, § 726.106, § 726.109, § 726.110, § 726.111, § 726.114, § 726.203, § 726.300, § 726.301, § 726.302, § 726.303, § 726.304, § 726.305, § 726.306, § 726.307, § 726.308, § 726.309, § 726.310, § 726.311, § 726.312, § 726.313, § 726.314, § 726.315, § 726.316, § 726.317, § 726.318, § 726.319, § 726.320, and part 727 (entire).

New Regulations Open for Comment

The Department's initial notice of proposed rulemaking contained a list of regulations, entitled ''Substantive Revisions,'' that the Department proposed to revise. 62 FR at 3340 (Jan. 22, 1997). That list of regulations is reproduced above with six additions. The Department is now proposing changes to ten regulations that were not open for comment previously: § 725.351, § 725.403, § 725.465, § 725.515, § 725.533, § 725.543, § 725.544, § 725.548, § 726.3, and § 726.203. Although the Department has not proposed any specific changes to section 726.203, the Department seeks comment from interested parties on the changes to that regulation suggested by the insurance industry. Accordingly, the Department now invites comment from all interested parties on the regulations listed above as Open Regulations.

Additional Technical changes

The Department's first proposal identified a number of regulations to which the Department was proposing to make technical revisions. *See* 62 FR 3340–41 (Jan. 22, 1997). The Department is now proposing additional technical revisions. Among other things, these proposed changes delete references to the control numbers used by the Office of Management and Budget to approve revisions to the regulations in 1984 because the inclusion of these numbers is neither necessary nor helpful to understanding the Department's regulations. *See, e.g.,* 20 CFR 718.102 (1999). In addition, at the request of the Office of the Federal Register, the Department is proposing to change references to various components of title 20 of the Code of Federal Regulations and to various statutory provisions and to add a colon to § 726.1. The following regulations should be added to the list of regulations to which the Department is making only technical revisions: Appendix A to Part 718, § 725.201, § 725.218, § 725.220, § 725.531, § 725.536, § 726.1, § 726.103, § 726.207, § 726.208, § 726.209, § 726.210, § 726.211, § 726.212, and § 726.213.

Complete List of Technical Revisions

The complete list of regulations to which the Department is making technical changes is as follows: § 718.1, § 718.2, § 718.4, § 718.303, Appendix A to Part 718, § 725.102, § 725.201, § 725.216, § 725.217, § 725.218, § 725.220, § 725.301, § 725.302, § 725.350, § 725.360, § 725.366, § 725.401, § 725.402, § 725.404, § 725.419, § 725.420, § 725.450, § 725.451, § 725.453A, § 725.455, § 725.459A, § 725.462, § 725.463, § 725.466, § 725.480, § 725.496, § 725.501, § 725.503A, § 725.504, § 725.505, § 725.506, § 725.507, § 725.510, § 725.513, § 725.514, § 725.521, § 725.531, § 725.532, § 725.536, § 725.603, § 725.604, § 725.605, § 725.607, § 725.701A, § 725.702, § 725.703, § 725.704, § 725.705, § 725.707, § 725.708, § 725.711, § 726.1, § 726.4, § 726.103, § 726.207, § 726.208, § 726.209, § 726.210, § 726.211, § 726.212, and § 726.213. Pursuant to the authority set forth in 5 U.S.C. 552(b)(3)(A), which allows federal agencies to alter ''rules of agency organization, procedure, or practice'' without notice and comment, the Department is not accepting comments on any of these regulations.

Unchanged Regulations

Certain regulations are merely being re-promulgated without alteration and are also not open for public comment. To the extent appropriate, the Department's previous explanations of

these regulations, set forth in the **Federal Register**, *see* 43 FR 36772–36831, Aug. 18, 1978; 48 FR 24272–24294, May 31, 1983, remain applicable. The same is true of those regulations to which the Department is making only technical changes. The following regulations are being re-promulgated for the convenience and readers: § 718.203, § 718.206, § 718.302, § 718.304, § 718.305, § 718.306, § 725.3, § 725.205, § 725.206, § 725.207, § 725.208, § 725.210, § 725.211, § 725.224, § 725.225, § 725.226, § 725.227, § 725.228, § 725.229, § 725.230, § 725.231, § 725.232, § 725.233, § 725.303, § 725.304, § 725.305, § 725.307, § 725.308, § 725.352, § 725.361, § 725.363, § 725.364, § 725.365, § 725.422, § 725.453, § 725.460, § 725.461, § 725.464, § 725.475, § 725.476, § 725.477, § 725.481, § 725.482, § 725.483, § 725.497, § 725.511, § 725.512, § 725.520, § 725.534, § 725.535, § 725.538, § 725.539, § 725.540, § 725.541, § 725.542, § 725.545, § 725.546, § 725.601, § 725.602, § 725.710, § 726.5, § 726.6, § 726.7, § 726.102, § 726.107, § 726.108, § 726.112, § 726.113, § 726.115, § 726.201, § 726.202, § 726.204, § 726.205, and § 726.206.

Changes in the Department's Second Proposal

The Department's second proposal contains substantive changes, either in the regulation or the preamble language, or both, to the following regulations: § 718.3, § 718.101, § 718.103, § 718.104, § 718.105, § 718.106, § 718.107, § 718.201, § 718.204, § 718.205, Part 718, Appendix B, § 725.2, § 725.101, § 725.209, § 725.223, § 725.309, § 725.310, § 725.351, § 725.367, § 725.403, § 725.406, § 725.407, § 725.408, § 725.409, § 725.411, § 725.414, § 725.416, § 725.456, § 725.457, § 725.459, § 725.465, § 725.491, § 725.492, § 725.493, § 725.494, § 725.495, § 725.502, § 725.503, § 725.515, § 725.533, § 725.543, § 725.544, § 725.547, § 725.548, § 725.606, § 725.701, § 726.3, § 726.8 and § 726.203. The Department has carefully considered all of the comments that it has received to date with regard to the regulations. The preamble contains an explanation of the Department's proposed changes as well as its reason for rejecting other suggestions.

In particular, the Department invites comment from small businesses that may not have been aware of the potential impact of the Department's proposed rule. In order to ensure that small businesses have adequate information, the Department intends to mail a copy of this proposal to each coal mine operator who is identified in current records maintained by the Mine Safety and Health Administration.

Several commenters suggest that the Department lacks the authority to revise the regulations governing claims filed under the Black Lung Benefits Act. Although some of these objections are limited to individual regulations, such as the definition of ''pneumoconiosis,'' and will be addressed in the discussion of those regulations, two of the objections apply to a substantial number of the revisions made by the Department. They are: first, that the Department lacks the authority to promulgate regulations covering matters that were the subject of an unsuccessful attempt to amend the Act in 1994; and, second, that the Supreme Court's decision in *Director,* OWCP v. *Greenwich Collieries*, 512 U.S. 267 (1994), prohibits the Department from adopting any regulation that requires coal mine operators to bear a burden of proof.

Regulatory Authority

In 1994, the 104th Congress considered legislation that would have amended the Black Lung Benefits Act by, among other things, limiting the amount of evidence parties may submit, providing claimants with overpayment relief, and allowing previously denied applicants to seek *de novo* review of their claims. The House passed a version of this legislation, H.R. 2108, on May 19, 1994, but the Senate adjourned in September, 1994 without acting on several similar bills. Numerous commenters have argued that in ''rejecting'' H.R. 2108, the Congress has already disapproved certain of the revisions now proposed by the Department. This argument fails on two grounds. First, Congress' failure to act does not deprive the Department of the authority to promulgate regulations otherwise conferred by the Black Lung Benefits Act. Second, Congress did not reject the legislation. Instead, the Senate adjourned without considering its version of the bill passed by the House.

The starting point for determining the validity of any regulation is the legislation authorizing the agency to issue binding rules. As a general matter, ''[t]he power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress.'' *Morton* v. *Ruiz,* 415 U.S. 199, 231 (1974). ''If Congress has explicitly left a gap for the agency to fill, there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation. Such legislative regulations are given controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute.'' *Chevron* v. *Natural Resources Defense Council,* 467 U.S. 837, 843–44 (1984).

In *Pauley* v. *Bethenergy Mines, Inc.*, 501 U.S. 680 (1991), the Supreme Court recognized the applicability of the *Chevron* analysis to regulations implementing the Black Lung Benefits Act:

> It is precisely this recognition that informs our determination that deference to the Secretary is appropriate here. The Black Lung Benefits Act has produced a complex and highly technical regulatory program. The identification and classification of medical eligibility criteria necessarily require significant expertise, and entail the exercise of judgment grounded in policy concerns. In those circumstances, courts appropriately defer to the agency entrusted by Congress to make such policy determinations.

Id. at 696. In addition to providing this general authority, the Black Lung Benefits Act contains several explicit provisions authorizing rule-making by the Department of Labor. Section 422(a) of the Act provides that ''[i]n administering this part [Part C of the Act], the Secretary is authorized to prescribe in the **Federal Register** such additional provisions * * * as [s]he deems necessary to provide for the payment of benefits by such operator to persons entitled thereto as provided in this part and thereafter those provisions shall be applicable to such operator.'' 30 U.S.C. 932(a). Section 426(a) of the Act similarly authorizes the Secretary to ''issue such regulations as [she] deems appropriate to carry out the provisions of this title.'' 30 U.S.C. 936(a). As the Fourth Circuit has pointed out, these two provisions represent a ''broad grant of rulemaking authority.'' *Harman Mining Co.* v. *Director,* OWCP, 826 F.2d 1388, 1390 (4th Cir. 1987). Finally, the Act contains several other provisions authorizing the Secretary to promulgate regulations on specific subjects. *See, e.g.*, 30 U.S.C. 902(f)(1)(D) (criteria for medical tests which accurately reflect total disability), 932(h) (standards for assigning liability to operators), and 933(b)(3) (required insurance contract provisions).

The Secretary's rulemaking authority is not unlimited. For example, section 422(a) prohibits the Department from promulgating regulations that are inconsistent with Congress's decision to exclude certain provisions of the Longshore and Harbor Workers' Compensation Act from those

incorporated into the Black Lung Benefits Act. Moreover, under *Chevron*, the Department clearly has no authority to issue regulations on a subject which Congress has addressed unambiguously. *Pittston Coal Group* v. *Sebben*, 488 U.S. 105 (1988). For example, in 1981, Congress amended the Act to limit the eligibility of surviving spouses of deceased coal miners who filed claims on or after January 1, 1982. Congress provided that such a spouse would be entitled to survivors' benefits only if [s]he could establish that the miner had died due to pneumoconiosis. Pub. L. 97–119, 95 Stat. 1635, § 203(a)(2), (3). The bill passed by the House in 1994 would have reinstated so-called unrelated death benefits so as to allow a surviving spouse to collect benefits, no matter the miner's cause of death, so long as the miner was totally disabled due to pneumoconiosis at the time of death. Because that bill did not become law, however, the 1981 requirement remains in effect, and quite obviously limits the Department's ability to regulate in this area.

The mere fact that Congress considered legislation affecting some of the same subjects addressed by the Department's regulatory proposal, however, cannot be construed as a similar limitation. ''Ordinarily, and quite appropriately, courts are slow to attribute significance to the failure of Congress to act on particular legislation.'' *Bob Jones University* v. *United States*, 461 U.S. 574, 600 (1983). In particular, the Department is not aware of any case holding that the failure of a previous Congress to enact legislation prevents an administrative agency from promulgating regulations on similar topics.

Moreover, the regulations proposed by the Department are, for the most part, quite different in content from the provisions of either the bill that was passed by the House or the bills that were under consideration by the Senate when it adjourned. The Department's proposed revision of the definition of ''pneumoconiosis'' is similar in one respect to a provision in H.R. 2108 (recognizing that both obstructive and restrictive lung disease may be caused by exposure to coal mine dust). Other provisions, however, are significantly different. For example, H.R. 2108 would have completely relieved claimants of the obligation to repay overpaid amounts. In contrast, the Department's proposal would ensure only that the rules governing waiver of overpayments are applied without regard to whether the overpayment was made by the Black Lung Disability Trust Fund or a responsible operator. In fact, the Department has specifically rejected comments urging it to use certain provisions incorporated from the Longshore and Harbor Workers' Compensation Act that would bar the recoupment of overpayments by employers, an approach similar to that considered by the 104th Congress. Although the Department is not proposing the widespread overpayment relief that was contained in H.R. 2108 and was sought by these commenters, the Department also does not believe that Congress intended that claimants who receive payment from the Trust Fund be treated differently than claimants who receive payments from liable coal mine operators. The Department's proposal would simply guarantee the equitable treatment of both claimant groups.

The Department's proposed evidentiary limitation is also significantly different from the limitation set forth in H.R. 2108. Under the bill passed by the House, claimants would have been allowed to submit three medical opinions, and responsible operators or the Trust Fund would have been allowed only one. The Department agrees that evidentiary limitations are needed to level the playing field between operators and claimants, but does not believe that the playing field should be tilted in favor of one party. Rather, the Department's proposal treats all parties equally and encourages them to rely on the quality of their medical evidence rather than its quantity. Hopefully, the proposal's evidentiary limitations will improve the decisionmaking process in black lung benefit claims.

Finally, the Department's treatment of denied claims also differs significantly from that proposed in the legislation. H.R. 2108 would have allowed any claimant denied benefits based on a claim filed on or after January 1, 1982 to seek readjudication of that claim without regard to the previous denial. The Department's proposed revision of § 725.309, on the other hand, specifically forbids the parties from seeking readjudication of the earlier denial of benefits. § 725.309(d). Instead, the Department has proposed the codification of a solution that has already been accepted by five courts of appeals with jurisdiction over more than 90 percent of black lung claims filed. That solution requires a claimant to establish, with new evidence, at least one of the elements previously resolved against him before a new claim may even be considered on the merits. Even if a claimant establishes his entitlement to benefits based on a subsequent claim, benefits will be paid based only on that application and not for time periods covered by the earlier, final denial.

The Department therefore cannot accept the argument that Congress' failure to enact legislation in 1994 prevents the Department from revising regulations that have not been amended since 1983. In many cases, the Department is simply proposing to codify the decisions of a majority of the appellate courts. In other cases, the Department's proposed revisions represent reasonable methods of dealing with problems that have arisen since the black lung benefits regulations were first promulgated in 1978. The Department's ability to address those problems in regulations is independent of any Congressional effort to reform the Black Lung Benefits Act, and should be judged according to the standards set forth in *Chevron*. For the reasons set forth in its initial notice of proposed rulemaking, 62 FR 3337 (Jan. 22, 1997) and in this notice, the Department believes that its proposed revisions meet those standards.

Administrative Procedure Act

A number of commenters also suggest that the Department's ability to create regulatory presumptions is constrained by the Administrative Procedure Act and the Supreme Court's decision in *Greenwich Collieries*. In *Greenwich Collieries*, the Supreme Court invalidated the use of the ''true doubt'' rule, an evidentiary principle that effectively shifted the risk of non-persuasion from black lung applicants to coal mine operators. Under the ''true doubt'' rule, fact-finders were required to resolve any issue in favor of the claimant if the evidence for and against entitlement was equally probative. In contrast, section 7(c) of the Administrative Procedure Act (APA), 5 U.S.C. 556(d), states that ''[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof.'' The Court held that, even assuming that the Department could displace the APA through regulation, the Department's existing regulation, 20 CFR 718.403, was insufficient to do so. Finally, the Court determined that the party assigned the ''burden of proof'' by the APA bore the risk of non-persuasion. As a result, the court held the APA required that the Department resolve cases of equally probative evidence against the claimant, the party seeking an order compelling the payment of benefits.

The commenters argue that the Court's decision effectively prohibits the Department from imposing any burden of proof on an operator under the Black Lung Benefits Act. The Department does

not believe that *Greenwich Collieries* requires such a result. At the outset, it should be clear that the Court's decision did not address the relationship between the Department's rulemaking authority and the APA. Section 956 of the Federal Mine Safety and Health Act (FMSHA) provides as follows:

> Except as otherwise provided in this chapter, the provisions of sections 551 to 559 and sections 701 to 706 of Title 5 shall not apply to the making of any order, notice, or decision made pursuant to this chapter, or to any proceeding for the review thereof.

30 U.S.C. 956. ''This chapter'' is a reference to chapter 22 of Title 30, United States Code, which codifies the FMSHA. Because the Black Lung Benefits Act is subchapter IV of the FMSHA, section 956 generally exempts the Act from the requirements of the section 7(c) of the APA. Similarly, although section 19 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 919, incorporated into the BLBA by 30 U.S.C. 932(a), makes the APA applicable to the adjudication of claims under the LHWCA, that provision is incorporated into the Black Lung Benefits Act only ''except as otherwise provided * * * by regulations of the Secretary.'' The clear language of the FMSHA and the BLBA thus authorize the Secretary to depart from the dictates of section 7(c) when she determines it is in the best interest of the black lung benefits program.

Moreover, the Court's decision in *Greenwich Collieries* did not purport to decide the issues on which a particular party bears the burden of persuasion. Rather, the Court merely decided that with respect to two issues on which the claimant bears the burden of proof under the Secretary's existing regulations (the existence of pneumoconiosis and the cause of that disease), the claimant must prevail by a preponderance of the evidence. As the Court observed in its subsequent decision in *Metropolitan Stevedore Co.* v. *Rambo*, 117 S. Ct. 1953, 1963 (1997), ''the preponderance standard goes to how convincing the evidence in favor of a fact must be in comparison with the evidence against it before that fact may be found, but does not determine what facts must be proven as a substantive part of a claim or defense.''

Under *Greenwich Collieries*, then, the Department remains free to assign burdens of proof to parties as necessary to accomplish the purposes of the Black Lung Benefits Act. The Department has historically used regulatory presumptions where they were appropriate. For example, current 20 CFR 725.492(c), presumes that each employee of a coal mine operator was regularly and continuously exposed to coal dust during the course of his employment. In promulgating this regulation, the Department noted that such a showing required evidence that was not generally available to the Department; rather such evidence was within the control of the employer. 43 FR 36802–03 (Aug. 18, 1978). Current 20 CFR 725.493(a)(6) presumes that a miner's pneumoconiosis arose in whole or in part out of employment with the employer that meets the conditions for designation as the responsible operator. Unless the presumption is rebutted, the regulation requires the responsible operator to pay benefits to the claimant on account of the miner's total disability or death. One commenter objected to this presumption, set forth in revised § 725.494(a), as a violation of *Greenwich Collieries*, notwithstanding the Act's specific provision authorizing the use of presumptions with respect to assignment of liability to a miner's former employers. 30 U.S.C. 932(h).

Even where the BLBA is silent, the Act grants the Secretary sufficiently broad rulemaking authority to authorize the adoption of other presumptions. In *American Hospital Association* v. *NLRB*, 499 U.S. 606 (1991), the Court considered the ability of the National Labor Relations Board, using similarly broad regulatory authority, to define an appropriate bargaining unit by rulemaking even though the statute required the Board to decide the appropriate bargaining unit ''in each case.'' Citing a series of previous decisions, the Court held that ''even if a statutory scheme requires individualized determinations, the decisionmaker has the authority to rely on rulemaking to resolve certain issues of general applicability unless Congress clearly expresses an intent to withhold that authority.'' *Id.* at 612. The Court expanded on the NLRB's rulemaking authority in *Allentown Mack Sales and Service, Inc.* v. *NLRB*, 118 S. Ct. 818 (1998). In *dicta*, the Court concluded as follows:

> The Board can, of course, forthrightly and explicitly adopt counterfactual evidentiary presumptions (which are in effect substantive rules of law) as a way of furthering legal or policy goals—for example, the Board's irrebuttable presumption of majority support for the union during the year following certification, *see, e.g., Station KKHI*, 284 N.L.R.B. 1339, 1340, 1987 WL 89811 (1987), *enf'd*, 891 F.2d 230 (C.A.9 1989). The Board might also be justified in forthrightly and explicitly adopting a rule of evidence that categorically excludes certain testimony on policy grounds, without regard to its inherent probative value. (Such clearly announced rules of law or of evidentiary exclusion would of course by subject to judicial review for their reasonableness and their compatibility with the Act.)

Id. at 828.

The NLRB's rulemaking authority in this regard is not unique. The federal courts have upheld the use of presumptions by agencies as diverse as the Department of Transportation, *see Chemical Manufacturers Association* v. *Department of Transportation*, 105 F.3d 702, 705 (D.C. Cir. 1997) (''It is well settled that an administrative agency may establish evidentiary presumptions''); the Interstate Commerce Commission, *see Western Resources, Inc.* v. *Surface Transportation Board*, 109 F.3d 782, 788 (D.C. Cir. 1997); the Nuclear Regulatory Commission, *see New England Coalition on Nuclear Pollution* v. *NRC*, 727 F.2d 1127, 1129 (D.C.Cir.1984) (Scalia, J.) (even a statutory mandate requiring consideration of a specific issue ''does not preclude the adoption of appropriate generalized criteria that would render some case-by-case evaluations unnecessary''); and the Department of Education, *see Atlanta College of Medical and Dental Careers, Inc.* v. *Riley*, 987 F.2d 821, 830 (D.C. Cir. 1993) (''* * * under the circumstances, it would seem quite reasonable for the Secretary to adopt regulations or even adjudicatory presumptions—bright-line rules—as to what a school must show * * *''). To the extent that the Department, like any other administrative agency, uses rulemaking to establish a presumption, that presumption must be based on a rational nexus between the proven facts and the presumed facts. *Chemical Manufacturers Association*, 105 F.3d at 705; *NLRB* v. *Baptist Hosp., Inc.*, 442 U.S. 773, 787 (1979).

The Department's proposed regulations include provisions that adjust burdens of proof among the parties. Section 725.495(c)(2), for example, provides that the potentially liable operator designated as the responsible operator by the Office of Workers' Compensation Programs bears the burden of establishing that another operator that employed the miner more recently is financially capable of assuming liability for the payment of benefits. Section 726.312 specifically allocates various burdens of proof between the Department and a coal mine operator against which the Department is seeking a civil money penalty for failure to secure the payment of benefits.

In its initial notice of proposed rulemaking, 62 FR 3337 (Jan. 22, 1997) and in this notice, the Department has demonstrated that such assignments of

burdens of proof have been carefully tailored to meet the specific needs of the black lung benefits program. Accordingly, the Department does not agree with those commenters who argue that the Supreme Court's decision in *Greenwich Collieries* prohibits the Department from requiring responsible operators and their insurers to meet any burden of proof in adjudications under the Act.

20 CFR Part 718—Standards for Determining Coal Miners' Total Disability or Death Due to Pneumoconiosis

Subpart A—General

20 CFR 718.3

(a) In its earlier proposal, the Department proposed to delete subsection (c) of § 718.3, which the Department had cited to the Supreme Court in support of its argument in favor of a ''true doubt'' rule. Under the ''true doubt'' rule, an evidentiary issue was resolved in favor of the claimant if the probative evidence for and against the claimant was in equipoise. In *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994), the Court held that an administrative law judge's use of the rule violated the Administrative Procedure Act, and that § 718.3 was an ambiguous regulation that could not be read as authorizing such a rule.

A number of commenters argue that the Supreme Court held any ''true doubt'' rule improper. Other comments urge the Department to reinstate the ''true doubt'' rule by promulgating a regulation that clearly authorizes fact-finders to use the rule in evaluating evidence in black lung benefits claims. Throughout this rulemaking, however, the Department has consistently stressed the need for factfinders to conduct in-depth analyses of the evidence based on its quality rather than quantity. Moreover, opinions by the courts of appeals and the Benefits Review Board over the past twenty years have firmly established that the evaluation of conflicting medical evidence includes consideration of a wide variety of disparate factors, thus making the applicability of any true doubt rule extremely limited. In the case of a medical report, for example, the factfinder must examine the report's documentation, its reasoning, its relationship to the other medical reports of record, and the physician's qualifications or other special status. The availability of all of these factors makes it unlikely that a factfinder will be able to conclude that the evidence, although in conflict, is equally probative. Accordingly, the Department does not believe that the promulgation of a revised ''true doubt'' rule will enhance decision-making under the Black Lung Benefits Act.

(b) Several comments urge the Department to retain subsection (c) of the current version of § 718.3. They argue that even if the language does not explicitly provide a ''true doubt'' rule, it is a useful reminder to factfinders of the purposes of the Black Lung Benefits Act. In particular, they point to the Department's quality standards for medical evidence and issues in which medical science does not provide a definitive answer. The Department recognizes that the adjudication of black lung benefits claims requires recognition of the difficulties faced by claimants in establishing their entitlement to benefits. Revised § 718.101, for example, will require ''substantial compliance'' with all of the quality standards applicable to medical evidence, rather than strict adherence. Requiring ''substantial compliance'' with the quality standards will give the fact-finder sufficient flexibility to determine whether a particular piece of evidence is probative of the claimant's condition notwithstanding its failure to meet a relatively minor quality standard provision. The Department does not agree, however, that section 718.3 should contain a separate, and wholly unenforceable, statement of general principles. Subsection (c) simply restates Congressional intent reflected in the legislative history of the 1972 and 1978 amendments to the Black Lung Benefits Act, *see* S. Rep. No. 743, 92nd Cong., 2nd Sess. 11, 1972 U.S.C.C.A.N. 2305; S. Rep. No. 95–209, 95th Cong., 2nd Sess. 13, 1978 U.S.C.C.A.N. 237. That legislative history may be used to support a party's argument regardless of whether it is repeated in the Secretary's regulations.

Subpart B

20 CFR 718.101

(a) The Department's proposed revision is intended to make clear its disagreement with Benefits Review Board case law holding that the Department's quality standards are applicable only to evidence developed by the Director, OWCP. *See Gorzalka* v. *Big Horn Coal Co.,* 16 Black Lung Rep. 1–48, 1–51 (Ben. Rev. Bd. 1990). Accordingly, the Department proposed to amend the regulations to ensure that all evidence developed in connection with black lung benefits claims meets certain minimal quality standards. One comment observes that, as drafted, the Department's revisions would allow factfinders to invalidate medical evidence in claims already pending before the Department although that evidence was valid under Board precedent when it was developed. The Department agrees that upsetting settled expectations regarding the applicability of the quality standards may work a substantial hardship in some cases, particularly those involving unrepresented claimants. Consequently, the Department has revised the language in section 718.101(b) to clarify that the mandatory nature and general applicability of the quality standards is prospective only. Once a final rule takes effect, any testing or examination conducted thereafter in connection with a black lung benefits claim that does not substantially comply with the applicable quality standard will be insufficient to establish the fact for which it is proffered.

(b) Four comments oppose the general requirement in § 718.101(b) that all evidence developed by any party in conjunction with a claim for black lung benefits must be in substantial compliance with the quality standards contained in subpart B. One comment notes the special hardship imposed on miners in trying to generate conforming evidence. Three comments assert that exclusion of nonconforming evidence violates the statutory mandate that ''all relevant evidence'' be considered in determining whether a claimant is entitled to benefits. 30 U.S.C. 923(b). The Department disagrees. The quality standards have been an integral part of claims development and adjudication since the Part 718 regulations were first promulgated in 1980. The Department has also consistently taken the position that the standards apply to all evidence developed by any party for purposes of prosecuting, or defending against, a claim for benefits. The proposed change simply makes this position clear. Finally, employing quality standards to ensure the use of reliable and technically accurate evidence is consistent with section 923(b). Evidence which fails the ''substantial compliance'' standard is inherently unreliable and thus necessarily inadequate to prove or disprove entitlement issues, and therefore is not ''relevant'' to the adjudication of the claim.

(c) One comment asks that the Department clarify that the quality standards represent the only basis on which the reliability of a medical opinion or test may be challenged. As an example, the comment states that physicians cite the correlation between the one-second Forced Expiratory Volume and the Maximum Voluntary Ventilation as a basis for invalidating a

pulmonary function test, even though the MVV is not a required part of the test. In the Department's view, the quality standards provide factfinders with flexibility in their examination of the medical evidence of record. If an alleged flaw in medical evidence is not relevant to the necessary test results, the factfinder may properly ignore that flaw. The Department's quality standards, however, are not intended to serve as the sole basis upon which medical evidence may be evaluated. Instead, parties are free to develop any evidence that pertains to the validity of the medical evidence in order to provide the factfinder with the best evidence upon which to base a finding regarding the miner's physical condition.

(d) Two comments are concerned that the quality standards could result in the exclusion of a miner's hospitalization and/or medical treatment records, or a report of biopsy or autopsy. Section 718.101, however, makes the quality standards applicable only to evidence ''developed * * * in connection with a claim for benefits'' governed by 20 CFR Parts 725 and 727. Therefore, the quality standards are inapplicable to evidence, such as hospitalization reports or treatment records, that is not developed for the purpose of establishing, or defeating, entitlement to black lung benefits.

(e) One comment advocates permitting consideration of nonconforming tests which produce clinical results comparable to conforming tests. This suggestion is rejected for the reasons expressed in paragraph (b): failure to comply with the applicable quality standards deprives the evidence of its probative worth. Moreover, a nonconforming test which produces results similar to a conforming test does not significantly enhance the fact-finding process, given the availability of the technically accurate results.

(f) One comment would require the Department to notify a party who submits nonconforming evidence, and afford an opportunity to rehabilitate the evidence. This requirement is unnecessary. Each party is responsible for developing evidence in support of its position which complies with the quality standards. Moreover, proposed § 725.406 does impose a duty on the district director to ensure that the medical examination sponsored by the Department is valid and conforming. If the district director identifies any deficiency in that examination, he must notify the physician and the miner, and take reasonable steps to correct that deficiency. Finally, evidence may be submitted up to twenty days before the formal hearing up to the limits provided in proposed § 725.414. If the opposing party submits evidence in rebuttal, proposed § 725.414 will permit the party that proffered the original evidence to attempt to rehabilitate evidence by submitting an additional report from the preparer of the original report.

(g) Other comments oppose the use of quality standards in general terms. For the reasons expressed in the preamble to the proposed regulations, 62 FR 3341–42 (Jan. 22, 1997), the Department believes that such standards are necessary to ensure the development of reliable and technically accurate evidence for the adjudication of claims. Several comments express general support for requiring all parties to develop their medical evidence in conformance with the relevant quality standards.

20 CFR 718.103

(a) One physician who testified at the Department's Washington, D.C. hearing objected to the proposal, set forth in Appendix B to Part 718, that would have precluded miners undergoing pulmonary function testing from taking an initial inspiration from room air and instead would have required an initial inspiration from the spirometer. Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), p. 306 (testimony of Dr. David James). Under questioning by the Department's medical consultant, Dr. Leon Cander, Dr. James stated that use of the flow-volume loop would be more widely acceptable than the Department's proposal prohibiting an initial open-air inspiration. Transcript, pp. 319–320. After careful consideration, the Department agrees that the flow-volume loop may offer a more reliable method of ensuring valid, verifiable results in pulmonary function testing, and proposes to revise § 718.103 in order to require that the flow-volume loop be used for every pulmonary function test administered to establish or defeat entitlement under the Black Lung Benefits Act. Spirometers capable of producing a flow-volume loop, and of electronically deriving a set of tracings showing volume versus time, are in use in a number of clinics and facilities specializing in the treatment of pulmonary conditions. While this notice of proposed rulemaking is open for public comment, the Department intends to conduct a survey of those clinics and facilities. Among the information the Department will seek is the extent to which they already use spirometers capable of producing flow-volume loops. The Department further notes that for clinics that do not already possess such a spirometer, the cost is less than $2,000. Because the use of flow-volume loops will increase the reliability of the pulmonary function study evidence submitted in black lung claims with only minimal cost, the Department proposes that all pulmonary function tests conducted after the effective date of the final rule be submitted in this form. Proposed changes have been made to subsections (a) and (b), as well as Appendix B, to accomplish this result. The Department invites comment on these changes.

(b) Dr. James also observed that the language of subsection (a) is misleading in suggesting that pulmonary function testing may produce either a Forced Vital Capacity (FVC) or a Maximum Voluntary Ventilation (MVV) value. Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), pp. 304–5 (testimony of Dr. David James). Dr. James noted that a test must produce an FVC value in order to obtain a Forced Expiratory Volume for one second (FEV1), which is required by the regulation. The Department agrees, and has proposed revising subsection (a) accordingly.

(c) The Department also proposes to revise subsection (b) in order to conform the regulation to the requirements of Appendix B. Currently, section 718.103(b) requires that three tracings of the MVV be performed unless the largest two values of the MVV are within 5 percent of each other. 20 CFR 718.103(b). Appendix B, however, provides that MVV results will be considered to have excessive variability if the two largest values vary by more than 10 percent. The Department proposes to adopt the 10 percent standard uniformly.

(d) Two comments request the Department to amend section 718.103 to ensure that a miner's failure to produce a valid MVV value will not affect the validity of the FEV1 and FVC values. The Department agrees that the validity of the two tests should be assessed independently. The proposed change to subsection (a) will highlight the optional nature of the MVV test. Both comments also suggest that the failure of a test report to meet all of the requirements of subsection (b), such as the DOL claim number, should not wholly invalidate a test. Like other medical evidence, pulmonary function tests will be subject to the requirement of proposed § 718.101 that they be in ''substantial compliance'' with the Department's quality standards. In a particular case, the parties remain free

to argue that a report's failure to meet certain technical requirements contained in the quality standards should not necessarily invalidate the report. The Department does not believe, however, that it would be appropriate to wholly remove these requirements from its quality standards.

(e) One commenter observes that pulmonary function tests are not appropriate in all cases, noting that such testing may pose a danger to the health of some claimants. Section 718.103 does not affirmatively require the performance of pulmonary function tests, but merely sets forth the standards applicable to such studies, if performed. The Department agrees, however, that there may be cases in which performance of a pulmonary function test may be medically contraindicated. As a result, the Department has proposed revising § 718.104(a)(6) to recognize that a medical report may not be excluded from consideration simply because the claimant's condition does not allow a physician to administer a pulmonary function test. The Department has also proposed reinstating language in § 718.204(b)(2)(iv) that was inadvertently deleted from its initial proposal, 62 FR 3377 (Jan. 22, 1997).

20 CFR 718.104

(a) One commenter objects to the requirement in subsection (a)(6) that all medical reports contain the results of pulmonary function testing. The commenter notes that in some cases, a miner may be physically unable to perform a pulmonary function test, or such a test may be medically contraindicated. The Department agrees, and has proposed revising subsection (a)(6) in order to recognize this possibility. When a miner cannot take a pulmonary function test, a physician writing a medical report must substantiate his conclusion(s) with other medically acceptable clinical and laboratory diagnostic techniques. This proposed addition merely recognizes the Department's longstanding position that pulmonary function tests may be medically contraindicated. The current regulation at 20 CFR 718.204(c)(4), which provides that a reasoned medical judgment may establish the presence of a totally disabling respiratory or pulmonary impairment, expressly recognizes that pulmonary function tests may be contraindicated. Similarly, the 1980 discussion accompanying promulgation of 20 CFR 718.103 acknowledged the same point: ''If the physician believes that pulmonary function testing would impose a risk to the patient's well-being, the physician should so state and refuse to have the patient perform the pulmonary function tests.'' 45 FR 13682 (Feb. 29, 1980).

(b) Several commenters request that the regulation recognize that a treating physician's opinion may be used to establish all elements of a miner's entitlement to benefits. Although the proposed regulation was not intended to restrict the use of such a report, the Department has revised subsection (d) to explicitly list the elements of entitlement which a treating physician's opinion may establish.

(c) Several commenters suggest that the Department accept a physician's statement as to the nature and duration of his relationship with the miner, and the frequency and extent of his treatment of the miner. The Department agrees that a claimant should not have to produce additional proof documenting these factors beyond that provided in the four corners of the physician's report unless the opposing party supplies credible evidence that demonstrates that the physician's statement is mistaken. The Department has therefore proposed an addition to subsection (d)(5) to make its intent clear.

(d) Proposed paragraph (d), which would allow a fact-finder to give controlling weight to the opinion of a treating physician provided certain conditions are met, elicited a great deal of comment. Many commenters supported the proposal, noting that a treating physician has a greater familiarity with the miner's physical condition than a doctor who has only seen him once. Others opposed giving special credence to ''small-town'' doctors without special expertise or training in respiratory or pulmonary disorders. Others simply expressed general opposition to the proposal. In the preamble accompanying its initial proposal, the Department explained that the proposed regulation attempted to codify existing case law and drew on a similar regulation adopted by the Social Security Administration, 20 CFR 404.1527(d)(2). *See* 62 FR 3338, 3342 (Jan. 22, 1997). The Department specifically invites comment on alternative methods for determining when a treating physician's opinion is entitled to controlling weight, including whether to adopt the Social Security Administration's rule.

(e) Several commenters suggest that the proposed subsection (d)(5) is unnecessary and undermines any Departmental attempt to give a treating physician's opinion controlling weight. They request that the Department delete certain language in subsection (d)(5), which requires the factfinder to consider not only the treating physician's documentation and reasoning but also the other relevant evidence of record in determining whether the treating physician's opinion is entitled to controlling weight. These commenters would have the finder of fact credit a treating physician's opinion which meets the criteria in (d)(1)–(4) and is documented and reasoned without regard to the other relevant evidence of record. Another comment suggests that the Department has already accomplished this result, in violation of section 413(b) of the Act, 30 U.S.C. 923(b). The Department does not accept either suggestion. The purpose of the regulation is not to limit a factfinder's consideration of any properly admitted medical or other relevant evidence. Indeed, to do so might result in a mechanistic crediting of a treating physician's opinion which the courts have cautioned the Department to avoid. *See Sterling Smokeless Coal Co.* v. *Akers*, 131 F.3d 438, 441 (4th Cir. 1997); 62 FR at 3342 (Jan. 22, 1997). Rather, the proposed regulation would mandate only that the factfinder recognize that a physician's long-term treatment of the miner may give that physician additional insight into the miner's respiratory or pulmonary condition.

(f) Several commenters oppose any rule suggesting treating physicians' opinions may be given controlling weight. They argue that a factfinder's evaluation of a medical opinion should be based solely on the documentation and reasoning of that opinion as well as the qualifications of the physician. As the Department noted in its initial notice of proposed rulemaking, 62 FR 3342 (Jan. 22, 1997), special weight may be given a treating physician's opinion because that physician has been able to observe the miner over a period of time, and therefore may have a better understanding of the miner's physical condition. Although the factfinder must still evaluate the treating physician's report in light of all of the other relevant evidence of record, he should nevertheless be aware of the additional insight that a treating physician may bring to bear on the miner's respiratory or pulmonary condition.

(g) Some commenters suggest that the ''treating physician'' rule should be removed from § 718.104 and made a separate regulation. One suggests that its current placement appears to require that the treating physician's opinion must conform to the quality standards applicable to a report of physical examination. The Department intends that all reports of physical examination, including a report submitted by the

miner's treating physician, conform to the quality standards set forth in § 718.104 if they are to be sufficient to establish or refute entitlement. The Department thus does not agree that subsection (d), governing treating physicians' opinions, should be made a separate regulation.

(h) Several commenters state that the miner should be able to submit his treating physician's opinion without regard to the limitation on the amount of evidence each party would be able to submit under § 725.414. These commenters argue that claimants, who are often unrepresented at the earliest stages of claims processing, will submit opinions from their treating physicians that do not conform to the Department's quality standards. The Department recognizes that the limitation on documentary medical evidence could have a substantial impact on unrepresented claimants who submit reports prematurely. Although the Department cannot agree to provide claimants with the opportunity to submit additional reports, the Department takes very seriously its obligation to inform all claimants of the evidentiary limitations in language that is clear and easily understood. In addition, as set forth in the proposed revision of § 725.406, the Department intends to make the objective test results from each miner's section 413(b) pulmonary evaluation available to his treating physician at the miner's request. By providing these test results to the treating physician, the Department hopes to ensure that the ensuing opinion is as well documented as the other medical opinions of record and meets the § 718.104 quality standard.

(i) Several commenters argue that the terms ''treating physician'' and ''controlling weight'' are not defined. The intent of subsection (d), however, is not to create a strict rule to determine the outcome of a factfinder's evaluation of the medical evidence. Instead, the Department's goal is simply to require the factfinder to recognize the additional weight to which a physician's opinion may be entitled, in light of all of the other relevant evidence of record, where that physician has observed and treated the claimant over a period of time.

(j) Several commenters object to certain language the Department used in the preamble of its initial notice of proposed rulemaking to explain its proposed revisions to § 718.104. In the ''Summary of Noteworthy Proposed Changes,'' 62 FR 3339 (Jan. 22, 1997), the Department indicated that in evaluating a treating physician's opinion, a factfinder ''must'' consider, among other things, the physician's training and specialization. The Department did not intend to suggest that a factfinder's failure to consider such factors would necessarily represent reversible error. Only when a party raises the issue, for example, in the context of comparing the credentials of physicians offering contrary opinions, would the factfinder be required to consider such a factor. Moreover, even under such circumstances, a physician's training and specialization are only one factor for the factfinder to weigh in his evaluation of this evidence.

(k) One commenter states that the quality standard applicable to medical reports should not require that the report include a chest X-ray. The Department disagrees. A chest X-ray, administered and read in accordance with § 718.102, is an important component of any evaluation for pneumoconiosis. Although a physician remains free to explain an opinion contrary to the medical testing that he conducted or reviewed, he must nevertheless have the benefit of that testing and account for its results. The requirement set forth in § 718.101, that all evidence must be in ''substantial compliance'' with the applicable quality standards, affords all parties the opportunity to establish the reliability of any evidence notwithstanding its failure to strictly conform to the quality standards.

(l) Two commenters request that the Department remove the clause from subsection (c) that limits the factfinder's use of non-conforming evidence in cases in which the miner is deceased and the physician is unavailable to clarify or correct his report. In such cases, the factfinder may consider a non-conforming medical report only if the record does not contain another conforming report. In this way, the Department hopes to ensure that entitlement determinations are based on the best quality medical evidence possible.

(m) One comment requests that the Department include ''cardio-pulmonary exercise testing'' as an ''other procedure[]'' under subsection (b). The Department does not intend that subsection (b) contain an exclusive list of medically acceptable procedures that may be used by a physician in the course of a physical examination. A physician is free to use any test, including cardio-pulmonary exercise testing, if he believes that it would aid in his evaluation of the miner.

20 CFR 718.105

(a) One comment directed toward Appendix C is also relevant to paragraph (c)(6). The comment notes that the correct nomenclature for partial pressure of oxygen and carbon dioxide is an upper-case ''P'', not the lower-case ''p'' currently in use. The comment is correct, and the reference to the partial pressures will be changed.

(b) Four comments oppose proposed paragraph (d), which requires the claimant to obtain a physician's opinion that a qualifying blood gas study conducted during a miner's terminal illness reflects a chronic respiratory or pulmonary condition caused by coal dust exposure. The comments suggest that qualifying scores should be presumed indicative of a totally disabling respiratory impairment unless the party opposing the claim produces evidence linking the test results to some other condition. While recognizing the concerns expressed by the comments, the Department nevertheless believes that paragraph (d) imposes an appropriate evidentiary burden on the claimant. Arterial blood gas studies conducted during a terminal illness hospitalization may be especially susceptible to producing low values unrelated to chronic respiratory or pulmonary disease. Consequently, reliance on such studies should be predicated on an additional showing that the qualifying (or abnormal) test results can be medically linked to chronic lung disease. One comment supported this proposal.

(c) Two comments object to the requirement in paragraph (d) that the chronic respiratory or pulmonary impairment demonstrated by the ''deathbed'' blood gas study must also be ''related to coal mine dust exposure.'' The Department agrees. The primary objective behind paragraph (d) is to ensure a connection between the qualifying blood gas values and a chronic respiratory or pulmonary impairment, rather than some other acute pathologic cause incidental to the miner's terminal illness. Thus, paragraph (d) addresses only the existence of a chronic respiratory or pulmonary impairment itself, not its cause. Including a requirement linking the chronic impairment to coal mine dust exposure is therefore inappropriate for purposes of § 718.105. The claimant must still prove that any totally disabling respiratory or pulmonary impairment demonstrated by these blood gas study results arose out of coal mine employment in order to receive benefits, 20 CFR 718.204(c)(1). Paragraph (d) has been revised to delete

the phrase ''related to coal mine dust exposure.''

20 CFR 718.106

(a) Five comments urge the Department to restore the current paragraph (c), 20 CFR 718.106(c), which was omitted from the proposed regulation. This paragraph provides that the negative findings on a biopsy are not conclusive evidence that pneumoconiosis is absent, while positive findings do constitute evidence of the disease. The omission was inadvertent, and paragraph (c) will be restored in the final rule.

(b) Two comments oppose the requirement in paragraph (a) that the autopsy protocol must include a gross macroscopic inspection of the lungs. The comments suggest that the requirement would implicitly preclude a pathologist from submitting an opinion based exclusively on a review of microscopic tissue samples. Paragraph (a) was not altered when the Department proposed changes to § 718.106. This provision only requires macroscopic findings for purposes of the autopsy itself; no such findings are required for a reviewing physician. Consequently, a physician other than the autopsy prosector may submit an opinion based exclusively on the microscopic tissue samples. No change is necessary to permit such opinions.

(c) Several comments urge the Department to adopt the criteria for diagnosing pneumoconiosis by autopsy or biopsy generated by the American College of Pathologists and Public Health Service in 1979. The Department has previously declined to promulgate specific pathological standards for diagnosing pneumoconiosis by autopsy or biopsy. 45 FR at 13684 (Feb. 29, 1980); 48 FR at 24273 (May 31, 1983). Furthermore, the record does not contain any evidence addressing, or establishing, a consensus in the medical community about the accepted standards for diagnosing pneumoconiosis by autopsy or biopsy. Although the comment refers to Kleinerman *et al.*, ''Pathologic Criteria for Assessing Coal Workers' Pneumoconiosis,'' in the *Archives of Pathology and Laboratory Medicine* (June 1979), the record does not establish whether this article reflects the current prevailing standards for diagnosing pneumoconiosis. The recommendation is therefore rejected.

20 CFR 718.107

(a) One comment suggests modifying the reference to ''respiratory impairment'' in paragraph (a) to ''respiratory or pulmonary impairment.'' The Department accepts this suggestion because the current paragraph (a) refers to ''respiratory or pulmonary impairment,'' and the omission of ''pulmonary'' was inadvertent. Another comment recommended adding disability and disability causation to the list of issues for which a party may submit ''other medical evidence.'' Paragraph (a) is unchanged from the current provision, except as described in the previous discussion, and satisfactorily sets forth the general purposes for which ''other medical evidence'' may be offered. The suggested change is therefore unnecessary.

(b) One comment supports the addition of proposed paragraph (b).

Subpart C

20 CFR 718.201

(a) In its initial notice of proposed rulemaking, 62 FR 3343, 3376 (Jan. 22, 1997), the Department proposed revising the definition of the term ''pneumoconiosis'' to recognize the progressive nature of the disease. The Department also proposed clarifying the existing definition to make clear that obstructive lung disease may fall within the definition of pneumoconiosis if it is shown to have arisen from coal mine employment. The proposal would not alter the current regulations' requirement that each miner bear the burden of proving that he has pneumoconiosis, 20 CFR 718.403, 725.202(b); proposed §§ 725.103, 725.202(d)(2)(i). Thus, notwithstanding the proposed revision, in order to demonstrate that he has pneumoconiosis, each miner would be required to prove that his lung disease arose out of coal mine employment. If a miner's chest X-rays, autopsy or biopsy demonstrate the presence of the disease, and the miner has at least ten years of coal mine employment, he is aided by a statutory presumption that his pneumoconiosis arose out of coal mine employment. 30 U.S.C. 921(c)(1). If, however, the miner fails to demonstrate the existence of pneumoconiosis by means of X-ray, biopsy or autopsy, he must prove that his lung disease arose out of coal mine employment in order to carry his burden of proof and establish that he has pneumoconiosis.

A number of commenters representing coal mine operators and the insurance industry object strongly to both revisions, arguing that the Department lacks the authority to elaborate on the statute's definition of pneumoconiosis, and that, in any event, the Department had violated the statute by failing to consult with the National Institute for Occupational Safety and Health (NIOSH) before proposing the changes. 30 U.S.C. 902(f)(1)(D). The commenters also argue that the Department's proposed revision lacks a sound medical basis and would therefore unjustifiably increase the number of claims approved. In support of their arguments, these commenters presented testimony at the Department's Washington, DC, hearing from a panel of physicians with expertise in pulmonary medicine. Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), pp. 19–83.

The Department also received comments, as well as testimony, supporting the proposed changes from black lung associations, miners, and several physicians with expertise in pulmonary medicine. Among the favorable comments was one from NIOSH, which approved both aspects of the Department's proposed revision to § 718.201. In so doing, NIOSH referenced its own 1995 publication, the same document that the Department had cited in its initial notice of proposed rulemaking, ''National Institute for Occupational Safety and Health, Occupational Exposure to Respirable Coal Mine Dust,'' §§ 4.1.2, 4.2.2 *et seq.* (1995). 62 FR 3343 (Jan. 22, 1997).

NIOSH was created by the Occupational Safety and Health Act ''in order to carry out the policy set forth in section 651'' of that Act as well as to perform certain functions in support of the Occupational Safety and Health Administration. 29 U.S.C. 671. Among its other provisions, section 651 encourages the Occupational Safety and Health Administration to ''explor[e] ways to discover latent diseases, establish [] causal connections between diseases and work in environmental conditions, and conduct [] other research relating to health problems.'' 29 U.S.C. 651(b)(6). Accordingly, Congress created NIOSH as a source of expertise in occupational disease and as an expert in the analysis of occupational disease research. Given the widely divergent comments received from medical professionals on this proposed regulation, the Department sought additional guidance from NIOSH by providing it with all of the comments and testimony the Department had received relevant to the proposed revisions to § 718.201. The Department requested that NIOSH advise it whether any of the material altered that agency's original opinion.

NIOSH concluded as follows:

The unfavorable comments received by DOL do not alter our previous position: NIOSH scientific analysis supports the proposed definitional changes. Research indicates that the proposed changes are reasonable and could be incorporated to further refine the definition of pneumoconiosis in the BLBA regulations.

Letter from Dr. Paul Schulte, Director, Education and Information Division (Dec. 7, 1998). In addition to the 1995 NIOSH publication, Dr. Schulte cited several recent studies and other sources: ''Coal mining and chronic obstructive pulmonary disease: a review of the evidence'' [Coggon and Newman-Taylor 1998]; ''The British Coal Respiratory Disease Litigation'' [Judgment of Mr. Justice Turner]; ''Progression of simple pneumoconiosis in ex-coalminers after cessation of exposure to coalmine dust'' [Donnan et al. 1997]; ''Adverse effects of crystalline silica exposure'' [American Thoracic Society (ATS) 1997]; ''Risk of silicosis in a Colorado mining community'' [Kriess and Zehn 1996]; and ''Risk of silicosis in a cohort of white South African gold miners'' [Hnizdo and Sluis-Cremer 1993]. He concluded as follows:

These publications provide additional support for the NIOSH position stated in the August 20, 1997 letter: ''NIOSH continues to support the proposed amendment to Section 718.201 to include chronic obstructive pulmonary disease in the definition of pneumoconiosis; NIOSH also supports the revision of the definition of pneumoconiosis to reflect the scientific evidence that pneumoconiosis is an irreversible, progressive condition that may become detectable only after cessation of coal mine employment, in some cases.''

Given this NIOSH review and conclusion, the Department sees no scientific or legal basis upon which to alter its original proposal. To the extent that the Department was required to consult with NIOSH, it has now done so. Finally, as addressed elsewhere in this proposal, the Department believes that it possesses the statutory authority to promulgate a legislative regulation defining the term ''pneumoconiosis.'' *See Old Ben Coal Co.* v. *Scott*, 144 F.3d 1045, 1048 (7th Cir. 1998), citing *Peabody Coal Co.* v. *Spese*, 117 F.3d 1001, 1009–1010 (7th Cir. 1997) (*en banc*).

(b) One commenter objects to the proposed definition of ''legal pneumoconiosis'' on the ground that § 718.202(a)(2) does not contain the requirement that the covered disease must be a ''dust'' disease of the lung. The commenter also believes that this definition would include all obstructive pulmonary disease. The Department disagrees with both points. Section 718.201 begins in paragraph (a) with the statutory definition of pneumoconiosis, stating that pneumoconiosis means a chronic ''dust'' disease of the lung and its sequelae. Paragraph (a)(2) is a subdivision of the introductory paragraph and in no way contradicts it. In fact, by its very terms, the proposed definition of pneumoconiosis would cover only that lung disease arising out of coal mine employment, *i.e.*, lung disease significantly related to, or substantially aggravated by, dust exposure in coal mine employment. § 718.201(b).

(c) Two commenters argue that Congress rejected an amendment to the definition of pneumoconiosis that would have included obstructive lung disorders, and that the Department therefore lacks the authority to make such a change. Above, the Department explained that Congress's consideration of, but failure to enact, legislation on particular subjects does not bar the Department from promulgating regulations on those subjects, provided the Department is acting within the scope of Congress's grant of regulatory authority. Thus, the Department does not agree that Congressional inaction renders invalid its proposed amendment of the definition of ''pneumoconiosis.''

20 CFR 718.204

(a) In reviewing the comments submitted in response to the initial notice of proposed rulemaking, the Department realized that it had inadvertently omitted language from the current version of 20 CFR 718.204(c)(4) setting out circumstances under which a claimant may establish total disability by means of a medical report. The Department intended no change in the regulation's meaning and has restored the omitted language to proposed § 718.204(b)(2)(iv).

(b) A number of commenters object to the Department's proposed amendment to subsection (a), while others support it. That revision is intended to ensure that disabling nonrespiratory conditions are not considered a bar to entitlement when the miner also suffers from totally disabling pneumoconiosis. As the Department explained in its initial notice of proposed rulemaking, the revision announces the Department's preference for the Sixth Circuit's decision in *Youghiogheny & Ohio Coal Co.* v. *McAngues*, 996 F.2d 130 (6th Cir. 1993), *cert. den.*, 510 U.S. 1040 (1994), over the Seventh Circuit's decision in *Peabody Coal Co.* v. *Vigna*, 22 F.3d 1388 (7th Cir. 1994). 62 FR 3344–45 (Jan. 22, 1997). After preparation of the Department's proposal, the Sixth Circuit held, for the first time in a Part 718 case, that a miner may not be denied black lung benefits simply because he may also be totally disabled by a coexisting non-respiratory impairment. *Cross Mountain Coal Co., Inc.* v. *Ward*, 93 F.3d 211, 216–217 (6th Cir. 1996). The commenters have provided no basis upon which to alter the Department's original proposal.

(c) A number of commenters object to the Department's proposal to revise subsection (b)(1) to codify the Department's position that a miner is entitled to benefits only if his respiratory or pulmonary impairment is totally disabling. The commenters urge that the Department adopt a ''whole person'' approach, allowing an award of benefits if pneumoconiosis contributed at least in part to the miner's overall disability, considering both respiratory and nonrespiratory impairments. Although the commenters argue that the Department's position violates the statute, the Third and Fourth Circuits have reached a contrary conclusion. *Beatty* v. *Danri Corp. & Triangle Enterprises*, 49 F.3d 993 (3d Cir. 1995); *Jewell Smokeless Coal Corp.* v. *Street*, 21 F.3d 241 (4th Cir. 1994). Because the commenters offer no other basis upon which to amend the Department's proposal, subsection (b)(1) has not been changed.

(d) A number of commenters take issue with the Department's proposal to define disability causation in subsection (c). Several commenters state that the Department has no authority to issue such a regulation, suggesting that the statutory language is clear. The Department disagrees. The statute authorizes the payment of benefits ''[i]n the case of total disability of a miner due to pneumoconiosis,'' 30 U.S.C. 922(a)(1), and explicitly provides that ''[t]he term ''total disability'' has the meaning given it by regulations * * * of the Secretary of Labor under part C of this title * * *.'' 30 U.S.C. 902(f)(1). Even absent such an explicit grant of rulemaking authority, Congress' use of the broad phrase ''due to'' leaves significant questions in resolving the issue of disability causation. In *Atlanta College of Medical and Dental Careers, Inc.* v. *Riley*, 987 F.2d 821 (1993), the D.C. Circuit noted that the Secretary of Education was authorized to promulgate interpretative regulations under the Student Loan Default Prevention Initiative Act. That statute authorized the Secretary to calculate a default rate from participating schools, but required him to exclude loans which ''due to improper servicing or collection, would result in an inaccurate or incomplete calculation.'' Addressing Congress' use of the phrase ''due to,'' the court held:

And must the school show ''but for'' causation, proximate causation or merely some reasonable link? The statute itself provides no answers to these riddles; accordingly, under Chevron's second step, we would defer to any reasonable interpretation of the ''due to'' language that the Secretary proffered. *See also* Jerry Mashaw, A Comment on Causation, Law Reform, and Guerilla Warfare, 73 Geo. L. Rev. 1393, 1396 (1985) (identifying the ''cause'' of something necessarily implicates a policy choice).

Id. at 830. The Department's definition of disability causation under the Black Lung Benefits Act is similarly necessary and well within the scope of its regulatory authority.

Other commenters argue that the Department has selected the wrong definition. Several commenters suggest that the Department delete the word ''substantially'' from paragraph (c)(1). Another asks that the standard be ''due at least in part.'' One commenter requests that the Department add the word ''substantially'' to paragraphs (c)(1)(i) and (c)(1)(ii). Several comments suggest that the term ''substantially contributing'' is undefined, and urge that the Department set a percentage of disability as the threshold, while another commenter asks that the Department use the term ''actual contributing cause'' in order to bar the award of benefits where pneumoconiosis has made only a *de minimis* contribution to total disability.

The Department discussed its selection of the ''substantially contributing cause'' standard in its initial notice of proposed rulemaking. 62 FR 3345 (Jan. 22, 1997). The Department explained that its selection was intended to codify a body of caselaw from various federal appellate courts that differed very little in determining disability causation. In addition, the proposal paralleled the standard used by the Department to determine whether a miner's death was caused by pneumoconiosis. Because the language of the death standard is a direct reflection of Congressional intent, *see* 48 FR 24275–24278 (May 31, 1983), the Department believes that it should be used for disability causation as well. Finally, the Department does not agree that a percentage threshold is appropriate. As the Department previously explained, the ''substantially contributing cause'' standard requires that pneumoconiosis make a tangible and actual contribution to a miner's disability. The standard is also further defined in the proposed regulation. It requires that pneumoconiosis must either have an adverse effect on the miner's respiratory or pulmonary condition or worsen an already totally disabling respiratory or pulmonary impairment. Whether a particular miner meets the ''substantially contributing cause'' standard is a matter to be resolved based on the medical evidence submitted in each case.

Finally, several commenters suggest that the Department's proposal will allow compensation where a miner's totally disabling respiratory impairment has been caused by cigarette smoking. Neither the Black Lung Benefits Act, nor the court of appeals decisions, nor the Department's proposed regulation allows benefits to be awarded where a miner's totally disabling respiratory impairment is caused solely by cigarette smoking. The courts have held irrelevant, however, the existence of causes of a miner's total respiratory or pulmonary disability in addition to pneumoconiosis. *See Jonida Trucking, Inc.* v. *Hunt*, 124 F.3d 739, 744 (6th Cir. 1997) (coexisting heart disease). In such a case, the miner meets the statutory and regulatory criteria for an award of benefits.

20 CFR 718.205

(a) Several comments request that the Department reinstate unrelated death benefits, that is, benefits to surviving spouses of miners who were totally disabled due to pneumoconiosis at the time of their death but who did not die due to pneumoconiosis. Although such benefits were formerly available, Congress amended the Act in 1981 to require that a surviving spouse who filed her claim on or after January 1, 1982 establish that the miner died due to pneumoconiosis. Pub. L. 97–119, 95 Stat. 1635, § 203(a)(2), (3). The Department cannot issue regulations contrary to the expressed will of Congress.

Another comment, however, suggests that the Department has done just that by proposing that a surviving spouse may establish death due to pneumoconiosis by proving that pneumoconiosis hastened the miner's death. The Department disagrees. Rather, the Department has simply proposed codifying a standard that has been unanimously adopted by the federal courts of appeals, a fact recognized by other commenters. In addition to the Third, Fourth, Sixth, and Seventh Circuit decisions cited in the initial notice of proposed rulemaking, 62 FR 3345–3346 (Jan. 22, 1997), the Tenth and Eleventh Circuits have also deferred to the Director's interpretation of the current regulation, and announced their support for the standard that the Department is proposing to codify. *Northern Coal Co.* v. *Director, Office of Workers' Compensation Programs*, 100 F.3d 871, 874 (10th Cir.1996); *Bradberry*, v. *Director, Office of Workers' Compensation Programs*, 117 F.3d 1361, 1365–1366 (11th Cir. 1997). The Department's proposal thus does no more than recognize the decisions of appellate courts with jurisdiction over more than 90 percent of the claims filed under the Black Lung Benefits Act. The suggestion that the Department has violated Congressional intent is simply incorrect.

(b) One commenter asks the Department to apply the standard set forth in subsection (b)(2) to claims filed on or after January 1, 1982, the effective date of the Black Lung Benefits Amendments of 1981. Subsection (b)(2) permits an award of benefits in a survivor's claim filed before January 1, 1982 if death was due to multiple causes, including pneumoconiosis, and it is not medically feasible to distinguish which disease caused death or the extent to which pneumoconiosis contributed to the miner's death. This provision is derived in substantial part from the presumption set forth in section 411(c)(2) of the Act, 30 U.S.C. 921(c)(2), and implemented by 20 CFR 718.304. Under section 411(c)(2), a deceased miner with ten or more years of coal mine employment, who died from a respirable disease, is presumed to have died due to pneumoconiosis. In implementing this provision, the Secretary added § 718.303(a)(1) to the regulations, allowing death to be found due to a respirable disease if such disease was one of several causes of the miner's death and it is not feasible to determine which disease caused death or the extent to which the respirable disease contributed to the cause of death. Section 718.205(b)(2) permitted an award under similar circumstances in cases in which the miner had less than 10 years of coal mine employment, but the survivor had established that pneumoconiosis was one of the multiple causes of death. In 1981, Congress eliminated the section 411(c)(2) presumption for survivors' claims filed on or after January 1, 1982. Pub. L. 97–119, § 202(b)(1). In promulgating regulations to effectuate Congress's intent, the Department applied the same limitation to subsection (b)(2). *See* comment (p), 48 FR 24278 (May 31, 1983). Because subsection (b)(2) is so closely connected with the section 411(c)(2) presumption, the Department continues to believe that it may not apply this regulatory provision to claims filed on or after January 1, 1982.

Appendix B to Part 718

(a) The proposed changes to Appendix B are designed to implement the Department's proposed requirement that physicians use the flow-volume loop in reporting the results of pulmonary function tests. *See* Explanation of proposed § 718.103. The Department invites comment on these changes.

(b) A number of commenters suggest that one Appendix provision is unnecessarily restrictive. It requires that the two highest FEV1 results of the three acceptable tracings agree within 5 percent or 100 ml, whichever is greater. Appendix B(2)(ii)(G). They suggest that the standard either be eliminated entirely, or that it be replaced with a variability limit of 10 percent or 200 ml. One comment recommends that the Department should have a separate standard for ensuring the reliability of FVC results. As proposed, Appendix B limits the variability only of FEV1 and MVV results.

The Department is reluctant to eliminate the Appendix B(2)(ii)(G) standard entirely; the standard provides a baseline measurement which serves to guarantee the reproducibility, and thus the validity, of each conforming pulmonary function study. However, the Department recognizes that there may be individuals who are physically unable to produce results that fall within the 5 percent limit, but whose results are, in the opinion of the physician administering the test, a valid reflection of the individual's best effort to perform the test. Accordingly, the Department invites comment as to how to maintain a standard that guarantees the reproducibility of the FEV1 and FVC values, but also allows consideration of valid FEV1 results in excess of the current 5 percent requirement.

(c) Several commenters argue that the Appendix B tables are too stringent and should be revised. These tables set forth pulmonary function test results which may establish that a miner's respiratory or pulmonary impairment is totally disabling. The Black Lung Benefits Reform Act of 1977 required the Department to consult with the National Institute for Occupational Safety and Health in the development of criteria for medical tests that accurately reflect total disability in coal miners. 30 U.S.C. 902(f)(1)(D). On April 25, 1978, the Department proposed the pulmonary function test criteria set forth in Appendix B, setting the ''qualifying'' values for the FEV1 and MVV test at 60 percent of normal pulmonary function, as adjusted for sex, height, and age. 43 FR 17730–31 (Apr. 25, 1978). When the Department published the final Part 718 rules on February 29, 1980, it added tables for the FVC test. 45 FR 13703–06 (Feb. 29, 1980). The Department also responded to comments urging that the qualifying values be reduced, observing that although there was no consensus on the correct values, the record contained substantial support from experts for the 60 percent figure. *Id.* at 13711. The Department did not re-propose the Appendix B tables in its initial notice of proposed rulemaking, *see* 62 FR 3373 (Jan. 22, 1997) (noting that the tables in Appendix B remain unchanged), and the commenters offer no medical support for the request that they be revised. Consequently, the Department has not proposed any revision of the table values.

20 CFR Part 725—Claims for Benefits Under Part C of Title IV of the Federal Mine Safety and Health Act, As Amended

Subpart A—General

20 CFR 725.2

(a) The Department has made several technical changes to the language of the proposed regulation to make the regulation easier to read.

(b) This proposal changes § 725.2(c) to add § 725.351 to the list of amended regulations which will apply only to claims filed after the effective date of the final rule. The Department's proposal requires the district director's development of a complete evidentiary record identifying the proper responsible operator. Once a case is referred to the Office of Administrative Law Judges, neither the Director, OWCP, nor a potentially liable operator identified by the district director will be able to submit any additional evidence on issues relevant to the responsible operator question. For example, only while a claim is pending before the district director may a potentially liable operator contest that it was an operator after June 30, 1973, that it employed the miner for one year, or that the miner's employment included at least one working day after December 31, 1969, § 725.408. Accordingly, the district director must be able to obtain all of the information necessary to meet the Department's burden of proof under § 725.495.

To aid the district director in gathering such information, this proposal revises and streamlines § 725.351, which grants district directors the power to issue subpoenas duces tecum. A district director will no longer be required to seek written approval from the Director, OWCP, prior to issuing such a subpoena. *See* explanation of § 725.351. Because the revised regulations governing the identification of responsible operators, §§ 725.407–.408, will apply only to newly filed claims, however, the district director's new authority under § 725.351 must be similarly limited. Accordingly, § 725.351 is added to the list of amended regulations which will not be effective with respect to claims pending on the effective date of the final rule.

(c) A number of comments request that the Department make the final rule applicable to all pending claims. As the Department explained in its original proposal, 62 FR 3347–48 (Jan. 22, 1997), however, it lacks the statutory authority to make many changes retroactive. In addition, certain changes, such as the limitation on the quantity of medical evidence, would seriously disrupt the adjudication of currently pending claims if they were made universally applicable.

(d) A number of commenters believe that the Department lacks the authority to make any of the changes retroactive, particularly because those changes will apply to subsequent claims filed by miners who have previously been denied benefits. They argue that subsequent claims are typically based on employment that ended many years ago, and that the insurance industry is not permitted to charge additional premiums in order to cover the increased liability that will result under the Department's proposal. In support of their argument that the Department is not permitted to effect such a change, they cite the Contract Clause of the United States Constitution. The Contract Clause is in Section 10 of Article I, which is a series of prohibitions against actions by state governments. In relevant part, it states that ''[n]o State shall * * * pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.'' The Supreme Court has observed that ''[i]t could not justifiably be claimed that the Contract Clause applies, either by its own terms or by convincing historical evidence, to actions of the National Government.'' *Pension Benefit Guaranty Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 732, n. 9 (1984). Thus, the Contract Clause does not bar Congress from enacting any legislation. Similarly, the Contract Clause is inapplicable to the Secretary's rulemaking by its very terms, and the comment has cited no precedent to the contrary.

Moreover, the Department does not agree that its proposed rulemaking results in the impairment of any contracts. At the hearing held in Washington, D.C., on July 22–23, 1997,

the Department heard testimony suggesting that the Supreme Court's recent decision in *United States* v. *Winstar*, 518 U.S. 839 (1996), prohibits the Department's regulatory efforts. At issue in *Winstar* was Congress's enactment of legislation that effectively revoked promises made by the Federal Home Loan Bank Board and the Federal Savings and Loan Insurance Corporation to induce three thrift institutions to acquire financially distressed savings and loans. Although the case did not produce a majority opinion, a majority of the Justices concurred in the holding that the United States was liable to the thrift institutions for breach of contract. Justice Souter's plurality opinion observed that the promises at issue were central to the institutions' agreement to acquire the troubled savings and loans; absent the government's promise, ''the very existence of their institutions would then have been in jeopardy from the moment their agreements were signed.'' 518 U.S. at 910.

The Department's regulatory revisions present a fundamentally different case. Initially, the Department notes that Justice Souter stated that the government's regulatory authority was unaffected by the contracts: ''the agreements [at issue in that case] do not purport to bind the Congress from enacting regulatory measures.'' 518 U.S. at 881. Instead, the Court held, the agreements obligated the government to assume the risk of loss, and thus be liable for damages, if the regulations were changed. By contrast, the contracts purchased by the coal mining industry to insure themselves against black lung claims contain no provision requiring the Department to assume any risk of loss. Although the Department prescribes the form of such contracts, and the Black Lung Disability Trust Fund may be considered a beneficiary of them, these are not contracts between the government and a private party. Moreover, as reflected in the endorsement authorized by the Department, § 726.203, the contracts specifically recognize the possibility that the Act may be amended while the policy is in force, and place the risk of those amendments on the insurer. *See National Independent Coal Operators Association* v. *Old Republic Insurance Company*, 544 F. Supp. 520 (W.D. Va. 1982). The Department has explained above that its rulemaking is fully consistent with, and authorized by, the provisions of the Black Lung Benefits Act. Accordingly, the Court's decision in *Winstar* presents no bar to the Department's promulgation of regulations, and does not obligate the Department to pay damages to the insurance industry.

(e) One comment urges the Department to adopt a bright-line test making all of the revisions applicable only to claims filed after the final rule becomes effective. In particular, the commenter points to changes in Part 726 which will unfairly prejudice coal mine operators that have purchased insurance in compliance with the existing regulations. As the Department explained in its earlier notice of proposed rulemaking, the only revisions which will apply to pending claims are those which clarify the Department's longstanding interpretation of the Act and the current regulations. 62 FR 3348 (Jan. 22, 1997). Those revisions are not considered retroactive. *See Pope* v. *Shalala*, 998 F.2d 473, 483 (7th Cir. 1993). The Department believes that they should be applied to all pending claims to ensure the claims' uniform treatment. Moreover, the Department does not believe that the changes to Part 726 will result in the imposition of any additional liability on the part of coal mine operators in compliance with the Act's insurance requirements.

20 CFR 725.101

(a) Several written comments and hearing statements oppose amending the definition of ''benefits'' in § 725.101(a)(6) to include the cost of the medical examination of the claimant authorized under § 725.406 and subsidized by the Trust Fund. The opponents suggest that the amended definition would impose the cost of the examination on the claimant if he later decides to withdraw the claim or becomes liable for the repayment of overpaid benefits. The Department acknowledges the commenters' concerns, but assures them that the cost of the examination, although a ''benefit'', cannot be shifted to the claimant. In the preamble accompanying the proposed revision of § 725.306, the Department stated it ''will not require reimbursement of the amount spent on the claimant's complete pulmonary evaluation as a condition for withdrawing a claim.'' 62 FR 3351 (Jan. 22, 1997). Similarly, a claimant who must repay overpaid ''benefits'' is not liable for reimbursing the Trust Fund for the medical examination. An overpayment encompasses payments to which the individual is ultimately not entitled, 20 CFR 725.540, while each applicant for benefits is entitled by virtue of the Black Lung Benefits Act to the complete pulmonary examination. 30 U.S.C. 923(b). In addition, § 725.522 contemplates that only payments made pursuant to an initial determination of eligibility by the district director or pursuant to an ''effective order by a district director, administrative law judge, Benefits Review Board, or court'' may be treated as an overpayment pursuant to § 725.540 in the event the claimant is ultimately found ineligible for benefits. The cost of the initial pulmonary evaluation is not such a payment. Consequently, the claimant cannot be required to repay the cost of that examination whatever the outcome of the adjudication of the claim.

(b) One comment opposes the revised definition of ''benefits'' in subsection (a)(6) because it imposes liability for the examination on the responsible operator if the claimant ultimately secures benefits. The comment argues that the cost-shifting is not authorized by the Black Lung Benefits Act. The Department, however, has consistently taken the position that an operator found liable for the payment of the claimant's benefits is also liable to the Trust Fund for the cost of the initial pulmonary evaluation authorized by 30 U.S.C. 923(b). This requirement is in the current regulations at 20 CFR 725.406(c). The revision of § 725.101(a)(6) merely makes this language consistent with § 725.406.

(c) The Department proposes to revise subsection (a)(6) in order to include a cross-reference to § 725.520(c), which defines the term ''augmented benefits.'' Because regulations that precede § 725.520, such as § 725.210, also use the term ''augmented benefits,'' the Department believes that the parties seeking a definition of that term should be able to find an appropriate reference in § 725.101.

(d) Three comments support the revised definitions of ''coal preparation'' (§ 725.101(a)(13)) and ''miner'' (§ 725.101(a)(19)), which exclude coke oven workers from coverage of the Black Lung Benefits Act.

(e) Two comments oppose the proposed revision of § 725.101(a)(31), which would exclude certain benefits paid from a state's general revenues from the definition of ''workers' compensation law.'' One comment supported the change. The opposing comments broadly suggest the proposed change would adversely affect the Trust Fund by making certain state benefits ineligible for offset against federal benefits, creating uncertainty in benefits funding, and contradicting the holding in *Director, OWCP* v. *Eastern Associated Coal Corp.*, 54 F.3d 141 (3d Cir. 1995). The Department disagrees. The Black Lung Benefits Act requires federal black lung benefits to be offset by any amount of compensation received under state or

federal workers' compensation laws for disability or death due to pneumoconiosis. In *Eastern Associated Coal,* the Third Circuit held that the BLBA is ambiguous as to the meaning of a ''workers' compensation law.'' The Court also held that the Director's long-standing practice of excluding state-funded benefits from the ambit of ''workers' compensation law'' was inconsistent with the plain meaning of the implementing regulations. Finally, the Court suggested the agency ''has the means and obligation to amend its regulations to provide for [an] exception'' for state benefits funded through general revenues. 54 F.3d at 150. The Department has therefore proposed to exercise its regulatory authority and eliminate any perceived inconsistency between the agency's position and the black lung program's implementing regulations. The Department's position is entirely consistent with the decision in *Eastern Associated Coal;* the Court held only that the agency's practice was inconsistent with existing regulations, and not that it was prohibited by the statute. Moreover, the Court invited the Department to undertake the present course of action.

(f) One comment opposes the revised definition of ''year'' in § 725.101(a)(32) because it includes approved absences from work in computing the length of time the miner worked for the coal company. Case law has established the validity of including certain periods of time when the miner is not working in establishing the duration of the miner's work relationship with a coal company. *Northern Coal Co.* v. *Director, OWCP [Pickup],* 100 F.3d 871, 876–877 (10th Cir. 1996); *Boyd* v. *Island Creek Coal Co.,* 8 Black Lung Rep. 1–458, 1–460 (1986); *Verdi* v. *Price River Coal Co.,* 6 Black Lung Rep. 1–1067, 1–1069/1–1070 (1984); *cf. Thomas* v. *BethEnergy Mines, Inc.,* 21 Black Lung Rep. 1–10, 1–16/1–17 (1997) (upholding inclusion of sick leave in determining length of miner's employment with operator, but rejecting Director's position that sick leave cannot be counted in determining whether miner was ''regularly'' employed during the year of employment with operator). No reason for deviating from this precedent has been offered.

(g) One comment broadly opposes the definition of the term ''year'' in subsection (a)(32), but identifies only one specific objection: the commenter contends that use of the 125-day exposure standard is invalid because of the reduced incidence of pneumoconiosis in current miners. A current reduction in the occurrence of pneumoconiosis, assuming that such a decline has occurred, is not a sufficient basis for revisiting the exposure standard. The pool of potential claimants who may apply for benefits under these regulations is not restricted to those individuals mining coal over the recent past. Consequently, a decline in the current incidence of the disease does not necessarily undermine the 125-day standard.

(h) One comment objects to the use of wages, compared to annual average wage rates, to calculate the miner's employment history for purposes of determining a ''year'' of coal mine employment under subsection (a)(32); two other comments generally support the definition, but express concern over the undue reliance on Social Security itemized wage earning records. All three comments emphasize the potentially inaccurate information contained in the itemized earnings records. No changes in the proposed definition are necessary to alleviate these concerns. Section 725.101(a)(32) does not accord special deference to any particular type of record for determining when a miner worked or how much he earned during any given period of time. In any specific case, a party may provide testimony or other evidence as to the length of coal mine employment, amount of wages, or accuracy or inaccuracy of any particular record.

(i) The Department is proposing one additional change to subsection (a)(32). In order to account for leap years, which have 366 days instead of 365, the Department proposes to use the larger figure in computing a ''year'' when one of the days in the period at issue is February 29.

Subpart B

20 CFR 725.209

The Department proposed a change to § 725.209(a)(2)(ii) in its initial notice of proposed rulemaking by adding a requirement that a dependent child who is at least 18 years of age and not a student must be under a disability which began before the age of 22 for purposes of augmenting the benefits of a miner or surviving spouse. 62 FR 3390 (Jan. 22, 1997). This proposal changes § 725.209(a)(2)(ii) to eliminate the age requirement. The change implements the statutory definition of ''dependent,'' as it pertains to a child. Section 402(a) of the Black Lung Benefits Act (BLBA) defines a ''dependent child'' to mean ''a child as defined in subsection (g) without regard to subparagraph (2)(B)(ii) thereof[.]'' 30 U.S.C. 902(a)(1). The reference to section 402(g)(2)(B)(ii) is the statutory requirement that a child be disabled before the age of 22. By removing the reference to age for purposes of a dependent child, Congress allowed any disabled child who meets the remaining statutory criteria to be considered a dependent of the miner or his widow without regard to when the child's disability began. A miner or his widow may receive augmented benefits for up to three dependents. 30 U.S.C. 922(a)(4). The Benefits Review Board has reached the same conclusion concerning the intended operation of 30 U.S.C. 902(a)(1). *See Hite* v. *Eastern Associated Coal Co.,* 21 Black Lung Rep. 1–46 (1997); *Wallen* v. *Director, OWCP,* 13 Black Lung Rep. 1–64 (1989). Finally, the change in the regulation effectuates a distinction between classes of dependent children drawn by the statute. In order for a child to establish dependency on a deceased miner as a condition to receipt of benefits in his own right, the BLBA requires the ''child'' to meet all the requirements of 30 U.S.C. 902(g). 30 U.S.C. 922(a)(3). These requirements include a deadline for the onset of disability: either age 22 or, in the case of a student, before the individual ceases to be a student. *See also* § 725.221. A child/beneficiary therefore must meet the age requirement for disability while the child/augmentee is relieved of this burden under the BLBA and the regulations. *Hite,* 21 Black Lung Rep. at 1–49; *Wallen,* 13 Black Lung Rep. at 1–67–68. Accordingly, the proposed version of § 725.209 is revised to reflect the statutory definition of ''dependent child'' and the distinction between a child/beneficiary and child/augmentee.

20 CFR 725.223

The Department proposed paragraph (d) in the initial notice of rulemaking to create a vehicle for reentitling a miner's dependent brother or sister whose eligibility terminates upon marriage, if that marriage ends and the individual again meets all the criteria for entitlement. 62 FR 3393 (Jan. 22, 1997). Upon further consideration, the Department has concluded that permitting reentitlement in such circumstances is contrary to longstanding and consistent agency policy. 20 CFR 725.223(c) (DOL regulation); 410.215(c), (d) (SSA regulation). The only situation in which reentitlement is allowed involves a surviving spouse or surviving divorced spouse who remarries after the death of, or divorce from, the miner, but later regains single status and satisfies the remaining criteria for eligibility. *See* response to comments, § 725.213. The Department has declined to extend similar treatment to children who marry

because marriage is a permanent bar to their entitlement under the statute. No reason exists to accord preferential treatment to the miner's surviving dependent siblings. Once an otherwise eligible brother or sister marries or remarries, entitlement terminates, and the marriage operates as a bar to future entitlement. If the brother or sister is already married when he or she becomes a dependent of the miner, the fact of marriage does not preclude entitlement if the brother or sister has not received any amount of support from his or her spouse. Once support is provided, then the married brother or sister loses eligibility. In either case, the termination of entitlement is justified by the reasonable assumption that the individual will receive financial support from the spouse during the marriage, and rely on savings or other benefits acquired during the marriage should it terminate. The Department therefore proposes to remove paragraph (d) from § 725.223.

Subpart C

20 CFR 725.309

(a) Numerous comments support this proposal, which simply reflects the nearly unanimous holdings of the federal courts of appeals affirming the Department's treatment of subsequent claims. The proposal also brought responses from a number of commenters, however, who generally oppose allowing claimants to file subsequent claims, and argue that the Department's proposal would further expand the right to file subsequent applications. Subsequent applications are filed more than one year after the denial of a previous claim. They may be awarded only if the claimant demonstrates that an applicable condition of entitlement has changed in the interim. As the Department explained in its initial proposal, the subsequent claims provision represents a recognition of the progressive nature of pneumoconiosis. *See* 62 FR 3351–3353 (Jan. 22, 1997).

The limited nature of the Department's proposed revisions cannot be overemphasized. The Third, Fourth, Sixth, and Eighth Circuits have adopted the Department's position. *Lovilia Coal Co.* v. *Harvey,* 109 F.3d 445 (8th Cir. 1997), *cert. denied,* 118 S. Ct. 1385 (1998); *Lisa Lee Mines* v. *Director, OWCP,* 86 F.3d 1358 (4th Cir. 1996); *LaBelle Processing Co.* v. *Swarrow,* 72 F.3d 308 (3d Cir. 1995); *Sharondale Coal Co.* v. *Ross,* 42 F.3d 993 (6th Cir. 1994). The Seventh Circuit's view is substantially similar. *Peabody Coal Co.* v. *Spese,* 117 F.3d 1001 (1997). Only the Tenth Circuit has adopted a contrary view. *Wyoming Fuel Co.* v. *Director, OWCP,* 90 F.3d 1502 (10th Cir. 1996). The Department's proposed regulation thus merely codifies caselaw that is already applicable to more than 90 percent of the claimants who apply for black lung benefits. In addition, as discussed earlier in this document, the Department's revisions will not result in the automatic reopening of claims, as was required by the Black Lung Benefits Reform Act of 1977, or the *de novo* adjudication of claims, as would have been required by H.R. 2108, the 1994 legislative initiative discussed in more detail above. The 1977 Reform Act resulted in the reopening of over 100,000 claims. The Department estimated that H.R. 2108 would have resulted in a substantial number of refilings based on its promise of *de novo* adjudication, that is, adjudication without the need to establish that the miner's condition has changed. By contrast, between January 1, 1982 and July 16, 1998, the Department received only 30,964 claims filed by claimants who had previously been denied. Because the revised regulations will offer no assistance to claimants whose condition has not changed, it is not likely to encourage the filing of a large number of additional subsequent claims.

Moreover, the Department's experience with subsequent claims clearly demonstrates the need for allowing miners to file them. Of the 49,971 first-time claims filed by living miners between January 1, 1982 (the date upon which the Black Lung Benefits Amendments of 1981 took effect) and July 16, 1998, 3,731, or 7.47 percent, were ultimately awarded. In that same time period, the Department received 30,964 subsequent claims from miners who had previously been denied benefits under the Act. Of those claims, 3,269, or 10.56 percent, were awarded. These figures suggest that many miners file applications for benefits before they are truly disabled. Elsewhere in this reproposal, the Department has outlined the steps it intends to take in order to provide claimants with a realistic view of their possible entitlement, including better initial pulmonary evaluations and better reasoned explanations of the denial of their claims. As a result of these steps, the Department hopes that claimants will be able to assess more accurately the strength of their applications throughout the process. To automatically deny those who previously filed claims, however, would unfairly penalize those miners who have truly become totally disabled due to pneumoconiosis and would deprive them of the benefits to which they may be entitled.

One commenter suggested that the Department's subsequent claims provision allows unsuccessful claimants to file multiple times, resulting in the waste of considerable resources by companies required to defend against them. The Department's experience with the current subsequent claims regulation, which has not been substantially changed, indicates that the provision has not led to widespread misuse. Approximately 107,000 claims were filed between January 1, 1982 and July, 1998. Approximately 1,400 of these were from individuals who had previously been denied benefits three or more times. This represents only 1.3 percent of the total. While the Department hopes to discourage filings by individuals who are not totally disabled due to pneumoconiosis by providing more information about the process to the potential claimant population, the Department does not believe that a strict rule requiring the denial of all subsequent claims is appropriate in a program intended to compensate the victims of a progressive disease.

(b) The Department's first proposal created a rebuttable presumption that the miner's physical condition had changed if the miner proved with new medical evidence one of the applicable conditions of entitlement. The regulation also included a provision allowing a miner to establish a serious deterioration in his physical condition whether or not the presumption was rebutted. The Department now believes that this regulatory presumption is unnecessary and would lead to considerable litigation. One commenter suggested its deletion. Accordingly, the revised proposal eliminates the presumption in favor of a simple threshold test: If the miner produces new evidence concerning his physical condition that establishes any of the elements of entitlement previously resolved against him, he is entitled to litigate his entitlement to benefits without regard to findings made in the earlier adjudication. The only exception is an issue resolved earlier by stipulation or by a failure to contest.

The Department's subsequent claims provision gives full effect to the Fourth Circuit's decision in *Lisa Lee Mines* v. *Director, OWCP,* 86 F.3d 1358 (4th Cir. 1996), *cert. denied,* 117 S.Ct. 763 (1997). In *Lisa Lee,* the *en banc* Fourth Circuit affirmed an award of benefits on a subsequent claim despite the operator's objections that the miner should have been awarded benefits in the prior claim

based on evidence of complicated pneumoconiosis. The court held that while the previous denial represented a final adjudication of the miner's condition at that time, that denial should not bar the miner from establishing his entitlement to benefits where his condition has clearly changed. The court's emphasis on accepting the correctness of the first adjudication, as well as the factual findings underlying that result, was echoed by Judge Niemeyer in his concurring opinion: ''This test avoids improper review of the first decision denying benefits.'' 86 F.3d at 1365 (Niemeyer, J., concurring).

(c) Several comments argue that the Department has incorrectly eliminated the requirement in the current regulations that a subsequent survivor's claim be automatically denied. That requirement is based on the common-sense premise that a miner's physical condition cannot change after his death, a premise with which the Department continues to agree. Thus, where the denial of a prior survivor's claim is based solely on the survivor's failure to establish that the miner suffered from pneumoconiosis, that the pneumoconiosis was caused by the miner's coal mine employment, or that the pneumoconiosis contributed to the miner's death, the Department agrees that a subsequent survivor's claim must be denied absent waiver by the liable party. Subsection (d)(3) is amended to clarify that intent. Where the earlier denial was based in whole or in part on a finding that is subject to change, however, for example, that the survivor had remarried, or a child has left school, it is inconsistent with the basic tenets of issue preclusion to prohibit that survivor from establishing entitlement to benefits. *See* 62 FR 3352 (Jan. 22, 1997). Accordingly, the Department has eliminated the automatic denial of all subsequent survivor's claims, and replaced it with a more equitable assessment of the survivor's right to assert entitlement. One comment suggests that allowing waiver of the provision requiring denial of a survivor's claim is inconsistent with the Secretary of Labor's fiduciary responsibility toward the Black Lung Disability Trust Fund. The Department is fully cognizant of its duty to protect the fund against non-meritorious claims. In exercising its responsibilities, however, the Department also believes that it should not deny meritorious claims on technical legal grounds where, for example, a surviving spouse was unable to obtain legal representation in the earlier proceeding.

(d) Several comments suggest that section 725.309 is impermissible in light of the one-year limitation for seeking reconsideration based on a change in conditions set forth in section 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 922. The Department disagrees. A section 22 reconsideration request asks that the existing denial be modified. A subsequent claim, however, does not allow reopening, or require relitigation, of the existing denial. Instead, it constitutes a new cause of action adjudicating the miner's entitlement at a later time. Thus, section 22 is not implicated by the subsequent claims provision. Moreover, even assuming that section 22 could be read to preclude subsequent claims under the Longshore and Harbor Workers' Compensation Act, the Department's authority to depart from the Longshore Act in order to administer the Black Lung Benefits Act is well established. *Director, OWCP* v. *National Mines Corp.*, 554 F.2d 1267, 1274 (4th Cir. 1977). The Department believes that a departure in this instance is fully justified. Unlike Longshore Act claims, the majority of which involve discrete, traumatic injuries, all claims filed under the Black Lung Benefits Act seek compensation for a latent, progressive disease. Moreover, the Supreme Court has construed the Longshore Act, in cases involving similar types of conditions, to allow the entry of nominal benefit awards which may be subject to later and repeated modification if the employee's condition worsens. *Metropolitan Stevedore Co.* v. *Rambo,* 117 S. Ct. 1953, 1963 (1997). Under the BLBA, however, entry of a nominal benefit award is not possible. Awards are permissible only in a case of total disability. Thus, the Department allows subsequent claims as an acknowledgment that the miner's condition may worsen.

(e) One comment argues that claimants should not have to relitigate elements of entitlement that they established in earlier litigation. For example, if the miner established that he suffers from pneumoconiosis, but failed to prove that he was totally disabled, he should not be required to re-prove the existence of the disease in a subsequent claim. The Department disagrees. Just as the rules of issue preclusion would not allow a coal mine operator to rely on the miner's previous inability to prove one element of entitlement when the miner's condition with respect to another element has changed, those rules also prohibit a miner from relying on a previous finding which the opposing party did not have an opportunity to fully litigate. Where a miner's claim was denied, and the miner did not file an appeal, the party opposing entitlement had no opportunity to seek to overturn findings that were favorable to the miner. Consequently, those findings may not have any preclusive effect.

(f) One comment suggests that the Department should clarify the date from which benefits are payable in subsequent claims. The date for commencing payment in subsequent claims is governed by the same rules applicable to any other claim, *see* 20 CFR 725.503, with the proviso that no benefits may be awarded for any period prior to the date on which the order denying the prior claim became final. This rule, spelled out in subsection (d)(5), gives effect to the language of the Fourth Circuit in *Lisa Lee,* that parties ''must accept the correctness of [the denial's] legal conclusion—[the claimant] was not eligible for benefits at that time—and that determination is as off-limits to criticism by the respondent as by the claimant.'' 86 F.3d at 1361.

(g) One comment argues that the Department's treatment of subsequent claims violates section 413(d) of the Act, 30 U.S.C. 923(d), which allows working miners who have been determined eligible for benefits to receive those benefits only if they terminate their employment within one year after the determination becomes final. The Department disagrees. Section 725.504, to which only technical changes were proposed, *see* 62 FR 3341 (Jan. 22, 1997), implements the Act's working miner provisions. The regulation currently allows individuals whose claims are denied as a result of continued coal mine employment for more than one year to file new applications after that employment ends. This regulation was first promulgated (as § 725.503A) in 1978, *see* 43 FR 36806 (Aug. 18, 1978), and the Department sees no need to revise it in light of the treatment afforded subsequent claims filed by individuals who do not continue to work. In neither case would the factfinder be permitted to look behind the denial of the earlier application. Moreover, miners who continue to work, and thus continue to be exposed to coal mine dust, present an even more compelling justification for being allowed to file subsequent claims than in the case of non-working miners.

20 CFR 725.310

(a) The Department is re-proposing section 725.310 in order to make two specific changes. The first, set forth in the third and fourth sentences of

subsection (d), would allow the Department or responsible operator, as appropriate, to recoup amounts paid erroneously to a claimant where the claimant is at fault in incurring the overpayment. For example, an overpayment may occur if a claimant in award status fails to timely notify the Department or responsible operator of an event requiring a reduction in the amount of monthly benefits paid. Such events might include an award of state workers' compensation benefits, a child's withdrawal from an educational institution, or a surviving spouse's remarriage. The second change, set forth in the fifth and sixth sentences of subsection (d), conforms the language of the regulation to the Department's intention, set forth in the Department's earlier proposal at 62 FR 3354 (Jan. 22, 1997). By making this change, the Department recognizes that those claimants whose awards have become final have a heightened expectation that they will be able to keep the monthly benefits they receive. Thus, if a final award is terminated after modification, those benefits paid pursuant to the award before modification commenced are not subject to recoupment. By contrast, those claimants whose awards are modified to denials while still on appeal may be the subject of recoupment proceedings. The two sentences at the end of subsection (d), as originally proposed, have been further divided in order to clarify the regulation's meaning.

(b) One comment objects that the revised regulation would prohibit an administrative law judge from denying a claimant's request for modification based on the claimant's failure to present any additional evidence. This comment is apparently based on the mistaken belief that the current regulations authorize such a denial. However, it is clear that any party has the right to seek modification under section 22 of the Longshore Act based ''merely on further reflection on the evidence initially submitted.'' *O'Keeffe* v. *Aerojet-General Shipyards, Inc.*, 92 S. Ct. 405, 407 (1971). The Department's current black lung regulations do not depart from this authority. Thus, current law prohibits an ALJ from denying a claimant's modification request based on a claimant's failure to submit new evidence. It is also well-established that a claimant who requests modification, whether or not he submits new evidence, is entitled to a *de novo* adjudication of his entitlement to benefits and, if requested, to a formal hearing before an administrative law judge. *Robbins* v. *Cyprus Cumberland Coal Co.*, 146 F.3d 425, 430 (6th Cir. 1998); *Cunningham* v. *Island Creek Coal Co.*, 144 F.3d 388, 390 (6th Cir. 1998). The revisions to subsection (c) merely restate these basic holdings. A similar comment suggests that the changes to subsection (c) create opportunities for claimants to file repeated requests for modification and thus avoid the one-year time limitation. Current law, however, does not permit a fact-finder to deny a modification request simply because a previous modification request has been denied. The one-year time limitation, in fact, commences to run anew when an earlier denial has become final. Subsection (c) does not alter the current state of the law.

(c) Two comments argue that the district director should not be permitted to initiate modification in any case in which a coal mine operator is liable for the payment of benefits to the claimant. The Department does not agree that such a limitation would be appropriate. Although coal mine operators are generally able to represent their own interests effectively, and thus to request modification when they believe it appropriate, section 22 of the Longshore Act specifically authorizes the district director to initiate modification on his own initiative. The Department sees no need to modify this Longshore Act provision in order to properly administer the Black Lung Benefits Act. In addition, there exists a group of awards in which a coal mine operator is nominally liable for the payment of benefits but, because of bankruptcy, dissolution, or other events, can no longer pay benefits. In such cases, the Trust Fund, pursuant to 26 U.S.C. 9501(d), must assume responsibility for paying benefits. The limitation urged by this comment would effectively prohibit the Department from initiating modification in those cases, a limitation that the Department considers unacceptable. For example, the Department must remain free to adjust the terms of an award of benefits to reflect changes in the number and status of the claimant's dependents, such as when a previously eligible child becomes ineligible for augmented benefits. Another comment suggests that parties should be able to initiate modification proceedings before an administrative law judge. The Department disagrees. Section 22 explicitly requires that modification proceedings under the LHWCA be commenced before the district director, and there is no need to alter this provision to meet the needs of the black lung benefits program. In fact, filing a modification request before the district director allows him to administratively process the request, develop the appropriate evidence, and attempt an informal resolution of the claim. *See Saginaw Mining Co.* v. *Mazzulli*, 818 F.2d 1278, 1282 (6th Cir.1987) (discussing the policy reasons supporting the regulation requiring modification proceedings to be commenced before the district director).

(d) The Department has extensively revised § 725.414 in order to define more precisely the quantitative limits on documentary medical evidence that the parties may submit. *See* explanation to § 725.414. Subsection (b) of § 725.310, which limits the amount of additional documentary medical evidence that parties may submit in cases involving requests for modification, contained language similar to the language deleted from § 725.414. In order to clarify the amount of evidence admissible in a modification case, the Department has made a corresponding change to subsection (b). Each party will be entitled to submit one additional chest X-ray interpretation, pulmonary function test, arterial blood gas study, and medical report. The opposing party may introduce one opposing interpretation of each objective test, in accordance with the rules set forth in § 725.414. Finally, the party that originally offered the evidence may seek to rehabilitate its evidence by introducing an additional statement from the physician who administered the test.

Subpart D

20 CFR 725.351

Section 725.351 was not among the provisions which the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997), and the Department did not receive any comments specifically directed to this section. In the course of reviewing the procedures to be used in the identification and notification of potentially liable operators, however, the Department has identified one aspect of this regulation which might benefit from change. The Department's proposal requires the submission to the district director of all evidence relevant to the identification of the liable responsible operator. §§ 725.408, 725.414(b). The Department must have access to this evidence while a claim is pending before the district director because it will be unable to identify additional responsible operators after a case is referred to the Office of Administrative Law Judges, § 725.407(d). It will therefore be the

district director's responsibility to develop the evidence necessary to meet the Director's evidentiary burden under the responsible operator regulations, Subpart G of Part 725.

In order to allow district directors to exercise their responsibilities more efficiently, and in a manner which does not unduly delay the adjudication of a claimant's entitlement, the Department proposes to eliminate the requirement that district directors obtain approval from the Director, OWCP, prior to the issuance and enforcement of subpoenas duces tecum. The authority to issue subpoenas requiring the production of documents is a well-recognized investigative tool of administrative agencies, *see* Comment, ''Administrative Subpoenas for Private Financial Records: What Protection for Privacy does the Fourth Amendment Afford?,'' 1996 Wisc. L. Rev. 1075, 1076–77 (1996), and the Department believes that the current additional layer of internal review is unnecessary. Instead, the Department fully expects that the district directors, working in cooperation with the appropriate officials of the Office of the Solicitor, will issue subpoenas that comply with the standards established by the Supreme Court in United States v. Morton Salt Co., 338 U.S. 632, 652 (1950). Those standards require that the information sought must be relevant to the district director's investigation and the subpoena must not be ''too indefinite.'' The latter requirement ensures that the district director's request not be excessively burdensome, *i.e.,* that compliance does not threaten the normal operation of the recipient's business. *See EEOC* v. B*ay Shipbuilding Corp.,* 668 F.2d 304, 313 (7th Cir. 1981).

20 CFR 725.367

(a) Several comments urge the Department to allow successful claimants' attorneys to collect reasonable fees for all necessary work they perform in a case rather than only the work performed after the liable operator first contested the claimant's eligibility or the fund first denied the claim. The Department agrees that such a change is appropriate. Since the revised version of section 725.367 was proposed on January 22, 1997, the Department has spent considerable time weighing how to adequately compensate claimants' attorneys under the Black Lung Benefits Act. The issue was raised in part by the Benefits Review Board's June 30, 1997 decision in *Jackson* v. *Jewell Ridge Coal Corp.,* 21 Black Lung Rep. (MB) 1–27 (en banc). In *Jackson,* the Board, by a 3–2 majority, held that successful claimants' attorneys in black lung cases are entitled to fees for all the work they perform, regardless of whether it is performed before or after the employer controverts the claimant's entitlement. The Fourth Circuit subsequently affirmed the Board's decision but disavowed its reasoning. *Clinchfield Coal Co.* v. *Harris,* 149 F.3d 407 (4th Cir. 1998). Faced with three seemingly reasonable interpretations of the statutory language and regulations, the Fourth Circuit deferred to the existing interpretation of the Director, Office of Workers' Compensation Programs. Under that interpretation, a claimant's attorney's fees are limited to those services performed after the agency's initial denial of the claim or the operator's rejection of the agency's initial approval. The court noted that the Director's interpretation was based on the agency's reasonable identification of the point in time at which a claimant would have reason to seek the assistance of an attorney. 149 F.3d at 310.

The evidentiary limitations now proposed by the Department, however, significantly alter the circumstances under which a claimant may be expected to seek representation. For example, although the Department now proposes the elimination of the requirement in the initial notice of proposed rulemaking that all medical evidence be submitted while a case is pending before the district director, these proposed regulations nevertheless still limit the amount of evidence each party may submit. Attorneys could play an important role in ensuring that this evidence, including evidence submitted before the Department's initial approval or denial of the claim for benefits, complies with the Department's quality standards and effectively presents the claimant's case. In addition, the Department is proposing significant changes in connection with the complete pulmonary evaluation afforded claimants under § 413(b) of the Act. As detailed in the explanation of these changes at § 725.406, the Department intends to send to the claimant a copy of the results of the objective tests obtained in the Department's evaluation, so that the claimant may in turn give those results to his treating physician. Obviously, the choice of whether or not to submit a report from that physician is important, in light of the regulations' evidentiary limitations. The Department intends to recommend that claimants seek legal advice before making that choice.

In light of the significant changes proposed by the Department, the commenters' suggestion is well-taken. Allowing successful attorneys to collect reasonable fees for all of the necessary work they perform, rather than only the work performed after creation of an adversarial relationship, hopefully will encourage early attorney involvement in these cases. Because such involvement can only improve the quality of evidence submitted, and thus the quality of decision-making in all claims for benefits, the Department proposes to amend section 725.367 to accomplish this result. Although the creation of an adversarial relationship and the ultimately successful prosecution of a claim are still necessary to trigger employer or fund liability for attorney's fees, the date on which the adversarial relationship commenced will no longer serve as the starting point for such liability.

(b) One comment suggests that lay representatives should be entitled to collect fees from responsible coal mine operators or the fund. The Department explained in 1978, when it rejected the same suggestion, that the statute does not require operators to pay the fees of representatives who are not attorneys. 43 FR 36789 (Aug. 18, 1978). It is the Department's intention in this regulation to make the trust fund's attorney's fee liability coextensive with a liable operator's, 62 FR 3354 (Jan. 22, 1997).

(c) One comment suggests that the Department erred in preferring the Third Circuit's decision in *Bethenergy Mines* v. *Director, OWCP,* 854 F.2d 632 (3d Cir. 1988) over the Sixth Circuit's decisions in *Director, OWCP* v. *Bivens,* 757 F.2d 781 (6th Cir. 1985) and *Director, OWCP* v. *Poyner,* 810 F.2d 99 (6th Cir. 1987). The Department's proposal, however, reflects no such preference. Both *Bivens* and *Poyner* stand for the proposition that the fund is liable for attorney's fees only when the Director, OWCP, unsuccessfully contests the claimant's entitlement to benefits. In *Bethenergy,* the Third Circuit held that a coal mine operator became liable for the payment of attorney's fees when it failed to accept liability for the claimant's entitlement within 30 days of the Department's initial finding that the claimant was not eligible for benefits. The Department's proposal is consistent with all three decisions. As in *Poyner* and *Bivens,* the regulations allow fees to be awarded against the trust fund only if the Department has denied the claimant's eligibility. In addition, the revisions follow *Bethenergy* in imposing liability on employers based either on their failure to respond to the Department's initial finding or their contest of it, whether or not the Department finds that the claimant is eligible for benefits.

In each case, the proposal allows the responsible party time to collect and evaluate medical evidence before determining whether to create the type of adversarial relationship that would result in liability for attorney's fees if the claimant ultimately proves successful.

(d) One comment states that the Department has ignored Supreme Court case law governing attorney's fee liability. The comment contains no citation to specific precedent and no further explanation. This sparse comment affords the Department an insufficient basis for altering its original proposal.

Subpart E

20 CFR 725.403

Section 725.403 was not among the regulations which the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). The regulation is applicable only to claims filed under section 415 of the Black Lung Benefits Act, 30 U.S.C. 925, between July 1 and December 31, 1973. Such claims were filed with the Department of Health, Education, and Welfare, but administered by the Department of Labor. Section 413(c) of the Act, 30 U.S.C. 923(c), provides that no benefits could be paid on any claim filed on or before December 31, 1973 unless the miner filed a claim for benefits under the applicable state workers' compensation law. Section 725.403 implemented this prohibition for purposes of section 415 claims. Because the deadline for filing section 415 claims expired over 25 years ago, the Department proposes to delete section 725.403. The Department does not intend to alter the rules applicable to any section 415 claim that may still be in litigation, and section 725.403 will remain applicable to any such claim. Parties interested in reviewing section 725.403 may consult earlier editions of the Code of Federal Regulations or the **Federal Register** in which the regulation was originally published. The Department invites comment on whether section 725.403 should be retained in the Code of Federal Regulations.

20 CFR 725.406

(a) The Department received a number of comments, from coal mine operators and miners alike, criticizing its initial proposal for providing claimants with the complete pulmonary evaluation required by 30 U.S.C. 923(b). Section 413(b) of the Act, 30 U.S.C. 923(b), requires the Department to afford each miner who applies for benefits an opportunity to substantiate his claim by means of a complete pulmonary evaluation. Under the Department's original proposal, a miner could either be examined by a physician selected by the Department or by a physician of his choosing. If the miner selected the physician, however, the report of that examination would count as one of the two pulmonary evaluations the miner was entitled to submit into evidence. § 725.414.

One comment suggested that the Department's proposal, in combination with the proposed limits on the quantity of documentary medical evidence each party may submit, would interfere with a miner's statutory right to have a complete pulmonary evaluation performed by a physician of his choice. Many miners, the commenter argued, would make a selection of the physician to perform the examination without the benefit of counsel, and would be able to submit only one additional medical report when they did secure counsel. Another comment suggested that the responsible operator be permitted to choose the physician, while a third comment suggested that the Department take steps to ensure that the facilities and physicians it uses to perform the complete pulmonary evaluation are impartial and of the highest quality.

The Department does not agree that the Black Lung Benefits Act guarantees claimants the right to have the Department pay for a pulmonary evaluation performed by a physician selected by the claimant. The statute obligates the Department only to provide a miner who applies for benefits ''an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation.'' 30 U.S.C. 923(b). In the past, when the regulations allowed parties to submit unlimited amounts of evidence in claims, the Department did allow miners to request a specific physician or facility to perform the complete pulmonary evaluation and to have the examination and/or testing done there as long as the miner's request was approved by the district director. 20 CFR 725.406(a).

The Department's proposal, however, now sets forth limitations on the quantity of evidence each side may submit. As a result, allowing a claimant to choose the physician to perform the initial pulmonary evaluation without the benefit of counsel could have an adverse effect on his case. Such a claimant might not obtain the best quality report, and would be able to submit only one more. The Department has considered a number of options to address this problem, and believes that the purposes of the Black Lung Benefits Act will best be served if the complete pulmonary evaluation authorized by 30 U.S.C. 923(b) is performed by an impartial and highly qualified physician, a solution proposed by one of the commenters. The Department will therefore maintain a list of physicians and facilities authorized to perform pulmonary evaluations. The Department will provide each miner with a list of authorized physicians and facilities in the state of the miner's residence as well as the states contiguous to that state. For example, a miner living in Ohio may choose from among authorized physicians and facilities in Ohio, Pennsylvania, West Virginia, Kentucky, Indiana, and Michigan. The Department will further inform the miner that the designated responsible operator may require him to travel 100 miles, or a distance comparable to the distance traveled for the section 413(b) examination, whichever is greater, in order to submit to additional medical examinations and testing. *See* discussion accompanying § 725.414.

Another suggestion, exempting the complete pulmonary evaluation performed by a doctor of the claimant's choosing from the evidentiary limitations, would be unfair to the party opposing entitlement. In that case, the claimant would effectively have the opportunity to submit three medical opinions, while the operator or fund would be limited to two. The Department also does not believe that it would be appropriate, as one commenter suggests, to allow the responsible operator to select the physician or facility. The purpose of the section 413(b) examination is to provide the claimant with an opportunity to have his physical condition assessed in a non-adversarial setting in an attempt to substantiate his application for benefits.

Using a smaller group of physicians to perform the complete pulmonary evaluation will also allow the Department to meet one of its primary goals in the initial processing stage: providing applicants with the best respiratory and pulmonary evaluation possible. A thorough examination, performed in compliance with the applicable quality standards, will provide each claimant with a realistic appraisal of his condition and will also provide a sound evidentiary basis for the district director's initial finding. Developing the best quality medical evidence possible will benefit all the parties. The Department intends therefore to develop more rigorous standards for physicians who perform complete pulmonary evaluations at the

Department's request. These standards may include: (1) The physician should be qualified in internal or pulmonary medicine so that he is better able to analyze respiratory and pulmonary conditions (a request of one commenter); (2) the facility must be able to perform each of the tests that the Department considers appropriate to an inquiry into a miner's respiratory or pulmonary condition, *see* § 718.104; (3) the physician must be able to schedule the claimant promptly for a pulmonary evaluation; (4) the physician must be able to produce a timely report, which includes a comprehensive narrative addressing each of the elements of entitlement; and (5) the physician must make himself available to answer follow-up questions from the district director, and must be willing to explain and defend his conclusions upon questioning by opposing parties. The Department specifically seeks comment as to these and any other standards which may be used to select physicians and facilities to perform complete pulmonary evaluations. The Department intends to consider all suggestions carefully, with the goal of improving the quality and credibility of the ensuing reports. A list of the standards ultimately selected will be included in the Black Lung Program Manual prepared and used by the Department in its administration of the program. This document is open to the public and is available in each district office. Finally, in order to ensure a pool of physicians who meet these high standards, the Department intends to re-evaluate the fees that it pays physicians, both to perform and explain the results of the pulmonary evaluation and to participate in depositions and/or other forms of cross-examination. The Department intends to provide physicians with compensation at the rates prevailing in their communities for performing similar services. Information available to the Department, for example, indicates that, as of June, 1999, the West Virginia Occupational Pneumoconiosis Board paid facilities $270.43 per claimant for performing pulmonary testing, and paid physicians $300 per hour for testifying before administrative law judges. The survey of clinics and facilities which the Department will conduct while this notice is open for public comment will also solicit information on the fees needed to attract highly qualified physicians to perform the testing and evaluation required by the Department.

The Department recognizes that this proposed revision would significantly change the manner in which it administers the complete pulmonary evaluation required by the Black Lung Benefits Act. By raising the quality of these evaluations, the Department hopes to provide each miner with the best possible medical assessment of his respiratory and pulmonary condition early in the processing of his application. Where a miner meets the Department's eligibility standards, the higher quality evidence produced by these evaluations will further Congress's intent that miners be given an opportunity to substantiate their claims. In the case of miners who do not meet those standards, the increased credibility of the initial pulmonary evaluation may reduce litigation before the Office of Administrative Law Judges, the Benefits Review Board, and the federal appellate courts.

The Department is aware of difficulties that claimants may encounter in generating legally sufficient medical evidence in support of their applications. Two commenters state that claimants must be given the right to select the physician who performs the complete pulmonary evaluation because they often cannot afford to obtain their own medical evidence. Developing medical evidence relevant to the evaluation of a claimant's respiratory and pulmonary condition, including the objective medical testing required by the Department's quality standards, § 718.104, can involve costs that are beyond the reach of some claimants. Accordingly, the Department proposes to add a provision (subsection (d)) requiring the district director to inform the claimant that he may have the results of the Department's initial objective testing sent to his treating physician for use in the preparation of a medical report that complies with the Department's quality standards. Such objective test results would include a chest X-ray reading, § 718.104(a)(5), the results of a pulmonary function test, § 718.104(a)(1), and the results of an electrocardiogram, blood gas studies, and other blood analyses, if conducted, § 718.104(b). In addition, the district director will inform the claimant that, if submitted, a report from his treating physician will count as one of the two reports that he is entitled to submit under § 725.414, and that he may wish to seek advice, from a lawyer or other qualified representative, before requesting his treating physician to supply such a report. By providing the miner's treating physician with the results of objective testing that the miner might not otherwise be able to obtain, the Department will assist claimants who may not be able to afford to pay for a complete pulmonary evaluation on their own.

(b) Two commenters state that the Department should impose limitations on the district director's ability to clarify ''unresolved medical issues'' under subsection (e). Both suggest that the district director should be required to ask the physician who performed the complete pulmonary evaluation whether he is aware of unresolved issues, and both commenters also object to any attempt on the part of the district director to question the credibility of the medical evidence obtained as part of the complete pulmonary evaluation. The Department does not agree. District directors must be allowed considerable discretion in fulfilling their responsibility to develop the medical evidence relevant to the claimant's respiratory and pulmonary condition. They must develop complete evidence of the best possible quality to allow them an adequate evidentiary basis to determine whether the claimant is initially entitled to benefits. Limiting district director discretion in the manner suggested by the commenters could result in evaluating a miner's entitlement with medical evidence that is neither complete nor credible. If the district director selects a different physician or facility to re-examine the miner under subsection (e), however, he will be limited to selecting that physician or facility from the same list available to the claimant. The district director may use a physician who is not on the approved list only under subsection (c), which allows the district director to seek a review of objective testing. For example, this provision allows a district director to have a chest X-ray reread by a qualified radiologist who meets the requirements for a ''B'' reader, *see* 20 CFR 718.202(a)(1)(ii)(E), but who is not qualified to perform a complete pulmonary evaluation. The Department also notes that the district director's use of the authority granted by subsection (e) should decrease under the revisions proposed in this notice. Under this proposal, the district director will be seeking an initial evaluation from a qualified physician with the ability to perform a complete evaluation in a timely manner, and likely will not have to seek a miner reexamination as provided by subsection (e). Finally, the Department has added language to subsection (e) to clarify that any additional report obtained by the district director shall not count against the limits on medical evidence imposed on parties other than the Director by § 725.414. Instead, where the district director requests merely that the

physician supplement his original report, the supplement shall be considered a part of that original report. Where the district director orders additional tests, however, the previous tests may not be admitted into the record at the hearing.

(c) Two commenters object to the contents of subsection (d), as originally proposed, now in subsection (c), which outlines the Department's obligation to evaluate each examination and objective test performed as part of the Department's section 413(b) pulmonary evaluation. The subsection allows the Department to determine whether all parts of the section 413(b) examination are in substantial compliance with the Department's quality standards. The Department's original proposal authorized the district director to seek additional tests where substantial compliance was lacking, except where the deficiencies in the testing were the result of a lack of effort on the part of the miner. The commenters argue that a miner whose test is considered invalid due to a lack of effort should be given an additional opportunity to obtain satisfactory results. The Department agrees. A number of factors may influence a miner's lack of effort on objective testing, including a failure to fully understand the test procedures. Accordingly, the Department proposes to revise this subsection to afford such miners one additional opportunity to produce results in compliance with the quality standards.

(d) Several comments argue that the Department should not provide complete pulmonary evaluations if the claim represents a request for modification or a subsequent claim. The Department does not provide an additional pulmonary evaluation if a claim is filed within one year of the date on which the claimant's previous application was finally denied. In such cases, the application is treated as a request for modification, *see Fireman's Fund Insurance Co.* v. *Bergeron*, 493 F.2d 545, 547 (5th Cir.1974), and has the effect of extending the processing and adjudication of the original claim. The Department has already satisfied its responsibilities under section 413(b) with respect to that claim, and does not provide an additional evaluation. By contrast, a subsequent claim is an entirely new assertion of entitlement to benefits, which covers a later period of time and is limited only by the requirement that the parties must accept as final the outcome of any earlier claims filed by the claimant. In such a case, the Department believes that section 413(b) requires that the claimant receive a new evaluation of his respiratory and pulmonary condition.

(e) The Department has made several technical changes to the language of proposed subsection (e) to make that provision easier to read.

20 CFR 725.407

(a) The Department has proposed to revise section 725.409 to require administrative law judges to remand cases in which they reverse a district director's determination that a claim should be denied by reason of abandonment. Because these cases will be returned to the district director for further administrative processing, the Department has revised section 725.407(d) to ensure that the district director retains the authority to notify additional potentially liable operators under such circumstances. Absent this revision, subsection (d) could have been read to prohibit further notification of operators on remand.

(b) One comment suggests that the Department provide guidelines limiting the circumstances under which it can identify more than one potentially liable operator in a claim. The commenter questions the Department's need to name multiple potentially liable operators in every case, citing the increased litigation costs which will be incurred by the operators named. The Department does not intend to name multiple operators in every case. The Department also does not believe, however, that guidelines are appropriate. A dispute over the identity of a liable responsible operator may present a variety of issues, such as the financial assets of a miner's employers, whether the claimant was employed as ''miner,'' and the consequences of various successor operator transactions. The Department's purpose is to ensure that liability for a miner's black lung benefits is borne by a miner's previous employer to the maximum extent possible. In light of the wide range of potential issues surrounding the naming of a responsible operator, the Department does not believe that guidelines are feasible.

(c) One comment supports this proposal, provided that when multiple potentially liable operators are named, they are collectively subject to the same limits on the quantity of documentary medical evidence as a single operator may submit. The Department has retained and applied the same limitation on the amount of documentary medical evidence that may be submitted in cases involving either one or multiple potentially liable operators. § 725.414(a)(3)(i), (ii). Two other comments offer similar support for the Department's proposal.

20 CFR 725.408

(a) Several comments suggest that the time allowed for submitting evidence regarding the identity of the responsible operator should be expanded, and that the Department should incorporate some provision for submitting later discovered evidence. Another comment similarly argues that the time frames in the proposed rules are unrealistic in light of the difficulties in obtaining necessary evidence. The comment points out that by the time miners file applications for benefits, their former employers may no longer be in operation, and necessary personnel records may have been lost, destroyed, or put into storage. At the Washington, D.C. hearing, representatives of the insurance and claims servicing industries suggested that the Department needed to provide more time, perhaps up to a year, within which to develop this evidence. Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), pp. 190 (testimony of Margo Hoovel), 193 (testimony of Betsy Sellers).

The Department appreciates the difficulty which may be faced by the insurance and claims servicing industries in developing employment information. Accordingly, the Department has extended the time under § 725.408 within which an operator must submit evidence from 60 days to 90 days following its receipt of notice of a claim pursuant to § 725.407. Because the Department hopes to streamline the processing and adjudication of claims for benefits under the Act, the Department declines to make this period longer. A longer time period could result in significant delays in the adjudication of an applicant's entitlement to benefits. Moreover, many applications for benefits under the Act are filed within a relatively short period of time after the miner leaves coal mine employment. In fact, one comment received on behalf of several coal companies indicated that the 60-day time limitation was inadequate only in the minority of cases. Finally, in cases in which even the 90-day period may not afford a potentially liable operator sufficient time to obtain employment evidence, this time period may be extended for good cause pursuant to the general authority for extensions of time contained in proposed § 725.423.

(b) One comment objects to the Department's proposal on the ground that it would require operator development of evidence in non-

meritorious claims. The Department recognizes that coal mine operators may currently ignore most claims of which they receive notice, because many claimants do not proceed after receiving an initial denial of benefits. The Department has been severely handicapped by this practice, however, because it did not know operators' positions with respect to their potential liability for benefits in cases that did proceed, and the Department was therefore unable to develop responsive evidence. See 62 FR 3355–3356 (Jan. 22, 1997) (discussing the proposed revision of section 725.408 set forth in the Department's previous notice of proposed rulemaking). The Department does not believe that it places an undue burden on potentially liable operators to request certain information at this early stage. The proposal would require them to submit only information regarding their status as a coal mine operator, their employment of the miner and their financial capacity to pay benefits. Contrary to the understanding of some commenters, information relevant to the identity of other potentially liable responsible operators need not be developed until after the issuance of an initial finding of the claimant's eligibility or, if the district director finds that the claimant is not eligible for benefits, after the claimant indicates his dissatisfaction with that result. Consequently, the Department does not believe that requiring the submission of a limited amount of evidence in every case would significantly increase the burden on coal mine operators.

(c) Several comments suggest that the Department provide a bifurcated hearing process to allow administrative law judges to resolve responsible operator issues prior to hearing the merits of entitlement. Although a bifurcated hearing would produce initial fact-finding on the issue, the Department cannot eliminate the possibility that an aggrieved party might appeal the ALJ's decision to the Benefits Review Board and the appropriate court of appeals. If the regulations authorized an immediate appeal of the responsible operator issue, there would be a substantial likelihood of significant delay in the adjudication of the claimant's entitlement. If, on the other hand, coal mine operators could appeal their responsible operator status only after an award of benefits, the proposed suggestion would not accomplish its purpose; the Department would still be required to keep each potentially liable operator as a party to the case to protect the Black Lung Disability Trust Fund in the event the liability determination was overturned on appeal. The Department thus cannot fashion a process which bifurcates the issues of liability and entitlement, but nevertheless serves the Department's purpose of ensuring a prompt adjudication of claimant entitlement involving all potentially liable parties.

20 CFR 725.409

(a) Several comments argue that the penalty for a claimant's failure to attend an informal conference without good cause, denial of the claim, is disproportionately harsh in comparison with the penalty imposed on an employer, waiver of the right to contest potential liability for an award. *See* § 725.416(c). The Department agrees that the proposed regulation may impose severe consequences on a claimant who fails to attend a scheduled informal conference without good cause. Unlike the situation involving potentially liable operators, however, the statute constrains the Department's ability to impose lesser sanctions on claimants. Requiring an operator to concede one of the issues being contested, such as its status as a responsible operator, limits that operator's ability to contest the claim without entirely foreclosing it. Requiring a claimant to concede an issue, however, is usually tantamount to a denial of benefits. The Department believes that a denial by reason of abandonment represents the only valid sanction for a claimant's failure to participate at each stage of the claims adjudication process, including the informal conference.

The Department could adjust the disproportionate effect of the penalty by imposing an equally severe sanction on an employer who fails to attend an informal conference without good cause. In general, however, the Department would prefer not to finally resolve a claim for benefits based solely on a party's failure to attend an informal conference. Where such a sanction is the only one available, as is the case with claimants, the Department has no alternative. In order to mitigate the disparity, however, and in recognition of the fact that, as several commenters point out, most claimants are unrepresented at this point in the proceedings, the Department proposes to add a new subsection, requiring the district director to affirmatively request that the claimant explain why he failed to attend the conference, and to evaluate the claimant's explanation in light of the claimant's age, education, and health as well as the distance of the conference from his residence. Elsewhere in this proposal, see proposed revisions to § 725.416, the Department has further required the district director to explain why he believes that an informal conference would assist in the voluntary resolution of issues in the case. The Department hopes that these revisions will lead to a better understanding of the informal conference process on the part of all parties, and that unjustified absences will be unusual.

(b) One comment urges that, in any case in which an administrative law judge finds that the district director erred in denying the claim by reason of abandonment, he should have the discretion to proceed to adjudicate the merits of the claimant's entitlement. The Department does not agree. A claim may be denied by reason of abandonment at several stages during the initial processing of that claim. For example, a claimant's unjustified failure to attend the required medical examination scheduled by the Department may result in a denial by reason of abandonment. At this stage, none of the evidence regarding issues such as potential operator liability would be in the administrative record, and it would be inappropriate for the administrative law judge to adjudicate the claim on its merits. Even when administrative processing is substantially complete before issuance of a denial by reason of abandonment, such as when a claimant refuses to attend an informal conference, a conference may nevertheless be appropriate. For example, the conference provides the district director with a final opportunity to question the claimant concerning his coal mine employment, and thus to ensure that all potentially liable operators are identified before the case is referred for a formal hearing on the merits. A conference also allows the district director to ensure that the claimant understands the requirements for establishing his entitlement to benefits. Consequently, the Department has added a sentence to subsection (c) to clarify the intent of the regulation and require that an administrative law judge remand a claim to a district director even if he finds that the district director erred in denying the claim by reason of abandonment.

(c) One comment suggests that the proposal will result in the filing of additional claims by applicants whose previous claims were denied by reason of abandonment. The Department does not believe that authorizing the dismissal of a claim based on the applicant's unexcused failure to attend an informal conference will result in a significant number of additional filings. In the Department's experience, the vast majority of informal conferences are attended by representatives of both parties. As a result, the authority set

forth in this section is not apt to be invoked frequently. The Department also believes, however, that the consequences of a claimant's unexcused failure to attend should be clearly explained. The commenter also states that the dismissal of a claim imposes additional burdens and costs on parties to the claim other than the claimant. Although this observation may be true when a claimant does file an additional claim, or further litigates the abandonment finding, the failure of one party to attend an informal conference also imposes significant costs on the parties who did attend and on the Department, whose officials scheduled the conference and set aside the time necessary to hold it. In order to reduce the possibility of needlessly incurring these costs, the Department has proposed a sanction which should ensure that all parties attend an informal conference that has been scheduled in accordance with § 725.416.

20 CFR 725.411

(a) Although the Department is not proposing any further revision to § 725.411, the Department wants interested parties to be aware that it intends to substantially rewrite the documents it uses in connection with an initial finding under § 725.411, in particular to assist unrepresented claimants who are denied benefits. The new letter will contain a detailed explanation, in clear language, of why the evidence developed up to that point fails to establish all of the necessary elements of entitlement. Revision of the initial finding letter is an important part of the Department's commitment to improve the quality of the information it provides parties to the adjudication of claims for black lung benefits. The Department hopes that this improved communication will accomplish two goals: (1) to make the processing of black lung claims by the Department's district offices easier to understand; and (2) to give claimants a clear picture of the medical evidence developed in connection with their claims so that they are able to make more informed decisions as to how to proceed.

(b)(i) Four comments express concern that subsection (a) prohibits treating a claimant's request for a hearing before an administrative law judge as a ''request for further adjudication'' if made within one year of the denial of a claim. The Department disagrees with this interpretation. The proposed regulation states explicitly that any expression of an intent to pursue a denied claim amounts to a ''request for further adjudication.'' An untimely hearing request would constitute a valid request for further adjudication by the district director.

(ii) Three comments also state that a claimant who responds to a denial by requesting a hearing should receive one. Paragraph (a) only precludes the claimant from receiving the hearing immediately as the next stage in the adjudication of the claim. Having invoked a continuation of the claims process by requesting ''further adjudication,'' the claimant must wait for the district director to issue a proposed decision and order. Once the district director issues such a decision, the claimant may pursue any available remedies, including a hearing, with an appropriate request. By invalidating premature hearing requests, the Department intends to ensure the orderly adjudication of claims through each sequential step in the process, and avoid the uncertainty engendered by case law such as *Plesh* v. *Director, OWCP*, 71 F.3d 103 (3d Cir. 1995) (holding that claimant's hearing request made before district director completed processing of claim and issued decision must nevertheless be honored after decision was issued, although not renewed by claimant). The Department has therefore made explicit that a hearing request is effective only when made within 30 days after the district director issues a proposed decision and order under § 725.419(a) or a denial by reason of abandonment under § 725.409(b). Any premature request will be ineffective as a request for a hearing before an administrative law judge.

(c) One comment contends the one-year period for requesting further adjudication in subsection (a) represents an impermissible extension of the one-year period for seeking modification of a claim under § 725.310 and § 922 of the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 922, as incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a). The commenter contends a claimant would have one year under paragraph (a) to request further adjudication of a denied claim, and one additional year to request modification of the claim. This interpretation, in effect, treats the two types of proceedings as mutually exclusive. The Department rejects this contention because it misinterprets the operation of, and relationship between, §§ 725.411 and 725.310.

Under modification, a claimant who has been denied benefits has one year in which to reopen the denied claim. The generally recognized standard for invoking the modification process is an intent to pursue the claim. *See generally Eifler* v. *Director, OWCP*, 926 F.2d 663, 667 (7th Cir. 1991). In its initial notice of proposed rulemaking, the Department explained at length that the one-year period for responding to a denial of benefits under § 725.411 merely reflects an incorporation of the one-year period for requesting modification. 62 FR 3356 (Jan. 22, 1997). By eliminating the hierarchy of response times in the current regulations, the Department has simplified the adjudication procedures for claimants. Under the current regulations, a claimant has 30 days, 60 days or one year in which to pursue a claim after the denial, depending on the type of decision and the options available. Proposed § 725.411 would replace this process with a single time period (one year) and a single action which the claimant may take: by indicating any intent to pursue the claim within one year, the claimant reopens the adjudication process and receives a new decision (a proposed decision and order) based on new evidence (if proffered) or reconsideration of the existing record. If the claimant is dissatisfied with that decision, (s)he may request a hearing before an administrative law judge. If, however, the claimant takes no action within one year of a denial, then the claim is finally denied and not subject to modification. The regulations specifically state that any submission by the claimant after the one-year time limit in § 725.411(a)(1)(i) will be treated as an intent to file a subsequent claim. *See* §§ 725.411(a)(1)(ii), 725.309. Consequently, § 725.411 does not violate the one-year modification period or expand the right of a claimant to reopen a denied claim.

(d) One comment offered in connection with proposed § 725.423 recommends permitting extension of the one-year period for requesting further adjudication in paragraph (a)(1)(i). The Department addressed this idea in its initial notice of proposed rulemaking. 62 FR 3361 (Jan. 22, 1997). The Department concluded that allowing an extension of the one-year period would not be appropriate because one year is an adequate response period, and any response within that period demonstrating an intent to pursue a claim is sufficient to reactivate the adjudication process. For those reasons, no change has been proposed in response to this comment.

20 CFR 725.414

(a) Numerous commenters criticized the Department's initial proposal which required the parties to submit all documentary medical evidence to the district director in the absence of extraordinary circumstances. A number

of commenters observed that claimants often are unable to obtain legal representation until after a case is referred to the Office of Administrative Law Judges. Thus, under the initial proposal, a claimant would often be making critical evidentiary decisions without the benefit of counsel. These commenters also stated that a miner should not be required to undergo five medical examinations (the section 413(b) pulmonary evaluation and the two examinations permitted each side) within the relatively short period from the date the claim is filed to the district director's conclusion of administrative processing. Other commenters stated that the Department's proposal would significantly increase operators' litigation costs by requiring them to develop medical evidence in all cases. Currently, operators have no need to develop medical evidence in cases in which the claimant does not take further action after the district director issues an initial denial of benefits. Statistics maintained by the Department indicate that in more than 60 percent of the black lung claims filed, adjudication ceases after a district director's decision.

The Department agrees that the required submission of all documentary medical evidence to the district director should be revised in light of the many valid objections received. Accordingly, the Department proposes instead to retain the current process for submitting documentary medical evidence into the record. Under this proposal, parties may continue to submit documentary medical evidence to the district director in accordance with the schedule issued under § 725.413. To the extent that those submissions do not reach the numerical limitations imposed on each side by § 725.414, the parties may submit additional documentary medical evidence into the record up to 20 days before an ALJ hearing, and even thereafter, if good cause is shown. The only other limitation on the submission of documentary medical evidence to the administrative law judge is found in the current regulations. The Department proposes to add subsection (e) to the revised version of this section in order to retain the requirement, set forth in the Department's current regulations at 20 CFR 725.414(e), that parties may not withhold evidence they develop while a case is pending before the district director. Such evidence will be admissible in further proceedings only if the party establishes extraordinary circumstances or obtains the consent of the other parties to the claim. *See Doss* v. *Director*, OWCP, 53 F.3d 654, 658 (4th Cir. 1995).

Although the Department now proposes to allow the submission of new documentary medical evidence while a case is pending before the Office of Administrative Law Judges, it has not altered the proposal with respect to the required submission to the district director of all evidence relating to potentially liable operators and the responsible operator. The Department explained in its previous notice of proposed rulemaking that this requirement is intended to provide the district director with all of the evidence relevant to the identification of the responsible operator liable for the payment of benefits, in the absence of extraordinary circumstances. 62 FR 3355–3356 (Jan. 22, 1997). The proposal was intended to accomodate two interests that may conflict in some cases: a claimant's interest in the prompt adjudication of his entitlement; and the Department's interest in protecting the Black Lung Disability Trust Fund from unwarranted liability. Under the Department's current regulations, the Director, OWCP, may seek to have a case remanded from the Office of Administrative Law Judges where evidence not previously submitted to the district director suggests that liability for a claim should be imposed on an operator that was not notified of its potential liability. Such remands necessarily delay the adjudication of the claimant's entitlement to benefits. Under the Department's proposed revision, the Director may not seek, and an Administrative Law Judge may not order, remand of a case to the district director's office in order to identify additional potentially liable operators. If the Department has failed to notify the correct operator of at least its potential liability, the Black Lung Disability Trust Fund will pay the claimant's benefits in the event of an award. The Department thus assumes the risk that its initial operator identification is flawed. This risk can be justified only if the Department is able to require the early submission of evidence relevant to the responsible operator issue.

Under proposed § 725.408, a potentially liable operator identified by the district director has 90 days from the date on which it is notified of that identification to submit evidence demonstrating that it does not meet the § 725.494 definition of a potentially liable operator with respect to a claim. For example, a potentially liable operator may submit evidence demonstrating that it did not employ the miner for at least one year, or that it was not an operator for any period after June 30, 1973. Following the district director's issuance of an initial finding, and a decision by a party aggrieved by that finding to seek further review, the operator designated as the responsible operator must develop and submit any evidence needed to support a contention that it is not the responsible operator liable pursuant to § 725.495 for the benefits payable to the claimant. This evidence, showing, for example, that a more recent employer should be liable for benefits, must be submitted to the district director in accordance with the schedule established under § 725.413. An administrative law judge may admit additional evidence on any issue regarding either potentially liable operators or the responsible operator only if the party submitting the evidence demonstrates extraordinary circumstances justifying its admission. The Department has also proposed revising subsection (c) to extend the extraordinary circumstances exception to testimony regarding such issues by a witness whose identity was not disclosed to the district director.

(b) Several commenters request that the Department further define a number of terms used in the initial proposal, such as ''rebuttal evidence,'' ''consultative report,'' and ''interpretive opinion.'' The Department agrees that some of the terms used in the proposal were ambiguous, and believes that the regulation would better serve all interested parties by describing the applicable evidentiary limitations in terms of the evidence needed to establish a claimant's entitlement to benefits under §§ 718.202 and 718.204. Accordingly, the Department is proposing extensive revisions to this section to ensure that the intended evidentiary limitations are clearly defined. Each party may submit two chest X-ray interpretations (of the same X-ray or two different X-rays, at the option of the party), the results of two pulmonary function tests and two arterial blood gas studies, and two medical reports. The medical reports may include a review of any other evidence of record. Each party may also submit one piece of evidence in rebuttal of each piece of evidence submitted by the opposing party, and may submit one piece of evidence challenging each component of the Department's complete pulmonary evaluation authorized by § 725.406. Thus, a party may have each chest X-ray submitted by the opposing party reread once, and may submit one report challenging the validity of each pulmonary function study or blood gas test submitted by the opposing party. In addition, one

commenter asked that the Department permit a party to rehabilitate evidence that has been the subject of rebuttal by the opposing party. For example, where a party submits a physician's opinion stating that the results of a pulmonary function study are invalid because the miner expended less than maximal effort in performing the test, the party submitting the test should be able to introduce a contrary statement from the physician who administered it. The Department agrees, and has revised paragraphs (a)(2)(ii) and (a)(3)(ii) accordingly.

(c) A large number of commenters favor the proposed limitation on the quantity of medical evidence each side may submit. A number of other commenters object to the proposed limitation on the amount of medical evidence. They argue: (1) That the limitation is unnecessary; (2) that the exclusion of evidence will decrease the quality of factfinding under the Black Lung Benefits Act; (3) that the limitation violates section 413(b) of the Act, 30 U.S.C. 923(b); (4) that the limitation violates the Administrative Procedure Act, 5 U.S.C. 551 et seq.; and (5) that the limitation violates employers' due process rights. The Department anticipated most of these criticisms in the explanation of § 725.414 contained in its initial notice of proposed rulemaking, 62 FR 3356–61 (Jan. 22, 1997), and the arguments advanced by the commenters provide no basis upon which to alter the regulation's proposed limitation as to the quantity of admissible evidence.

The Department continues to believe that the limitation represents a reasonable means of focusing the fact-finder's attention on the quality of the medical evidence in the record before him. In particular, the limitation ensures that the claimant will undergo no more than five pulmonary evaluations (two claimant evaluations, two responsible operator evaluations, and the initial pulmonary evaluation provided by the Department under 30 U.S.C. 923(b)) for purposes of assessing claimant's entitlement to benefits. In light of the strenuous nature of pulmonary testing, including both pulmonary function tests and arterial blood gas tests, no claimant should have to undergo repeated evaluations simply to create a numerically superior evidentiary record for one side or the other. Instead, five evaluations should be sufficient in most cases to allow the fact-finder to assess the miner's pulmonary condition. In the Department's view, additional evaluations would be of only marginal utility.

The Department's initial notice did not explicitly address, however, the extent to which a party's due process rights might be compromised by the Department's limitation on the amount of evidence that party may submit. The due process clause of the Fifth Amendment of the Constitution precludes governmental deprivations of life, liberty, or property without due process of law. Due process ''is not a technical conception with a fixed content unrelated to time, place and circumstances,'' but rather, a ''flexible'' doctrine that requires ''such procedural protections as the particular situation demands.'' *Mathews* v. *Eldridge,* 424 U.S. 319, 334 (1976). At a minimum, it requires an opportunity to be heard ''at a meaningful time and in a meaningful manner.'' *Id.* at 333. A meaningful administrative hearing does not require the ''wholesale transplantation'' of judicial rules and procedures. *Id.* at 348. Nonetheless, the judicial model is a guide for assuring ''fairness.'' *Id.* In the end, due process cases turn on ''the procedure's integrity and fundamental fairness.'' *Richardson* v. *Perales,* 402 U.S. 389, 410 (1971).

In determining whether an administrative practice satisfies due process, the courts balance three distinct factors:

> the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Mathews, 424 U.S. at 335.

The Department recognizes that both operators and claimants have significant, albeit competing, private interests at stake. Operators and their insurers have a monetary interest in each claim (involving an average payout over the life of the claimant of $175,000) and an interest in not being required to pay benefits in nonmeritorious cases. Claimants, on the other hand, are interested in the financial benefit of an award and in the opportunity to substantiate their claims without being overwhelmed by the superior economic resources of their adversaries.

As a general rule, the Department does not believe that there is a significant risk of the erroneous deprivation of private interests on either side if both the claimant and the party opposing entitlement are subject to similar limitations on the quantity of the evidence that they may develop. Applicants with non-meritorious claims will find it difficult to generate two favorable medical reports, accompanied by supportive objective testing, from well-credentialed physicians. Faced with well-documented reports from an equal number of physicians retained by operators and their insurers, claimants will be unable to meet their burden of establishing each element of entitlement. Consequently, there is no increased risk of an erroneous deprivation of the interests of parties opposing entitlement. Similarly, the Department does not believe that the proposed evidentiary limitations will result in the denial of meritorious claims that are currently being awarded. Awards are typically issued in cases containing qualifying objective testing, or a reasoned and documented medical report by a physician with in-depth knowledge of both the miner's respiratory and pulmonary condition and the exertional requirements of the miner's usual coal mine work. Moreover, the overwhelming support for this proposal from claimant groups and attorneys suggests that they also do not believe that it will erroneously deprive meritorious claimants of benefit awards.

In order to allow for the more careful consideration of the unique facts and circumstances of each case, however, and to provide an additional procedural safeguard, the Department has revised § 725.456 as initially proposed to permit an administrative law judge to admit medical evidence into the record in excess of the limits outlined in § 725.414 upon a showing of good cause. The Department's prior proposal would have permitted the admission of such evidence only if a moving party could demonstrate extraordinary circumstances. By adopting the more permissive good cause standard, the Department recognizes that a rigid rule prohibiting additional evidence may increase the risk of an erroneous deprivation of private interests in particular cases. For example, one commenter states that hearings in the Western states are frequently rescheduled due to weather conditions and rescheduling requests of the parties. In light of the time which elapses between the hearing request and the actual hearing, and the progressive nature of pneumoconiosis, the commenter argues that parties must be able to obtain and submit into the record more recent medical evidence. The commenter suggests that if a party has already submitted the maximum amount of evidence long before a case is heard, the record will be devoid of any evidence regarding the miner's

current medical condition. The Department agrees that in such a case, an administrative law judge may authorize the development of additional medical evidence in a manner that is equitable to all parties. Thus, to the extent that the evidentiary limits might heighten the risk of the erroneous deprivation of a private interest, the Department seeks to limit that result by allowing the submission of additional medical evidence upon a showing of good cause.

The Department continues to believe that the amount of medical evidence admissible under this provision will generally be adequate to guarantee a full and fair adjudication of the miner's entitlement to benefits. The government also has an interest in maintaining that guarantee, and in improving the public's perception of the fairness of the process. The government's interest represents the third factor to be balanced under the Supreme Court's due process analysis. The additional flexibility contained in the Department's revised proposal, requiring that a party seeking to submit additional medical evidence in any individual case must establish good cause justifying its admission, will not impair the government's interest. Moreover, the Department's proposal will provide additional safeguards to ensure that the adjudication process properly balances the interests of all parties to a black lung claim. Accordingly, the Department does not believe that the evidentiary limitations contained in this provision will be considered a violation of the due process clause.

(d) One comment objects to the Department's proposal to limit claimants' travel for responsible operator testing and/or examination to 100 miles from their homes. The Department's initial proposal contained the same restriction as does its current regulation (current 20 CFR 725.414(a); proposed § 725.414(a)(3)(i), limiting the ability of coal mine operators to compel miners to travel more than 100 miles to undergo an evaluation). The commenter argues that such a travel restriction on operators is not justified absent a comparable restriction on claimants. The Department does not believe that it would be appropriate to impose such a limitation on miners. The Department's proposed revision to § 725.406, however, allows a miner to select the physician or facility to perform the complete pulmonary evaluation guaranteed under section 413(b) of the Act, 30 U.S.C. 923(b), from among authorized physicians or facilities in the state of his residence or any contiguous state. The limitation in the current regulations and the Department's initial proposal was intended to ensure that a coal mine operator not be able to subject a miner to undue hardship in traveling to the site of a physical examination. Where the miner selects a facility or physician more than 100 miles from his residence, however, he has demonstrated his willingness to undertake additional travel. In such cases, absent a change in the miner's health, the designated responsible operator should be entitled to compel the miner to travel an equivalent distance. Where the miner selects a physician within a 100-mile radius of his residence, the original rule should remain in effect. In order to effectuate these changes, the Department proposes revising subsection (a)(3)(i).

(e) Several comments have asked the Department to alter the evidentiary limitations set forth in this section. One commenter urges the Department to exempt the report of a claimant's treating physician from the limitations while another feels that one examination per side is adequate. Another commenter suggests that the Department permit the responsible operator to submit only as much evidence as the claimant submits, thus allowing the claimant to determine the size of the evidentiary record. A fourth commenter suggests limiting responsible operators to no more than one medical report authored by a physician who examined the miner. The Department does not believe that any of these suggestions would be appropriate. The evidentiary limitations should not be skewed to allow one party to submit more evidence than another, or evidence of a different quality. Instead, each party must remain free to tailor the presentation of its case to the facts while functioning within the same evidentiary limitations applicable to other parties. The Department also notes that, to the extent these suggestions are based on a well-founded concern over requiring the miner to undergo up to five physical examinations within a short time, a specific concern of one commenter, the Department's proposal allowing parties to submit evidence to the OALJ will extend the period within which the parties may seek to have the miner examined.

(f) One commenter urges the Department to allow a physician who prepared a medical report to rely on the opinion of the miner's treating physician in the course of preparing his report. The Department's proposal permits physicians to consider other physicians' opinions only if the medical reports of those physicians are independently admitted into the record in accordance with the regulation's evidentiary limitations. In addition, physicians preparing medical reports may rely on any treatment or hospitalization record that is admitted into the record under subsection (a)(4). The Department does not believe, however, that the regulations need contain any special treatment of the opinion of a miner's treating physician other than is provided in § 718.104(d).

(g) The Department has revised subsection (c) in order to clarify its intent and prevent parties from exceeding the evidentiary limitations by designating additional physicians as hearing witnesses. As revised, subsection (c) will permit testimony, either at the formal hearing or by deposition, by physicians who prepared medical reports. Other physicians may testify only to the extent that the party offering their testimony has not reached the limitation imposed by the regulation on the number of admissible medical reports, or if the administrative law judge finds good cause for allowing a party to exceed that limitation. In effect, testimony by a physician who did not prepare a documentary report will be considered a medical report for purposes of the evidentiary limitations. Thus, if a party has submitted only one documentary medical report, it may offer the testimony of one additional physician. If a party has not submitted any documentary medical reports, it may offer the testimony of two physicians.

(h) Several commenters believe that each potentially liable operator should be entitled to obtain its own medical evidence. In its initial notice of proposed rulemaking, the Department explained that the limitation on the submission of medical evidence in cases involving more than one potentially liable operator is necessary to ensure that claimants are not subject to multiple examinations simply because they have an employment history that leaves the identity of the responsible operator in some doubt. 62 FR 3360–61 (Jan. 22, 1997). The comments offer no basis upon which to revise this provision. One comment supports the Department's proposal as in accord with the Federal Judicial Center's *Manual for Complex Litigation, 3d* (1995), § 20.22–20.222. Another comment states that district directors should never permit a potentially liable operator, other than the designated responsible operator, to submit evidence. The Department disagrees. Even in multiple operator cases, the proposed regulations allow all of the potentially liable operators to collectively submit no more evidence than that permitted the claimant. In the

event the designated responsible operator fails to develop the evidence, however, the district director must have the authority to permit the submission of medical evidence by another potentially liable party. Ultimately, of course, it will be the responsibility of the administrative law judge to ensure that the adjudication of the miner's entitlement is fair.

(i) Several commenters generally request the Department to clarify the admissibility of hospital records, and the results of autopsies and biopsies as proposed in § 725.414(a)(4). The Department believes that proposed subsection (a)(4) would require the admission of any medical record relating to the miner's respiratory or pulmonary condition without regard to the limitations set forth elsewhere in § 725.414. To be sufficient to establish an element of entitlement, however, a report of autopsy or biopsy must substantially comply with the applicable quality standards, § 718.106. *See* § 718.101(b). The Department has not included an independent provision governing rebuttal of this evidence. As a general rule, this evidence is not developed in connection with a party's affirmative case for or against entitlement, and therefore the Department does not believe that independent rebuttal provisions are appropriate. Any evidence that predates the miner's claim for benefits may be addressed in the two medical reports permitted each side by the regulation. If additional evidence is generated as the result of a hospitalization or treatment that takes place after the parties have completed their evidentiary submission, the ALJ has the discretion to permit the development of additional evidence under the ''good cause'' provision of § 725.456.

20 CFR 725.416

A number of commenters, including representatives of claimants, coal mine operators and their insurers, urge the Department to eliminate informal conferences altogether. They argue that informal conferences seldom accomplish any purpose, and thus waste considerable time and resources. The Department disagrees. In the explanation of § 725.416 that appeared in its initial notice of proposed rulemaking, 62 FR 3361 (Jan. 22, 1997), the Department explained that informal conferences serve a variety of useful purposes, including narrowing issues, achieving stipulations, and crystallizing positions. The comments received by the Department provide no reason to alter this view. In order to increase acceptance of the informal conference procedure, however, the Department believes that the district director should be able to articulate, in each case, why he believes that an informal conference would be helpful in the processing of the claim. Accordingly, the Department proposes to revise subsection (b) in order to require the district director to provide the parties with a statement articulating specific reasons why an informal conference would assist in the voluntary resolution of issues. The reasons must be tailored to the specific facts of that case. The district director's failure to include such a statement in his notification of conference will foreclose the use of sanctions set forth in paragraph (c). In addition, in order to reduce the parties' costs in participating in an informal conference, the Department proposes to formally recognize the district offices' current practice of allowing parties to participate by telephone in appropriate cases. Although the decision to allow telephone participation is committed to the discretion of the district director, the Department's regulations should explicitly acknowledge the availability of this option, and allow the parties to request its use by filing a request with the district director.

(b) One comment states that the proposed sanctions set forth in subsection (c) will lead to further litigation and/or refilings. The Department has previously addressed this comment. *See* discussion of § 725.409.

Subpart F

20 CFR 725.456

(a) The Department proposes to retain the current rules governing time periods for submitting documentary medical evidence into the record. A change has been made to paragraph (b)(1) to reflect this decision, and new paragraphs (b)(2)–(4) and (c) have been added to the proposal from the Department's current rules (20 CFR 725.456(b)(1)–(3), (c), (d)). These revisions are fully explained above.

(b) Paragraph (f) has been revised to take into account changes to section 725.406. Since the proposal would now require that the § 725.406 pulmonary evaluation be performed by a facility or physician selected from a list maintained by the Office, language in subsection (f) that contemplated examination and/or testing by a facility or physician not approved by the Office has been deleted. *See* discussion accompanying § 725.406.

(c) All of the comments related to the Department's proposed revision of § 725.456 are discussed under § 725.414.

20 CFR 725.457

(a) The Department has explained its proposal to retain the current rules governing the timely submission of medical evidence in connection with its explanation of changes to § 725.414. The § 725.414 revision requires a corresponding change in the rule governing the identification of witnesses in proceedings before the Office of Administrative Law Judges. The revised regulation allows the testimony of witnesses relevant to the liability of a potentially liable operator and/or the identification of the responsible operator only if the identity of that witness was disclosed to the district director or the administrative law judge finds extraordinary circumstances. A physician may testify only if he prepared a medical report admitted into the record by the district director or administrative law judge. Alternatively, a physician may testify if his testimony, when considered as a medical report, does not result in a violation of the limitations on the quantity of evidence permitted by § 725.414, or if the administrative law judge finds good cause for allowing the party offering the testimony to exceed those limitations.

(b) A number of commenters objected to the Department's proposal limiting the scope of a physician's testimony. They argued that physicians who testify must be allowed to address all of the medical evidence of record in order to explain their conclusions, and that cross-examination of those physicians will depend on reference to objective testing and medical conclusions contained in other reports. The Department agrees that the original proposal's limitation was inappropriate, and has revised paragraph (d) accordingly. As revised, the regulation will only prevent a physician from testifying with respect to medical evidence relevant to the miner's condition that is not admitted into the record.

20 CFR 725.459

One commenter suggests that the Black Lung Disability Trust Fund should be liable for witness fees incurred by an indigent claimant when cross-examining an adverse witness. Another commenter argues that the Department's original proposal, under which the party seeking to cross-examine a witness must pay the necessary fees to secure that witness, violates section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 928, as incorporated by 30 U.S.C. 932(a). Section 28 generally requires that employers pay the reasonable costs

of successful claimants. In light of these comments, the Department has reconsidered its approach to the payment of expenses associated with cross-examination.

The Department now proposes that the costs of cross-examination be borne by the party relying on the affirmative testimony of that witness. For example, where an employer submits a report by a physician, and the claimant seeks to summon the physician to the hearing for cross-examination, the employer must bear the costs of reimbursing its own physician. Under the regulation, the employer may request that the administrative law judge authorize a less intrusive method of cross-examination, including a deposition, telephone deposition, or interrogatories, provided that the method authorized will produce a full and true disclosure of the facts.

The only exception to this general rule is in the case of an indigent claimant. The Department agrees that a claimant's medical evidence should not be excluded based on a claimant's financial inability to make a physician available for cross-examination. Accordingly, the Department proposes to revise paragraph (b) to allow an administrative law judge to apportion the costs of cross-examination where the claimant demonstrates his indigence. The Department does not agree, however, that the trust fund may be held liable for such fees in every case. Although the statutory provision governing the disbursement of monies from the fund, 26 U.S.C. 9501, permits the fund to pay administrative expenses associated with the black lung benefits program, the Department does not believe that the expenses of cross-examination should necessarily be included in this category. Rather, the responsible operator seeking to cross-examine claimant's witness should bear liability for such fees, an expense which the operator may easily control. The fund will be liable for such witness fees in cases in which there is no coal mine operator liable for the payment of benefits. *See, e.g., Republic Steel Corp.* v. *U.S. Department of Labor,* 590 F.2d 77 (3d Cir. 1978) (holding the fund liable for the payment of attorney's fees because the fund, the party liable for the payment of claimant's benefits, stood in the shoes of a responsible operator). Accordingly, in a case in which the claimant is indigent and a party seeks to cross-examine a witness of claimant's, the administrative law judge must apportion the costs among the claimant and the party opposing the claimant's entitlement. Where that party is an operator, the operator may be asked to bear all or part of the costs of cross-examination, as appropriate. Where that party is the fund, the fund is subject to the same apportionment rules. In addition, the fund will bear liability for the costs of cross-examining the doctor who administered the section 413(b) pulmonary evaluation. *See* § 725.406.

The Department's proposal has several advantages. First, it avoids potential due process problems associated with the Department's previous proposal because no financial burden is placed on parties who wish to exercise their right to cross-examination except in the case of a claimant who is unable to pay the associated costs. At the same time, requiring the parties to show the necessity of a specific means of cross-examination, and allowing the administrative law judge to exercise sound discretion in addressing requests for cross-examination, protects witnesses from undue burdens and parties from undue expense. Under this proposal, operators would be required to bear the cost of witness fees only for their own witnesses, indigent claimants' witnesses, and for claimants who are ultimately successful in establishing their entitlement to benefits.

20 CFR 725.465

Section 725.465 sets forth the conditions under which an administrative law judge may dismiss a claim, and also authorizes the administrative law judge to dismiss a party who is not a proper party to the claim under § 725.360. The regulation was not among the provisions the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997), and the Department did not receive any comments directed to this section. The Department now proposes to revise this regulation, however, to ensure that all potentially liable operators remain parties to proceedings before the administrative law judge in the absence of the Director's agreement to their dismissal. In proposing new regulations governing the identification of responsible operators, the Department intends that all potentially liable operators named by the district director have the opportunity to participate in the adjudication of the claimant's entitlement both before the administrative law judge and on appeal. Thus, under this proposed change, even if an administrative law judge concludes that one of the potentially liable operators is the responsible operator as defined by Subpart G of Part 725, he may not dismiss the other potentially liable operators absent the Director's consent. In the event that his responsible operator finding is reversed or vacated by either the Benefits Review Board or a federal court of appeals, the dismissal of other potentially liable operators before or simultaneously with adjudication of the claimant's entitlement would adversely impact the financial interests of the Black Lung Disability Trust Fund. Given the absence of the correct potentially liable operator as a party to a case, liability might well be imposed on the fund, especially since the proposal prohibits the re-naming of potentially liable operators after a case is referred to the Office of Administrative Law Judges, § 725.407(d).

Subpart G

20 CFR 725.491

(a) One commenter objects to the Department's attempt to clarify the liability of independent contractors under the Black Lung Benefits Act. The commenter argues that in imposing liability on independent contractors who do not have a ''continuing presence'' at the mine, the Department is exceeding its statutory mandate. Specifically, the commenter objects to the Department's decision to codify the D.C. Circuit's decision in *Otis Elevator Co.* v. *Secretary of Labor,* 921 F.2d 1285 (D.C. Cir. 1990), instead of the Fourth Circuit's decision in *Old Dominion Power Co.* v. *Donovan,* 772 F.2d 92 (4th Cir. 1985). The Department has consistently advocated a broad interpretation of the statutory provision defining ''operator'' and its application to independent contractors, both in the context of litigation under subchapters 1 through 3 of the Federal Coal Mine Health and Safety Act and under the Black Lung Benefits Act. The D.C. Circuit accepted the Department's views in *Otis Elevator* while the Fourth Circuit rejected the Department's position in *Old Dominion Power.* In addition, while the Department was preparing its initial notice of proposed rulemaking, the Tenth Circuit announced its agreement with *Otis Elevator*: ''Although Congress may have been specially concerned with contractors who are engaged in the extraction process and who have a continuing presence at the mine, * * * section 3(d) by its terms is not limited to these contractors.'' *Joy Technologies* v. *Secretary of Labor,* 99 F.3d 991, 999 (10th Cir. 1996), *cert. denied,* 117 S. Ct. 1691 (1997).

The commenter cites the Third Circuit's decision in *National Industrial Sand Ass'n* v. *Marshall,* 601 F.2d 689 (3d Cir. 1979), in support of its position that the term ''operator'' should be narrowly construed. In *National*

Industrial Sand, however, the Third Circuit recognized that, as of the date of the court's opinion, the Department of Labor had not yet promulgated regulations under the Federal Mine Health and Safety Act defining the degree to which independent contractors were subject to that Act's health and safety provisions. The *dicta* cited by the commenter thus does not constitute a rejection of the Department's position on coverage. Given the adoption of its position by the D.C. and Tenth Circuits, and its rejection by only the Fourth Circuit, there appears to be no reason for the Department to adopt in its regulations a decision at odds with its consistent interpretation, and the commenter provides none.

The same commenter suggests that the Department's interpretation would result in the coverage of food and beverage workers who serve lunch to coal miners. The Act requires that those who contract pneumoconiosis as a result of work in the Nation's coal mines receive compensation for the totally disabling effects of that disease. Although it is difficult to imagine that food and beverage workers will be sufficiently exposed to coal mine dust to contract pneumoconiosis, those individuals who are totally disabled as a result of that exposure, and who meet the definition of ''miner'' (''* * * any individual who * * * has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal,'' 30 U.S.C. 902(d)), are no less entitled to compensation than are other miners. The employer of such individuals must assume liability for the payment of any benefits to which they are entitled, provided that the employer meets the criteria for a potentially liable operator set forth in § 725.494.

(b) One commenter argues that the Department's exclusion in § 725.491(f) of both state and federal governments from potential liability under the Act is inappropriate. The commenter suggests that the Department's proposal excluding the United States will cause federal employees to file claims under the Black Lung Benefits Act rather than the Federal Employees Compensation Act (FECA). The Department disagrees; the proposed regulation merely codifies the holding of the Fourth Circuit in *Eastern Associated Coal Corp.* v. *Director, OWCP*, 791 F.2d 1129 (4th Cir.1986). The court in that case held that the United States could not be considered a responsible operator based on the miner's most recent employment as a federal coal mine inspector. To the extent that such employees develop pneumoconiosis as a result of previous coal mine employment, they must be permitted to file claims under the Act. To the extent that they are injured during the course of their federal employment, FECA provides the appropriate remedy. The Department does not agree that its adoption of the Fourth Circuit's decision in *Eastern Associated Coal* will result in an increase in unwarranted claims under the Act.

The same commenter argues that the Department cannot relieve state governments of their liability under the Act, and that the Department's approach under the Black Lung Benefits Act is inconsistent with its approach under the Fair Labor Standards Act. The comment, however, fails to recognize a fundamental difference between the two statutes: the Black Lung Benefits Act contains no mention of states as employers subject to potential liability for black lung benefits, while the Fair Labor Standards Act explicitly lists state governments among the ''public agencies'' that may be considered employers for FLSA purposes. Supreme Court caselaw illustrates the importance of this distinction. In *Gregory* v. *Ashcroft*, 501 U.S. 452 (1991), the Court considered the applicability of the Age Discrimination in Employment Act to judges employed by the State of Missouri. The Court observed that, although the Tenth Amendment to the United States Constitution did not prohibit Congress from exercising the power derived from the Commerce Clause with respect to state governments, ''we must be absolutely certain that Congress intended such an exercise.'' 501 U.S. at 464. The Fair Labor Standards Act meets this test; Congress clearly intended that the FLSA apply to public agencies, including state governments. In the absence of similar language in the Black Lung Benefits Act, however, the Department cannot seek to hold states liable for the payment of black lung benefits.

(c) One comment states that the rebuttable presumption of exposure to ''coal dust'' set forth in subsection (d) is inconsistent with the presumption set forth in § 725.202 of this part. The Department agrees that the two provisions should be harmonized. Both the Third and Eleventh Circuits have agreed that the Department's use of the term ''coal mine dust'' in § 725.202 represents a permissible reading of the Black Lung Benefits Act. *Williamson Shaft Contracting Co.* v. *Phillips*, 794 F.2d 865, 870 (3d Cir. 1986); *William Brothers, Inc.* v. *Pate*, 833 F.2d 261, 264 (11th Cir. 1987). Congress intended that the Black Lung Benefits Act provide compensation for any ''chronic dust disease of the lung * * * arising out of coal mine employment.'' 30 U.S.C. 902(b). The Department has consistently interpreted this mandate broadly, by including diseases such as silicosis in the definition of the term ''pneumoconiosis,'' provided they arise out of coal mine employment. *See* 43 FR 36825 (Aug. 18, 1978). The Department accordingly proposes to revise subsection (d) to make it conform with § 725.202, and to revise subsection (a)(2)(i) to ensure the consistent use of the phrase ''coal mine dust.''

20 CFR 725.492

(a) One commenter suggests that the Department's proposed regulations would require the purchaser of a coal mine company's assets in a bankruptcy proceeding to assume the bankrupt company's black lung benefits liabilities, and that this provision would destroy the coal mining industry in Maryland. The Secretary's regulations merely repeat the language of the statute, which provides that successor operator liability may arise from ''corporate reorganizations'' and ''liquidations,'' among other listed transactions. 30 U.S.C. 932(i)(3)(A). The Department is not free to disregard Congress' explicit intent to cover a wide variety of transactions in which coal mine assets may be sold. The Act and regulations generally impose potential liability on a successor operator, however, only after the transfer of coal mine assets from a seller that has failed to secure its potential liability in violation of the statutory mandate at 30 U.S.C. 933(a); if the seller obtained black lung insurance, a purchaser of its coal mine assets will probably not face any black lung liabilities arising from the seller's previous operation of the mine.

(b) Another commenter observes that the Department's regulations would shift liability to a successor operator, notwithstanding the fact that a prior operator that had gone out of business had insurance to cover a given claim. The Department disagrees that the proposed regulations would produce this outcome. The Department's first notice of proposed rulemaking contained an example in an attempt to make the intent of the regulation clear. *See* 62 FR 3365 (Jan. 22, 1997). Indeed, the regulations specifically provide that a prior operator shall remain liable if it meets the requirements of § 725.494, § 725.492(d). *See also* § 725.493(b)(1). One of § 725.494's requirements is that the prior operator must remain financially capable of assuming liability for the payment of benefits. An operator is deemed capable of assuming liability

for a claim if it obtained insurance and the insurance company is not insolvent, § 725.494(e)(1). Section 725.495 assigns liability to the operator that most recently employed the miner. Thus, if a miner's most recent employer obtained insurance and subsequently sold its assets or dissolved into a parent corporation, section 725.495 would require the most recent employer's insurer to assume liability for any benefits payable to the claimant. Only if that insurer is no longer solvent will the Department seek to impose liability on a successor or parent corporation. Because the Department believes that the regulations are clear on this point, no changes have been made.

20 CFR 725.493

(a) The Department has made a technical change to the language of subsection (a)(2) to make the regulation easier to read.

(b) One comment objects to subsection (a)(1) as an attempt to redefine independent contractors and sole proprietors as employees, in order to force coal mine operators to assume liability for any benefits payable to those individuals. In administering the Black Lung Benefits Act for the past 25 years, the Department has seen coal mine companies use a variety of financial arrangements in an effort to avoid liability for black lung benefits. These have included the designation of all miners as partners, the use of 11-month employment contracts with an operator's subsidiaries, and the establishment of separate, underfunded companies to provide labor to a coal mine operator. Subsection (a)(1) is intended to foreclose those efforts by recognizing a broad range of employment relationships between coal mine companies and those individuals who actually mine coal. By proposing more specific language defining an ''employment relationship,'' the Department hopes to ensure that coal mine operators provide compensation to all their employees with totally disabling pneumoconiosis. It is not the Department's intent, however, to redefine ''independent contractor'' or ''sole proprietor'' simply to make coal mine operators liable for those individuals' benefits. The Department has added language to subsection (a)(1) to clarify its purpose, and invites comment on whether the proposed language accomplishes the Department's intent.

(c) One comment suggests that the ''control'' test of subsection (a)(2) is unconstitutional insofar as it creates federal common law. The comment contains no citation to specific precedent and no further explanation. The comment therefore provides the Department with an insufficient basis for altering the proposal.

20 CFR 725.494

(a) The Department has made several technical changes to the language of the proposed regulation to make the regulation easier to read.

(b) One comment suggests that the presumptions set forth in subsections (a) and (e) are illegal and violate the Supreme Court's decision in *Greenwich Collieries.* The Department's authority to create regulatory presumptions is discussed in detail elsewhere in this preamble. The Department notes that the presumption set forth in the proposed version of subsection (a) merely reflects the presumption currently contained in § 725.493(a)(6). Subsection (e) is not a presumption at all, but merely a recitation of the evidence that will support a finding that a coal mine operator is financially capable of assuming liability for the payment of benefits, one of the Secretary's prerequisites for naming a company a potentially liable operator.

(c) One miner comments that the only coal mining company he worked for after 1969 is now bankrupt, so that the § 725.494(d) requirement is not met in his case. He asks where that leaves miners like him. A miner's failure to meet this requirement has no impact on his potential entitlement to benefits. It merely means that if he is found entitled, his benefits will be paid by the Black Lung Disability Trust Fund rather than a coal miner operator or its insurer.

20 CFR 725.495

Several commenters argue that § 725.495 impermissibly shifts the burden of proof as to the identity of a responsible operator from the Department to employers. The commenters state that the proposed language does not codify current law, but rather the unsuccessful litigation position advanced by the Department in *Director, OWCP* v. *Trace Fork Coal Co.*, 67 F.3d 503 (4th Cir. 1995). In its explanation of the proposed revision of § 725.495, the Department acknowledged that its proposal addressed issues not resolved by the current regulations. 62 FR 3364–65 (Jan. 22, 1997). The commenters' implication that the proposal violates the Fourth Circuit's decision, however, is mistaken. In *Trace Fork*, the court explicitly observed that ''[t]he Black Lung Benefits Act and its accompanying regulations do not specifically address who has the burden of proving the responsible operator issue.'' 67 F.3d at 507. In the absence of specific guidance, the court concluded that the Secretary bore this burden. In proposing these regulations, the Department is not violating *Trace Fork*, but rather filling the void noted by the court. The Department's prior explanation in its original proposal, 62 FR 3363–65 (Jan. 22, 1997), contains a full explanation of the Department's proposed changes.

Subpart H

20 CFR 725.502

(a) Paragraph (b)(1), as originally proposed, made monthly benefits due on the ''first business day of the month following the month for which the benefits are payable.'' 62 FR 3412 (Jan. 22, 1997). Although no comments were received concerning this provision, the Department has determined that paragraph (b)(1) should be changed to make monthly benefits due on the fifteenth calendar day of the month. This change reflects current departmental practice with respect to the payment of benefits by the Trust Fund. The change will promote consistency on the part of the Trust Fund and operators by requiring the payment of monthly benefits on the same schedule. Thus, the change will allow uniform claimant expectation as to the regular date of payment, notwithstanding the identity of the payor.

The proposed change also affects the example of hypothetical due dates for the payment of benefits contained in the initial notice of proposed rulemaking, 62 FR 3366 (Jan. 22, 1997). In that example, an administrative law judge's order awarding benefits issues on August 15, 1996. Under paragraph (b)(1), as originally proposed, the operator must pay the monthly benefits due for August within ten days after the first business day of September (*i.e.*, September 10, 1996) to avoid a penalty; September is the ''month following the month for which the benefits are payable.'' Paragraph (b)(1), as reproposed, would require the operator to pay the monthly benefits for August within ten days after the fifteenth of September to avoid the late-payment penalty (*i.e.*, September 25, 1996). As discussed in the January 1997 preamble, retroactive benefits covering the period before the ALJ's August 15, 1996, award, will not be due until the district director completes the computation of these amounts and notifies the parties. Such notification will be completed within 30 days of August 15, 1996.

(b) Several comments state that imposition of the twenty percent penalty for failure to commence the

timely payment of benefits after entry of an effective award is unfair and punitive when the penalty applies to an award which is still in litigation. The Department disagrees. The Black Lung Benefits Act incorporates the twenty percent penalty provision of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 914(f), as incorporated by 30 U.S.C. 932(a). The purpose of the penalty is to ensure prompt compliance by an employer with its benefits obligations under the terms of an award, and without regard to further proceedings involving the claim. *See* 43 FR 36815 (Aug. 18, 1978), § 725.607, Discussion and changes (a). The existence of the Black Lung Disability Trust Fund does not change that purpose. As discussed in the first notice of proposed rulemaking, 62 FR 3365–66 (Jan. 22, 1997), only some responsible operators commence the payment of benefits upon entry of an award when further proceedings are pending; even fewer pay retroactive benefits. Noncompliance shifts the burden of paying interim monthly benefits to the Trust Fund to ensure the claimant receives benefits until compliance ensues, or the litigation terminates with affirmation of the award or its reversal. Operators therefore routinely use the Trust Fund as a surrogate to defer liabilities or reduce the risk of losing interim payments in the event an award is reversed, and the beneficiary cannot repay the interim benefits. The Department recognizes the fiscal reasoning behind this practice. Congress, however, imposed primary responsibility for paying benefits on the coal mining industry, and intended individual operators to assume liability to the maximum extent possible. *See generally Old Ben Coal Co.* v. *Luker*, 826 F.2d 688, 693 (7th Cir. 1987), *quoting* S. Rep. No. 209, 95th Cong., 1st Sess. 9 (1977). Congress created the Trust Fund to fulfill two limited roles: pay claims for which no individual operator could be held liable, and assume temporary liability if the responsible operator fails or refuses to pay. 26 U.S.C. 9501(d). With respect to the latter role, the Fund acts to protect the claimant by ensuring the continuous and timely receipt of benefits until the operator pays or the award is overturned. This objective does not extend to insulating the responsible operator from the economic risks of paying benefits on an award which might ultimately be reversed. Moreover, requiring payment of benefits on a non-final award does not infringe the operator's right to challenge the award. Section 725.502 simply shifts the economic risk that the initial award is incorrect from the Trust Fund to the operator. The operator receives adequate protection of its interests through its right to develop evidence and participate in the adjudication process. Such participation gives the operator a voice in the merits of the award and the opportunity to challenge an award if it disagrees with it. Consequently, the Department believes that the availability of penalties to foster *prompt* compliance with the terms of an award is warranted, even if the operator pursues an appeal. Section 725.502 implements the Congressional mandate that individual coal mine operators bear the burden of paying benefits whenever liability exists.

(c) One comment objects that Congress never intended to require a responsible operator to pay retroactive benefits before an award becomes final in claims filed after 1981. In general, the party liable for the payment of a claim must pay all benefits due under the terms of an award when that award becomes effective. Congress has permitted one exception. Under 26 U.S.C. 9501(d)(1)(A), the Trust Fund will pay benefits on a claim filed after January 1, 1982 ''only for benefits accruing after the date of such initial determination'' if the Fund is paying interim benefits on behalf of an operator who has not made a payment which is due. This statutory exception, by its language, applies only to the Fund, and only to interim benefits payments. In all other situations, the claimant is entitled to the full payment of benefits authorized by the award even if litigation continues. If payments are withheld by the operator until the award becomes final in a post-1981 claim, the operator must pay interest as well. 30 U.S.C. 932(d). Contrary to the commenter's view, Congress clearly intended responsible operators to pay retroactive benefits as well as monthly benefits immediately when a claimant's entitlement is established by an effective benefits award.

(d) One comment objects to the requirement in paragraph (b)(2) that an operator must pay retroactive benefits despite continuing litigation over the propriety of the award itself. The commenter argues that an operator has no realistic chance of recovering the benefits if the award is ultimately reversed, and suggests the Trust Fund should reimburse an operator who pays retroactive benefits. A right to benefits established by an award, however, cannot be conditioned on the likelihood the operator will recover the benefits if the claimant is ultimately found ineligible. If the claimant has a present right to receive benefits, then the operator must pay according to the terms of the award without regard to the possibility of a later reversal. The terms of the award include all benefits to which the miner is entitled, including retroactive benefits. The Department also rejects the suggestion that the Fund reimburse any operator who pays retroactive benefits but thereafter defeats the claim. The Fund is not authorized to reimburse operators except for those claims for which liability has transferred to the Fund pursuant to law. *See* 26 U.S.C. 9501(d)(6), (7).

(e) One comment suggests three additions to this section: (i) a requirement that the Trust Fund pay interim benefits if a responsible operator obtains a stay of payments pursuant to 33 U.S.C. 921(c), as incorporated by 30 U.S.C. 932(a), until the stay is dissolved; (ii) clarification that a responsible operator must pay benefits during the pendency of its modification petition until the petition is granted; and (iii) language stating that an administrative law judge's award becomes final despite any order leaving the computation of benefits to the district director. No changes are necessary in response to the commenter's suggestion. (i) The Department agrees that the Trust Fund must pay benefits on an interim basis if the operator obtains a stay of payments. This obligation derives from Section 9501 of the Internal Revenue Code, which defines the Fund's operation and payment obligations. 26 U.S.C. 9501. The expenditures which the Fund may undertake include the payment of benefits when the operator liable for benefits ''has not made a payment within 30 days after that payment is due[.]'' 26 U.S.C. 9501(d)(1)(A)(ii). If an operator obtains a stay and a benefit payment comes due during the pendency of the stay, the Trust Fund will make the payment. (ii) Clarification of an operator's benefits obligation during modification proceedings is unnecessary. Section 725.502(a)(1) is unambiguous: ''An effective order shall remain in effect unless it * * * is superseded by an *effective* order issued pursuant to § 725.310'' (regulation implementing modification). Once an effective order exists requiring an operator to pay benefits, the operator must pay until that order is overturned. Filing a modification petition does not supersede an otherwise effective award. The petition merely initiates the process to reopen the award. During the pendency of the modification proceedings and prior to entry of an effective decision on modification, the terms of the existing decision prevail,

and the operator must pay benefits in compliance with that decision. (iii) The commenter cites *Keen* v. *Exxon Corp.*, 35 F.3d 226 (5th Cir. 1994), as a potential loophole to the finality of administrative law judge decisions. In *Keen*, an administrative law judge approved a claim under the Longshore and Harbor Workers' Compensation Act, but ordered the district director to calculate the amount of compensation due. The employer paid the benefits within ten days of the district director's order rather than the administrative law judge's decision. The Court acknowledged that the employer possessed sufficient information to determine for itself the amount of benefits due, rather than wait for the district director's findings. The Court, however, stressed that the administrative law judge's decision was not ''final'' precisely because it required the district director to make the actual computation. No change in the regulations is necessary to account for the practice followed by the administrative law judge in *Keen*. Section 725.502(a)(2) states that an administrative law judge's order becomes ''effective'' when it is filed in the office of the district director. Once an administrative law judge's order is effective, benefits are due under § 725.502(a)(1) and ''shall be paid.'' In any event, orders akin to the one issued in *Keen* are rarely, if ever, used in the black lung program. Awards by administrative law judges ordinarily identify the number of beneficiaries and the onset date(s) for payment. The amount of the prospective benefits to be paid within these parameters is fixed by law; no independent computation by the district director is therefore needed. Moreover, the Department has already placed the burden of computing the retroactive benefits on the district director in § 725.502(b)(2), and made clear that those benefits are not due until the district director issues an order setting the amount. Since § 725.502(b)(1) is unambiguous that prospective benefits must commence by a date certain once an award is effective, the operator cannot use the corollary order for retroactive benefits as a pretext to avoid paying the prospective benefits.

20 CFR 725.503

Several comments take issue with the Department's treatment of the date from which benefits are payable in cases in which a factfinder grants modification on the ground of a change in conditions. One comment urges the Department to require that when the evidence does not establish the specific month in which the miner became totally disabled due to pneumoconiosis, benefits be made retroactive to the date of the adverse decision that was the subject of modification. Another comment states that the revised proposal permits the payment of benefits before the onset of the miner's totally disabling pneumoconiosis, in violation of incorporated provisions of the Longshore Act.

The Department's initial proposal could have led to considerable litigation as to the date from which benefits should be paid in change of condition cases. The Department now proposes a different method to determine this commencement date, one which will give preclusive effect to an earlier factfinder's denial, but will also be relatively easy to apply. In all other successful miners' claims, benefits are awarded as of the month of onset of the miner's totally disabling pneumoconiosis. If that month cannot be established, benefits are payable from the month in which the miner filed his application, based on the logical premise that the filing date would be relatively close to the date on which the miner believed that he was entitled to benefits. This method has worked well in the adjudication of black lung claims in general, and the Department is therefore proposing a similar method for determining the commencement date in change of condition cases. Although every effort will be made to determine the precise date on which the miner became totally disabled due to pneumoconiosis, the date on which the miner requested modification of a previous denial represents an equitable fallback in cases in which the evidence is insufficient to resolve the issue. In determining the commencement date, a factfinder may award benefits prior to the date of the modification request only where credible medical evidence demonstrates that the miner's pneumoconiosis became totally disabling prior to that date. In no event may such evidence be used to justify an award which predates the effective date of the most recent factfinder's denial of the claim. Conversely, a factfinder may not award benefits retroactive to the date of the request where more recent credible evidence demonstrates that the miner did not become totally disabled until a later date.

20 CFR 725.515

The Department did not propose revisions to § 725.515 in its initial notice of proposed rulemaking, 62 FR 3338 (Jan. 22, 1997). The Department has since determined that the regulation should be amended to conform it to applicable law. Section 16 of the Longshore and Harbor Workers' Compensation Act prohibits the garnishment of benefits, 33 U.S.C. 916; this provision is incorporated into the Black Lung Benefits Act. 30 U.S.C. 932(a). Section 725.515 implements section 16. 20 CFR 725.515. In 1975, Congress enacted section 459 of the Social Security Act, 42 U.S.C. 659, to permit the garnishment of federal pay and benefits for alimony and child support obligations. Congress thereafter amended the garnishment provisions in 1977 to clarify their applicability to benefits payments made by the federal government; black lung benefits were specifically excluded from coverage. Congress removed the exclusion, however, in 1996 legislation, which became effective on February 22, 1997. Pub. L. No. 104–193, § 362(d), 110 Stat. 2247. Thus, black lung benefits paid by the Black Lung Disability Trust Fund are subject to garnishment for child support and alimony. The Office of Personnel Management (OPM) is authorized to issue garnishment regulations for the Executive Branch implementing 42 U.S.C. 659. Exec. Order No. 12,105, 43 FR 59,465 (Dec. 19, 1978). OPM recently amended its regulations to conform to the 1996 amendments and permit garnishment of federal black lung benefits paid by the Trust Fund. 63 FR 14,756, 14,758 (March 26, 1998) (to be codified at 5 CFR 581.103(c)(6)). Because 42 U.S.C. 659 is a waiver of sovereign immunity, however, it does not alter any anti-alienation provision governing payments by private parties. *See generally Moyle* v. *Director, OWCP*, 147 F.3d 1116 (9th Cir. 1998), *pet. for cert. filed*, No. 98–927 (Dec. 3, 1998) (holding that 42 U.S.C. 659 authorizes garnishment of longshore benefits payable by the Special Fund to satisfy beneficiary's obligation to pay alimony despite 33 U.S.C. 916, which applies only to private employers or insurers). Consequently, 20 CFR 725.515 must be amended to reflect the limitations on the coverage of section 16: benefits payments by a responsible operator cannot be garnished to satisfy alimony or child support obligations, while payments which are the liability of the Trust Fund can be garnished.

20 CFR 725.533

Section 725.533 was not among the provisions which the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). In connection with the proposed deletion of section 725.403, however, which governs claims filed under section 415 of the Act, 30 U.S.C. 925, the Department proposes

corresponding deletions to paragraphs (b) and (c) of section 725.533. These paragraphs govern the payment of benefits in section 415 claims. Paragraphs (d)–(g) have been redesignated paragraphs (b)–(e). The Department does not intend to alter the rules applicable to any section 415 claim that may still be in litigation, and 20 CFR 725.533(b), (c) will remain applicable to any such claim. Parties interested in reviewing section 725.533 may consult earlier editions of the Code of Federal Regulations or the **Federal Register** in which the regulation was originally published. The Department invites comment on whether section 725.533 should be retained in the Code of Federal Regulations.

20 CFR 725.543

Section 725.543 was not among the provisions which the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997), and the Department did not receive any comments specifically directed to this section. The Department did receive a number of general comments critical of the application of the criteria used to determine whether recoupment of an overpayment would defeat the purposes of title IV of the Federal Coal Mine Health and Safety Act or would be against equity and good conscience. Although the Black Lung Benefits Act incorporates these waiver criteria from the Social Security Act, 30 U.S.C. 923(b), 940, incorporating 42 U.S.C. 404(b), § 725.543 currently incorporates the regulations promulgated by the Social Security Administration under its administration of Part B of the Black Lung Benefits Act. Because virtually no new applications for benefits are filed under Part B, it is unlikely that the Part B regulations will be amended to reflect new interpretations of the statutory criteria by the Social Security Administration and the federal courts. In fact, the Part B regulations currently incorporated in § 725.543 which define ''fault,'' ''defeat the purpose of title IV,'' and ''against equity and good conscience,'' §§ 410.561b, 410.561c, and 410.561d, were last published in the **Federal Register** in 1972. By contrast, the regulations governing claims under Title II of the Social Security Act, contained in 20 CFR Part 404, have been amended to keep pace with current law. Accordingly, the Department proposes to amend section 725.543 to incorporate Social Security's more current standards for establishing waiver of recovery of an overpayment.

20 CFR 725.544

Section 725.544 was not among the regulations which the Department opened for comment in its previous notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). One comment pointed out, however, that current law allows agencies of the United States to compromise claims of the United States government of not more than $100,000. The Department proposes to amend the regulation to reflect this change, and to delete the reference to the Federal Claims Collection Act of 1966, which has been repealed. The relevant provision governing compromise of claims by the United States is now codified in the United States Code at 31 U.S.C. 3711.

20 CFR 725.547

(a) The original proposal extended the right to seek waiver of recovery of an overpayment to all claimants, without regard to whether recovery was sought by a responsible operator or the Black Lung Disability Trust Fund. Many commenters urge the Department to promulgate rules governing recovery of overpayments based on the incorporated provisions of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 914(j), 922, as incorporated by 30 U.S.C. 932(a). Pursuant to these provisions, overpaid amounts may be recovered only by withholding future benefit payments. Other commenters object to the proposal on the ground that it will make more difficult operator recovery of overpayments. The policy considerations governing this regulatory revision were fully discussed in the Department's original proposal, 62 FR at 3366–3367 (Jan. 22, 1997), and the comments suggest no new basis for further change.

(b) Several comments state that this rule would unconstitutionally deprive operators of property rights, while other comments argue that it would deprive operators of an effective right of appeal. The process used to adjudicate applications for black lung benefits provides coal mine operators with the right to notice and the opportunity for a hearing before the issuance of an effective award, the only award which mandates payment by a coal mine operator. Federal courts have considered similar allegations with respect to the entitlement adjudication scheme used under the Longshore Act, a scheme identical to that used to adjudicate claims for black lung benefits, and have unanimously concluded that the Longshore Act does not violate employers' constitutional rights. *Schmitt* v. *ITT Federal Electric Int'l.*, 986 F.2d 1103 (7th Cir. 1993); *Abbott* v. *Louisiana Insurance Guaranty Ass'n.*, 889 F.2d 626 (5th Cir. 1989), *cert. denied*, 494 U.S. 1082 (1990). Because the Longshore Act is even more restrictive regarding an employer's right to recover an overpayment than the Department's proposed black lung benefits regulations, *see* 62 FR 3366 (Jan. 22, 1997), the Department does not agree that the proposed scheme is unconstitutional. Similarly, there is no constitutionally recognized right of appeal. As under the Longshore and Harbor Workers' Compensation Act, operators may appeal in order to reduce their future benefit obligations, but success on appeal does not necessarily mandate the repayment of all previously paid benefits. Moreover, notwithstanding the proposal, coal mine operators may seek recoupment of any overpaid amounts. In fact, they are entitled to repayment provided the claimant is not entitled to waiver. These waiver provisions have been used by the Department throughout its administration of Part C of the Act to determine whether an overpaid claimant must repay amounts owed the Black Lung Disability Trust Fund. The Department's experience clearly demonstrates that application of these waiver criteria does not wholly foreclose the recoupment of overpaid amounts.

(c) One comment states that the Department's legal analysis of the overpayment issue neglected § 430 of the Black Lung Benefits Act, 30 U.S.C. 940. Section 430 provides that the provisions of the Black Lung Benefits Act of 1972, the Black Lung Benefits Reform Act of 1977, and the Black Lung Benefits Amendments of 1981 applicable to Part B of the Black Lung Benefits Act shall also apply, as appropriate, to Part C of the Act. None of these statutory enactments prohibits the Department from applying the same waiver criteria to the recoupment of overpaid amounts by both operators and the Black Lung Disability Trust Fund.

(d) Several comments address the test used to determine whether or not claimants are entitled to waiver of recoupment, §§ 725.542, 725.543. The Department also heard considerable testimony at both hearings on the overpayment issue. The Department does not contemplate changing the legal test for waiver since it is based on statutory language incorporated into the BLBA from the Social Security Act, 30 U.S.C. 923(b), 940, incorporating 42 U.S.C. 404(b). The Department has altered § 725.543 to make the Department's interpretation of these criteria consistent with the current

Social Security Administration standards.

20 CFR 725.548

In both its current version and the Department's proposed revision, section 725.547 is titled ''Applicability of overpayment and underpayment provisions to operator or carrier.'' Despite this title, the regulation contains two paragraphs, (c) and (d), that are intended to apply to overpayment and underpayment issues regardless of whether the Black Lung Disability Trust Fund or a responsible operator is liable for the payment of benefits. These paragraphs authorize the district director to enter appropriate orders to protect the rights of the parties with regard to overpayments or underpayments, and provide that disputes arising out of such orders are to be resolved using the same procedures used to resolve entitlement and liability issues. In reviewing its proposed revision to section 725.547, the Department realized that the title of the regulation might mislead parties into believing that paragraphs (c) and (d) are applicable only in cases involving responsible operator liability. Because the Department intends that the same procedures be used to adjudicate overpayment and underpayment issues regardless of the liable party, the Department proposes that paragraphs (c) and (d) be relocated in a separate regulation with a more general title. Consequently, the Department proposes the addition of section 725.548, titled ''Procedures applicable to overpayments and underpayments.''

Subpart I

20 CFR 725.606

(a) Paragraph (c), as originally proposed, contains a typographical error. In the first sentence, the second reference to paragraph (a) should be a reference to paragraph (b). Paragraph (b) describes the amount of negotiable securities which an employer must deposit with a Federal Reserve Bank to secure the payment of benefits.

(b) One comment disagrees generally with the requirement for post-award security by coal mine construction employers, and the imposition of personal benefits liability on certain corporate officers if the employer fails to obtain security. The objection to post-award security is unfounded because the Black Lung Benefits Act authorizes it. Any operator of a coal mine, as defined by 30 U.S.C. 802(d), is required to obtain insurance or qualify as a self-insurer to ensure its financial ability to meet its potential benefits liabilities. 30 U.S.C. 933(a). Section 422(b) excepts certain employers engaged in coal mine construction or transportation from these requirements, provided they are not also operators of coal mines. 30 U.S.C. 932(b). The exception effectively permits these employers to confront their liabilities as they occur on a claim-by-claim basis, rather than anticipate funding for their liabilities through insurance or self-insuring. Section 422(b), however, further states: ''Upon determination by the Secretary of the eligibility of the employee, the Secretary may require [a coal mine construction or transportation] employer to secure a bond or otherwise guarantee the payment of such benefits to the employee.'' 30 U.S.C. 932(b). Although these employers need not insure themselves against prospective liability, they may be required to secure benefits once a claim is awarded. If the employer fails or refuses to obtain security for an existing award after being ordered to do so, that employer is no different than a coal mine operator who does not fulfill its legal obligation to insure or self-insure its potential liability for future awards. While the statute provides several coercive remedies against such employers, section 423(d)(1) also authorizes the Department to impose liability, in the case of a corporation, on its president, secretary and treasurer for any benefits which accrue during the period of the corporation's dereliction. No reason exists to treat corporate officers of a construction or transportation firm differently from corporate officers of a coal mine operator. In either case, the employer is legally required (by the statute or Secretary's order) to secure its liability, and has failed to satisfy that requirement. Section 423(d)(1) simply provides the Department with one tool to enforce the liable employer's obligation.

The same commenter also states that proposed § 725.606 addresses a nonexistent problem because the construction industry already complies with its obligations. The commenter's observation does not provide a legal basis for excluding construction companies from the employer community subject to security requirements imposed by statute. The original notice of proposed rulemaking, 62 FR 3367–3368 (Jan. 22, 1997), describes the Department's objectives for improving and clarifying the operation of the security provisions. The possible absence of a significant problem does not relieve the Department of its responsibility to identify all parties' obligations under the Black Lung Benefits Act and to set forth more efficient procedures to enforce them.

(c) One comment supports requiring the posting of security for the payment of benefits by coal mine construction and transportation employers.

Subpart J

20 CFR 725.701

(a) A number of commenters objected to the Department's initial proposal governing the compensability of medical benefits, because it included a rebuttable presumption that if a miner receives treatment for a pulmonary disorder, that disorder is caused or aggravated by the miner's pneumoconiosis. 62 FR 3423 (Jan. 22, 1997). Several commenters argued that this presumption would impose significantly greater costs on responsible operators and result in the payment of medical bills related to smoking. Others argued that the Department had no authority to promulgate such a presumption and that the presumption was medically unsound. The Department disagrees and believes that the proposed presumption is both appropriate and necessary.

In its initial notice of proposed rulemaking, the Department cited the Fourth Circuit's decision in *Doris Coal Co.* v. *Director, OWCP,* 938 F.2d 492 (4th Cir. 1991), in support of its proposal to codify a rebuttable presumption that treatment that a miner receives for a pulmonary condition, as described in § 725.701, represents treatment for the miner's pneumoconiosis and therefore is compensable. As proposed, this presumption would be available only to miners who have established their total disability due to pneumoconiosis arising out of coal mine employment and are therefore already entitled to monthly cash benefits. The presumption would also apply only to treatment, enumerated in the regulation, for a pulmonary disorder. The presumption could be rebutted by evidence demonstrating that the condition for which the miner received treatment was unrelated to, and was not aggravated by, the miner's pneumoconiosis.

Since publication of the Department's initial notice of proposed rulemaking, the Sixth Circuit has also issued a decision addressing the compensability of medical expenses incurred as a result of treatment for totally disabling pneumoconiosis. In *Glen Coal Co.* v. *Seals,* 147 F.3d 502 (6th Cir. 1998), a majority of the panel (Judges Dowd and Boggs) held that the administrative law judge and the Benefits Review Board

had erred in applying the *Doris Coal* presumption to a miner whose coal mine employment took place within the jurisdiction of the Sixth Circuit. Although Judge Dowd's majority opinion would have invalidated the presumption on a number of grounds, including its inconsistency with Congressional intent underlying the BLBA, *see* 147 F.3d at 513, Judge Boggs's concurrence (necessary for the majority's holding) did not extend so far. Instead, Judge Boggs specifically noted that he would ''agree with the dissent (and disagree with Judge Dowd) that it would not necessarily contravene *Greenwich Collieries* for the Secretary to adopt a regulation shifting the burden of production in the manner of *Doris Coal*.'' *Id.* at 517. Finally, Judge Moore's concurring and dissenting opinion would have upheld the *Doris Coal* presumption on deference grounds.

Recently, the Fourth Circuit clarified the presumption it created in *Doris Coal.* In *Gulf & Western Indus.* v. *Ling,* __F.3d__, 1999 WL 149851 (4th Cir. Mar. 19, 1999), the court held that the *Doris Coal* presumption does not shift the burden of persuasion to the employer to prove that the miner's respiratory or pulmonary treatment was not related to black lung disease. Rather, the burden of proving that the medical expense is covered by the black lung benefits award remains always on the miner. The *Doris Coal* presumption simply eases the miner's initial burden by allowing the miner to present a bill for treatment of his respiratory or pulmonary disorder or related symptoms. If the employer then

> produces credible evidence that the treatment is rendered for a pulmonary disorder apart from those previously associated with the miner's disability, or is beyond that necessary to effectively treat a covered disorder, or is not for a pulmonary disorder at all, the mere existence of a medical bill, without more, shall not carry the day. The burden of persuading the factfinder of the validity of the claim remains at all times with the miner.

1999 WL 149851 at *5.

The Department believes that black lung benefit claims adjudication should vary as little as possible from circuit to circuit, and consequently has proposed a regulatory presumption that would apply nationwide. Like any agency, however, the Department may only promulgate a regulatory presumption when there exists a rational connection between the proven facts and the presumed facts. *Chemical Manufacturers Association* v. *Department of Transportation,* 105 F.3d 702, 705 (D.C. Cir. 1997); *NLRB* v. *Baptist Hosp., Inc.,* 442 U.S. 773, 787 (1979). The proposed § 725.701 presumption would arise only after the miner establishes that he suffers from totally disabling pneumoconiosis arising out of coal mine employment, a fact that must be considered conclusively proven absent a successful request for modification from the responsible operator or fund. In addition, before invocation of the presumption, the miner must show that he received medical treatment within the scope of § 725.701 for a respiratory or pulmonary condition. Thus, prior to invocation of this presumption, the miner has demonstrated by means of credible medical evidence that he suffers from a compensable total disability. In addition, the miner has established that he received treatment covered by the proposed regulation for a pulmonary disorder. The Department's proposal would presume only one fact: that the pulmonary treatment for which the miner seeks payment was for his already-established totally disabling pneumoconiosis.

The Department's proposed definition of pneumoconiosis demonstrates the rational connection between the facts the miner must prove and the resulting presumption. Pursuant to proposed § 718.201, which has been endorsed by the National Institute of Occupational Safety and Health, a miner who has established the existence of pneumoconiosis has necessarily established that he suffers from a ''chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'' § 718.201(b); *see also* 20 CFR 718.201 (1998). Consequently, any treatment for the miner's compromised respiratory or pulmonary condition suggests, even if it does not conclusively demonstrate, that the miner's previous dust exposure has contributed to the need for that treatment. In addition, the miner's proof that he is totally disabled due to pneumoconiosis establishes that his pneumoconiosis is a substantially contributing cause of his total disability. § 718.204(c). This fact also suggests that the treatment of the miner's respiratory or pulmonary system is made necessary by his pneumoconiosis. Finally, the Department notes that it receives 12,000 to 15,000 medical bills per week, most of which are for relatively small amounts, $25.00 to $75.00. The Department must process these claims in a cost effective and prompt manner. The Department believes that it would be unreasonable to require miners to prove that each treatment expense is for pneumoconiosis when: (1) Each miner has already proven that he is totally disabled by pneumoconiosis arising out of coal mine employment; (2) the bills are for treatment of a pulmonary disorder, and (3) the bills are generally for relatively small amounts. In such circumstances, the Department believes it appropriate to presume that the miner's treatment for a pulmonary disorder is treatment for pneumoconiosis. The Department also believes it appropriate to require coal mine operators to produce credible evidence that the disorder being treated is neither related to nor aggravated by pneumoconiosis in order to escape liability. The Department does not agree, however, that the presumption will require operators to pay for medical treatment attributable to smoking alone. Operators remain free to rebut the presumption in such cases with appropriate medical evidence.

(b) The Department proposes to delete the reference in subsection (b) to ''ancillary pulmonary conditions.'' In light of the confusion reflected in Judge Dowd's majority opinion in *Seals,* and given the broad statutory and regulatory definition of the term ''pneumoconiosis,'' the Department does not believe that this language is necessary. The proposed revision is not intended to narrow the scope of medical benefits available under the Black Lung Benefits Act. Under subsections (b) and (c), a broad range of medical services and supplies will be considered necessary for the treatment of a miner's pneumoconiosis. The proposed presumption in subsection (e) will further ensure that miners who have been determined to be totally disabled due to pneumoconiosis are compensated for any medical service or supply necessary for the treatment of a pulmonary condition unless the responsible operator or fund can prove that the medical service or supply was not for a covered pulmonary disorder as defined in § 718.201. In order to further clarify the Department's intent, the Department proposes to revise the language in subsection (e) by replacing the word ''treatment'' with the phrase, ''medical service or supply.'' This change is intended to ensure that the subsection (e) presumption covers any medical supply or service that may be considered necessary under subsections (b) and (c).

The Department also proposes to amend the language in subsection (f) to clarify its intent. Evidence which is inconsistent with the established facts underlying the miner's entitlement to benefits cannot be used to show that the treatment is not compensable. An

attempt to use such evidence in this context would amount to impermissible relitigation of facts which have been finally determined. In determining whether the treatment is compensable, a treating physician's opinion may be entitled to controlling weight pursuant to § 718.104(d). In addition, a finding that a particular medical service or supply is not compensable shall not otherwise affect the miner's entitlement to benefits.

20 CFR Part 726—Black Lung Benefits; Requirements for Coal Mine Operators' Insurance

Subpart A—General

20 CFR 726.8

(a) In the initial notice of proposed rulemaking, the Department proposed new definitions of ''employ'' and ''employment'' which apply to both Part 725 and 726. *See* 62 FR 3410 (§ 725.493(a)(1)), 3426 (§ 726.8(d)) (Jan. 22, 1997). The definitions were identical. For the reasons set forth in the response to comments concerning § 725.493(a)(1), the Department has determined that more specific language defining ''employment'' is appropriate to clarify its purpose. The same change is incorporated into § 726.(8)(d) for the same reason.

(b) One comment contends that section 726.8(d) is ''illegally'' retroactive in operation and creates unfunded liabilities for insurance carriers by expanding coverage. For the reasons set forth in the response to comments concerning § 725.2, the Department does not believe that the retroactive application of regulatory changes is prohibited, or the instrument for the creation of additional liability.

The same commenter also states that the proposed regulatory definitions intrude on insurance functions reserved for the states. Because the commenter does not cite any legal authority or identify which state functions the proposed regulation affects, the Department is unable to determine the commenter's precise concerns. Moreover, the Seventh Circuit has held that the Black Lung Benefits Act ''specifically relates to the business of insurance and therefore does not implicate the McCarran-Ferguson Act,'' 15 U.S.C. 1012, which confers primacy on state law for the regulation of the insurance industry unless a conflicting federal statute specifically provides otherwise. *Lovilia Coal Co.* v. *Williams,* 143 F.3d 317, 325 (7th Cir. 1998). The commenter's objection therefore provides no basis for the further revision of this regulation.

(c) Two comments state that the proposed definitions are overbroad and make impossible the identification of which employees are covered by an insurance policy. The Department disagrees. The definition of ''employee'' must be read in context with the definition of ''miner'' in § 725.202. Only coal miners (and their survivors) are entitled to benefits under the Black Lung Benefits Act, and only those individuals are of concern to an insurance carrier writing a policy under the Act. In determining whether a particular employee is covered by the insurance policy, the insurer must determine whether the individual is a ''miner'' as defined by the Act and § 725.202. The insurer therefore must conduct a thorough investigation of the employer's business, the nature of the contacts with the coal mining industry, and the type of work each employee performs. This information will provide the basis for calculating the premium necessary for full coverage of the employer's potential liabilities. The burden of covering the responsible operator's liability and obtaining an appropriate premium rests on the insurer. *See Lovilia Coal Co.* v. *Williams,* 143 F.3d 317, 323 (7th Cir. 1998) (holding that insurance carrier must cover operator's entire liability under the Act and ''bears the burden of collecting proper premiums for all covered miners.''). Finally, the Department notes that the goal of broad insurance coverage for employees implements Congress' express intent to hold the coal mine operator community liable for individual claims to the maximum extent possible. *See* S. Rep. No. 95–209, *reprinted in* Comm. On Education and Labor, House of Representatives, 96th Cong., ''Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977'' (Comm. Print) at 612. Section 726.8(d) reflects the Department's policy to vigorously effectuate that intent. Because an insurance carrier assumes the responsibility for benefits ascribed to its insured operator, that responsibility must encompass every employee of the operator who qualifies as an eligible miner under the Act. *Williams,* 143 F.3d at 323; *see also National Mines Corp.* v. *Carroll,* 64 F.3d 135, 140 (3d Cir. 1995); *Tazco, Inc.* v. *Director, OWCP,* 895 F.2d 949, 951 (4th Cir. 1990).

Subpart C

20 CFR 726.3

Section 726.3 was not among the regulations which the Department opened for comment in its previous notice of proposed rulemaking. 62 FR 3350 (Jan. 22, 197). In reviewing the current proposal for publication, the Office of the Federal Register requested that the Department revise paragraph (b) in order to clarify how cases will be treated when the regulation in Part 726 appear to conflict with regulations incorporated from 725. This revision is not intended to make any substantive change in the regulation. In addition, the Department is removing references to Parts 715 and 720 from paragraph (a). Those parts were repealed in 1978, 43 FR 36772 (Aug. 18, 1978), and the regulations they contained should no longer be considered applicable to Part 726.

Subpart C

20 CFR 726.203

Section 726.203 was not among the regulations which the Department opened for comment in its previous notice of proposed rulemaking. 62 FR 3341 (Jan. 22, 1997). At the Washington, D.C. hearing, however, the Department heard testimony indicating that the insurance industry has used a different version of the endorsement contained in subsection (a) since 1984. An insurance industry representative testified that the change was ''acknowledged by the department as language acceptable for securing workers compensation under the federal Act.'' Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations,* July 22, 1997, p. 127 (testimony of Robert Dorsey). In its written comments, the insurance industry noted that after notification of changes in the insurance policy language, ''the Department agreed that the new endorsements were acceptable.'' The version provided by the insurance industry states as follows:

This endorsement applies only to work in a state shown in the Schedule and subject to the Federal Coal Mine Health and Safety Act of 1969 (30 USC Sections 931–942). Part One (Workers Compensation Insurance) applies to that work as though that state were shown in item 3.A. of the Information Page.

The definition of workers compensation law includes the Federal Coal Mine Health and Safety Act of 1969 (30 U.S.C. Sections 931–942) and any amendment to that law that is in effect during the policy period.

Part One (Workers Compensation Insurance), section A.2., How This Insurance Applies, is replaced by the following:

Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period or, when the last exposure occurred prior to July 1, 1973, a claim based on that disease must be

first filed against you during the policy period shown in item 2 of the Information Page.

Schedule
State

Following the hearing, the Department searched its records. Although those records reflect a meeting with a representative of the insurance industry in 1984, the Department was unable to find any document authorizing the use of the different endorsement. If the insurance industry has such a document in its files, the Department requests that it send it to James L. DeMarce at the address listed in this notice. In addition, to allow thorough evaluation of the endorsement the industry now suggests, the insurance industry should supply the Department with a copy of the insurance policy to which the endorsement is attached. Finally, although it is not currently proposing revision of § 726.203, the Department requests comment on the possible use of this endorsement. In preparing those comments, individuals should take note of the Department's requirement in § 726.205 that endorsements other than those provided by § 726.203 may be used provided they do not ''materially alter or attempt[] to alter an operator's liability for the payment of any benefits under the Act * * *'' 20 CFR 726.205.

Drafting Information, this document was prepared under the direction and supervision of Bernard Anderson, Assistant Secretary of Labor for Employment Standards.

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Executive Order 12866

The Office of Information and Regulatory Affairs of the Office of Management and Budget has determined that the Department's proposed rule represents a ''significant regulatory action'' under section 3(f)(4) of Executive Order 12866 and has reviewed the rule.

Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995, as well as E.O. 12875, this rule does not include any federal mandate that may result in increased expenditures by State, local and tribal governments, or increased expenditures by the private sector of more than $100 million.

Paperwork Reduction Act

The proposed changes would establish no new record keeping requirements. Moreover, they seek to reduce the volume of medical examination and consultants' reports which are currently created solely for the purpose of litigation by limiting the amount of such medical evidence which will be admissible in black lung proceedings.

Regulatory Flexibility Act, as Amended

The Regulatory Flexibility Act (''RFA'') was enacted by Congress in 1980 ''to encourage administrative agencies to consider the potential impact of nascent federal regulations on small businesses.'' *Associated Fisheries of Maine, Inc.* v. *Daley*, 127 F.3d 104, 111 (1st Cir. 1997). Unless the agency is able to certify that the rule will not have ''a significant economic effect on a substantial number of small entities,'' 5 U.S.C. 605, each agency that publishes a notice of proposed rulemaking must prepare an ''initial regulatory flexibility analysis'' describing the impact of the proposed rule on small entities. 5 U.S.C. 603(a). That analysis, or a summary of the analysis, must be published in the **Federal Register** when the notice of proposed rulemaking is published, and a copy of the analysis must be sent to the Chief Counsel for Advocacy of the Small Business Administration.

In its initial notice of proposed rulemaking, the Department certified that the proposed revisions would not have a significant effect on a substantial number of small businesses. 62 FR 3371–73 (Jan. 22, 1997). The Department's certification was criticized by both the coal mining industry and the Small Business Administration's Office of Advocacy. Industry argued that the Department had grossly underestimated the effect of the proposed rule. The Office of Advocacy observed that the Department had not used the size standards established by the Small Business Administration, and that the Department did not provide a factual basis for its certification. In particular, the Office of Advocacy took issue with the Department's interpretation of the term ''significant economic effect.''

In light of the concerns raised by the commenters, the Department has determined that an initial regulatory flexibility analysis is appropriate. The RFA mandates that each analysis contain certain components: (1) a statement of the reasons for issuing the proposed rule; (2) a statement of the objectives of, and legal basis for, the proposed rule; (3) a description and, where feasible, an estimate of the number of small businesses to which the rule will apply; (4) a description of projected reporting, recordkeeping, and other compliance requirements of the proposed rule; and (5) an identification of any rules that overlap, duplicate, or conflict with the proposed rule. 5 U.S.C. 603(a). Finally, the analysis must contain a description of significant alternatives to the rule that accomplish the stated objectives and minimize the significant economic impact on small businesses, including the establishment of different compliance requirements or exemptions for small businesses. 5 U.S.C. 603(b). In determining the effects of a proposed rule, or alternatives to the proposed rule, ''an agency may provide either a quantifiable or numerical description of the effects * * * or more general descriptive statements if quantification is not practicable or reliable.'' 5 U.S.C. 607. Once the analysis has been published in the **Federal Register**, either in full or in summary form, the RFA also requires administrative agencies to assure that small businesses have a full opportunity to participate in the rulemaking by providing them with additional notification. 5 U.S.C. 609.

Reasons for, and Objectives of, the Proposed Rule

The Department's proposal is intended to update the regulations that implement that Black Lung Benefits Act. The Act provides both monetary and medical benefits to miners who are totally disabled by pneumoconiosis arising out of coal mine employment, and monthly monetary benefits to the survivors of miners who die as a result of the disease. These regulations establish: (1) the procedures used to process and adjudicate benefit applications (Part 725); (2) the criteria used to determine whether applicants are eligible for benefits (Parts 718 and 727); (3) the requirements for coal mine operators who must secure the payment of benefits (Part 726); and (4) the standards for approving state workers' compensation programs (Part 722). The Department has proposed revising these regulations in order to accomplish several goals:

(1) A substantial number of the proposed rules would simply codify decisions by the courts of appeals and the Benefits Review Board. In many cases, these decisions were issued by courts with jurisdiction over the states

in which most of the country's coal mining takes place, and thus already govern the adjudication of a majority of claims. In order to make sure all interested parties are aware of these decisions, and in particular to ensure that claimants who are not represented by counsel are not disadvantaged by being unaware of these decisions, the Department is proposing to codify these decisions in its implementing regulations. Codification of court decisions in rules of nationwide applicability will ensure uniform treatment of the parties. The Department's proposed revisions also codify changes to statutes other than the Black Lung Benefits Act which affect the Department's administration of the Act, including changes to the Social Security Act governing garnishment, and the statute governing the collection of debts owed the federal government.

(2) In addition, the Department is proposing these revisions to make the adjudication of claims a more equitable process, and to ensure that the affected public perceives the process as fair. For example, the Department has proposed limiting the amount of documentary medical evidence parties to a claim may submit in order to encourage the parties to focus on the quality of the medical evidence they develop instead of its quantity. The Department has also proposed requiring that the factfinder recognize certain factors that may make the opinion of the miner's treating physician worthy of more weight. Similarly, the proposal would ensure that claimants who receive overpayments are treated equally regardless of whether the overpayment was made by the Black Lung Disability Trust Fund or a coal mine operator. Finally, the Department has proposed revisions to the rules governing attorneys' fees in an effort to make attorneys more willing to represent black lung claimants.

(3) Several of the proposed revisions are designed to simplify the regulatory language and clarify the Department's original intent when the regulations were first promulgated. These proposals include ensuring the uniform application of the quality standards to medical evidence developed in connection with a black lung benefits claim and refining the definitions of key terms such as ''miner'' and ''one year.'' The Department has also proposed revisions to the regulations governing the eligibility of dependents and survivors in order to clarify the statute and insure implementation of Congressional intent.

(4) The Department has proposed several measures designed to protect the Black Lung Disability Trust Fund, which pays claimants benefits when no coal mine operator or insurer may be held liable. Specifically, the Department proposes to revise the regulations governing the imposition of civil money penalties on coal mine operators that fail to secure the payment of benefits as required by the Act, either by purchasing commercial insurance or by qualifying as a self-insurer. The Department has also proposed revisions to the process used to identify the party responsible for the payment of benefits, including changes to regulations governing the submission of evidence relevant to operator liability and the substantive criteria used to determine such liability. Finally, the Department has proposed revising the process by which uninsured coal mine operators, including coal mine construction and transportation companies, may be compelled to post security once they have been found liable for the payment of an individual claim.

(5) A number of the regulatory proposals are designed to improve the services the Department provides to parties to black lung benefits claims. These proposals include revisions that streamline the adjudication of claims, for example, by defining the parties' obligation to attend an informal conference. They also include revisions intended to ensure that beneficiaries receive all of the benefits to which they are entitled in a timely manner. The Department has proposed eliminating or replacing outdated regulations, such as those governing the Department's certification of state workers' compensation programs.

(6) Finally, the Department is proposing revisions that take into account changes that have occurred over the past 20 years in the diagnosis and treatment of pneumoconiosis. For example, the Department has proposed revising the definition of pneumoconiosis to recognize the progressive nature of the disease and the possibility that a miner's coal mine dust exposure may have contributed to the development of either obstructive or restrictive lung disease. The Department has also proposed revisions in the standards for administering pulmonary function tests and in the adjudication of the compensability of medical expenses.

Legal Basis for the Proposed Rule

The Black Lung Benefits Act grants the Secretary broad authority to issue regulations. Section 422(a) of the Act provides that ''[i]n administering this part [Part C of the Act], the Secretary is authorized to prescribe in the **Federal Register** such additional provisions * * * as [s]he deems necessary to provide for the payment of benefits by such operator to persons entitled thereto as provided in this part and thereafter those provisions shall be applicable to such operator.'' 30 U.S.C. 932(a). Section 426(a) of the Act similarly authorizes the Secretary to ''issue such regulations as [she] deems appropriate to carry out the provisions of this title.'' 30 U.S.C. 936(a). The Act also authorizes the Secretary to promulgate regulations on specific subjects, such as criteria for medical tests, 30 U.S.C. 902(f)(1)(D), standards for assigning liability to coal mine operators, 30 U.S.C. 932(h), and regulations governing insurance contracts, 30 U.S.C. 933(b)(3). In addition, the Department, like any other administrative agency, possesses the inherent authority to promulgate regulations in order to fill gaps in the legislation that it is responsible for administering. *Chevron* v. *Natural Resources Defense Council,* 467 U.S. 837, 843–44 (1984); *Pauley* v. *Bethenergy Mines, Inc.,* 501 U.S. 680, 696 (1991).

Small Businesses to which the Rule will Apply

The Regulatory Flexibility Act requires an administrative agency to describe and, where feasible, estimate the number of small entities to which a proposed rule will apply. 5 U.S.C. 603(b)(5). Small entities include small businesses, small organizations, and small governmental jurisdictions. 5 U.S.C. 601(6). The Black Lung Benefits Act, however, does not seek to regulate small organizations or small governmental jurisdictions. Accordingly, this analysis is limited to the effect of the proposed rule on small businesses. By its terms, the Black Lung Benefits Act imposes obligations on coal mine operators. 30 U.S.C. 932(b) (''each such operator shall be liable for and shall secure the payment of benefits * * *.''). An operator is defined, for purposes of the black lung benefits program, as ''any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine.'' § 725.491(a)(1); 30 U.S.C. 802(d).

In assessing the impact of the proposed rule on operators that may be considered small businesses, the RFA requires an agency to use the definitions of the term ''small business'' used by the Small Business Administration unless the agency, after consultation with SBA's Office of Advocacy and opportunity for public comment, establishes its own definition. 5 U.S.C. 601(3). SBA's definitions, set forth in 13

CFR 121.201, are grouped according to Standard Industrial Codes (SICs) used by the Bureau of the Census. For purposes of identifying the small businesses to which the Black Lung Benefits Act and its implementing regulations apply, two categories are applicable: Coal Mining (SIC Codes 1220, 1221, 1222, 1230, and 1231) and Coal Mining Services (SIC Codes 1240 and 1241). SBA defines a small business in the coal mining industry as one with fewer than 500 employees, and a small business in the coal mining services industry as one with less than $5 million annually in receipts.

The Department has prepared an extensive economic analysis of the effect of the proposed rule on small businesses in the coal mining industry. A copy of that analysis is available on request from James L. DeMarce, Director, Division of Coal Mine Workers' Compensation, Room C–3520, Frances Perkins Building, 200 Constitution Ave., N.W., Washington, DC 20210. In the analysis, the Department specifically requests comments on a number of the assumptions underlying its conclusion. These include the relationship between increases in the claims approval rate and increases in insurance premiums; the relationship between increased medical costs and increases in insurance premiums; and the extent to which promulgation of these revisions will result in an increase in the number of claims filed.

The Department's analysis, using data maintained by the Mine Safety and Health Administration, indicates that, in 1995, 2,811 of 2,822 establishments, consisting of mines and preparation plants, employed less than 500 people (Exhibit C, total of all establishments employing less than 500 people). Of these establishments, 1,581 were associated with mining bituminous coal at a surface mine, 1009 mined bituminous coal underground, and 221 mined anthracite coal. When individual establishments are aggregated into parent companies, the Department found that 898 of 933 companies employed less than 500 people, and thus meet SBA's definition of a small business (Exhibit D).

It is not feasible to estimate precisely the number of independent contractors engaged in coal-mine related activities that meet SBA's definition, for example, those involved in coal mine construction and coal transportation. Data provided the Department by SBA (also available at http://www.sba.gov/ADVO/) with respect to firms in the coal mining services industry does not permit the direct identification of specific firms with less than $5 million annually in receipts. The data lists firms in categories according to the number of employees (*e.g.,* 1–4, 5–9), and provides the total estimated annual receipts for all of the firms in each category. Thus, at best, the data allows only an estimate of the average annual receipts of each firm within a given category. In the case of firms engaged in coal mining services, SBA data suggests that firms with 20 or more employees have average annual receipts that exceed the SBA cutoff. For example, 9 firms with between 20 and 24 employees had total annual estimated receipts in 1994 of $48,240,000. Thus, the average annual receipts of each firm in this category exceeds $5 million. Because 209 of the 275 firms engaged in coal mining services have fewer than 20 employees, the Department estimates that no more than 209 coal mining services firms will be affected by the proposed rule. The Department notes that this estimate may not include all coal mine construction and coal transportation companies. Because coal mine construction or coal transportation may not be the primary source of income for these companies, they may not appear in the SBA's data under the SIC Code covering coal mining services. The Department cannot estimate the number of firms that are excluded from SBA's data.

Projected Reporting, Recordkeeping, and Other Compliance Requirements of the Proposed Rule

The revisions proposed by the Department to its black lung regulations will not impose any additional reporting or recordkeeping requirements on small businesses. The analysis of additional costs that follows is derived from the Department's extensive economic analysis of the effect of the proposed rule on small businesses in the coal mining industry. References are to exhibits that accompany that report. The costs associated with the proposed rule involve possible increases in benefit payments, including monetary disability benefits and medical benefits, and increases in transaction costs incurred in the defense of claims under the Act. These costs will be imposed on coal mine operators either directly, in the case of coal mine operators that self-insure their obligations under the Act, or indirectly, in the case of coal mine operators that purchase commercial insurance. The latter group will absorb the increased costs through increases in insurance premiums. Because self-insurers are required to have a net worth of more than $10 million, and are able to take advantage of economies of scale in absorbing these costs, the Department's economic analysis focused on companies with commercial insurance. Increased costs on commercially insured operators will be higher than those imposed on self-insurers (which would have purchased commercial insurance if it were less expensive) and thus will overstate the costs to the coal mining industry as a whole.

The Department has concluded that insurance rates, typically between $.56 (for bituminous coal operators in Pennsylvania) and $5.38 (for anthracite coal operators in Pennsylvania) per $100 of payroll (Exhibit F), may be expected to rise by a total of 41.7 percent in the first two years and 39.3 percent in the long term. The Department has calculated the percentage increase in price that operators in a representative sample of states will need to charge in order to cover increased cost of the Department's proposed revisions. That cost ranges from .35 % (for West Virginia operators with 50 to 100 employees) to 3.3 % (for anthracite operators) (Exhibit O). The Department concludes that these price increases will fall most heavily on coal mine operators with less than 20 employees. The increases will clearly be significant, and although a number of small mine operators will be able to recoup their costs, less well-positioned bituminous operators and contract mine operators will face the greatest difficulty in doing so. As a result, some operators in those groups may be forced to suspend operations.

In addition, the proposed rule requires several specific actions on the part of coal mine operators. Operators that do not purchase commercial insurance to secure their liability for black lung benefits, including both operators that are authorized to self-insure and operators that are not required to obtain insurance, will be required to respond more promptly to notice from the Department that a claim has been filed by one of their former employees. *See* § 725.407. Specifically, they will have 90 days from receipt of notice to supply the Department with information relevant to their employment of the miner. Operators that have not secured their liability will also be required to post security in the event that they are held liable for the payment of benefits on an individual claim. *See* § 725.606. Operators that have been authorized to self-insure their liability under the Act will be required to maintain security for their claims even after they leave the coal mining business. *See* § 726.114. Finally, the Department's revisions are intended to enhance its ability to enforce civil

money penalties against operators that fail to comply with the Act's security requirements, and thus may impose additional costs on operators that are not currently in compliance with the Act's requirements. *See* Part 726, Subpart D. The remaining revisions do not impose on operators any additional compliance requirements beyond those in the Department's current regulations.

Rules that Overlap, Duplicate, or Conflict with the Proposed Rule

There are no other rules of which the Department is aware that overlap, duplicate, or conflict with the Department's proposed rule.

Significant Alternatives to the Rule

The Regulatory Flexibility Act requires the Department to consider alternatives to the rule that would minimize any significant economic impact on small businesses without sacrificing the stated objectives of the rule. 5 U.S.C. 603(b). The Black Lung Benefits Act places severe constraints on the Department's ability to target its proposed rule in order to minimize its impact on small business. The use of SBA's size standard would require the Department to seek ways of protecting more than 96 percent of the companies in the coal mining industry (898 of the 933 companies). Even using a 20-employee size standard, and thus focusing attention on the operators most likely to face significant additional costs, the Department's ability to reduce the economic impact of the proposal is limited.

Most of the revisions proposed by the Department affect the criteria used to determine a claimant's entitlement to benefits. The Black Lung Benefits Act requires that benefits be paid to each miner who is totally disabled as a result of pneumoconiosis arising out of coal mine employment, 30 U.S.C. 922(a)(1), and each dependent survivor of a miner who died due to pneumoconiosis or, if the claim was filed before January 1, 1982, was totally disabled at the time of death by the disease. 30 U.S.C. 922(a)(2), (3), (5). As an initial matter, then, the Act simply does not permit the Department to adjust its entitlement regulations based on the size of the miner's former employer. In effect, the Department cannot deny a claim because the miner was employed by a small business.

The Department has proposed revisions to the regulations governing the identity of the party liable for the payment of benefits. Like the current regulations, the Department's proposal would impose liability on the coal mine operator that most recently employed the miner for a period of not less than one year, provided that the operator meets other specified criteria. Among these criteria is the operator's financial ability to assume responsibility for the payment of benefits. *See* § 725.494(e). Because coal mine operators are required to secure their liability under the Act by purchasing commercial insurance or by self-insuring, however, this condition typically affects only two classes of operators: those that have failed to comply with the Act's security requirement, and those construction and transportation employers that are not subject to the security requirement. Such a company may avoid liability for a particular claim by demonstrating that it is financially incapable of assuming the payment of monthly and retroactive benefits.

Although the use of a financial capability standard might be considered a benefit to small businesses, using either SBA's definition or the 20-employee cutoff, the Department does not believe that it can provide any other similar benefit. In theory, of course, the Department could specifically limit liability under the Act in cases involving operators below a certain size. To do so, however, the Department would have to increase the obligations borne by larger coal mine operators (who may be the miner's second or third most recent employer) or the Black Lung Disability Trust Fund. Such a result, however, would violate Congress's clear intent: ''It is further the intention of this section, with respect to claims related to which the miner worked on or after January 1, 1970, to ensure that individual coal operators rather than the trust fund bear the liability for claims arising out of such operator's mines, to the maximum extent feasible.'' S. Rep. 209, 95th Cong., 1st Sess. 9 (1977), reprinted in House Comm. On Educ. And Labor, 96th Cong., Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977, 612 (Comm. Print 1979).

One area in which the Department may appropriately impose lesser costs on small businesses is the assessment of civil money penalties for failure to secure the payment of benefits. The Act merely provides that operators that fail to secure their liability are subject to a civil money penalty of up to $1,000 a day. The current regulations authorize the imposition of the ''maximum penalty allowed'' in the absence of mitigating circumstances. 20 CFR 725.495(d). By contrast, the Department's proposed regulations recognize that smaller companies may cause less harm by failing to secure the payment of benefits. The Department's proposal therefore establishes different base penalty amounts for operators who fail to insure, depending on the number of their employees. Thus, where the Act permits the Department to exercise flexibility with regard to small business, the Department has done so.

The Department invites comment from interested parties, particularly coal mine operators that are considered small businesses, as to other possible means of reducing the financial impact of the proposed rules on the small business community. Commenters should bear in mind that the fundamental purpose of the Black Lung Benefits Act is to provide benefits to disabled miners and their survivors, and that all applicants and beneficiaries must be treated fairly.

List of Subjects in 20 CFR Parts 718, 722, 725, 726, 727.

Black lung benefits, Lung disease, Miners, Mines, Workers' compensation, X-rays.

Signed at Washington, D.C., this 15th day of September, 1999.

Bernard Anderson,

Assistant Secretary for Employment Standards.

For the reasons set forth in the preamble, 20 CFR Chapter VI is proposed to be amended as follows:

1. The authority citation for part 718 continues to read as follows:

Authority: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 et seq., 902(f), 925, 932, 934, 936, 945; 33 U.S.C. 901 et seq., 42 U.S.C. 405, Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

2. Part 718 is proposed to be amended by removing subpart E, revising subparts A through D, revising Appendices A and C, and revising the text of Appendix B (the tables, B1 through B6, in Appendix B remain unchanged):

PART 718—STANDARDS FOR DETERMINING COAL MINERS' TOTAL DISABILITY OR DEATH DUE TO PNEUMOCONIOSIS

Subpart A—General

Subpart B—Criteria for the Development of Medical Evidence

Subpart A—General

§ 718.1 Statutory provisions.

(a) Under title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1972, the Federal Mine Safety and Health Amendments Act of 1977, the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Amendments of 1981, and the Black Lung Benefits Revenue Act of 1981, benefits are provided to miners who are totally disabled due to pneumoconiosis and to certain survivors of a miner who died due to or while totally or partially disabled by pneumoconiosis. However, unless the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982, benefits are payable on survivors' claims filed on or after January 1, 1982, only when the miner's death was due to pneumoconiosis, except where the survivor's entitlement is established pursuant to § 718.306 on a claim filed prior to June 30, 1982. Before the enactment of the Black Lung Benefits Reform Act of 1977, the authority for establishing standards of eligibility for miners and their survivors was placed with the Secretary of Health, Education, and Welfare. These standards were set forth by the Secretary of Health, Education, and Welfare in subpart D of part 410 of this title, and adopted by the Secretary of Labor for application to all claims filed with the Secretary of Labor (see 20 CFR 718.2, contained in the 20 CFR, part 500 to end, edition revised as of April 1, 1979). Amendments made to section 402(f) of the Act by the Black Lung Benefits Reform Act of 1977 authorize the Secretary of Labor to establish criteria for determining total or partial disability or death due to pneumoconiosis to be applied in the processing and adjudication of claims filed under part C of title IV of the Act. Section 402(f) of the Act further authorizes the Secretary of Labor, in consultation with the National Institute for Occupational Safety and Health, to establish criteria for all appropriate medical tests administered in connection with a claim for benefits. Section 413(b) of the Act authorizes the Secretary of Labor to establish criteria for the techniques to be used to take chest roentgenograms (X-rays) in connection with a claim for benefits under the Act.

(b) The Black Lung Benefits Reform Act of 1977 provided that with respect to a claim filed prior to April 1, 1980, or reviewed under section 435 of the Act, the standards to be applied in the adjudication of such claim shall not be more restrictive than the criteria applicable to a claim filed on June 30, 1973, with the Social Security Administration, whether or not the final disposition of the claim occurs after March 31, 1980. All such claims shall be reviewed under the criteria set forth in part 727 of this title (see 20 CFR 725.4(d)).

§ 718.2 Applicability of this part.

This part is applicable to the adjudication of all claims filed after March 31, 1980, and considered by the Secretary of Labor under section 422 of the Act and part 725 of this subchapter. If a claim subject to the provisions of section 435 of the Act and subpart C of part 727 of this subchapter (see 20 CFR 725.4(d)) cannot be approved under that subpart, such claim may be approved, if appropriate, under the provisions contained in this part. The provisions of this part shall, to the extent appropriate, be construed together in the adjudication of all claims.

§ 718.3 Scope and intent of this part.

(a) This part sets forth the standards to be applied in determining whether a coal miner is or was totally, or in the case of a claim subject to § 718.306 partially, disabled due to pneumoconiosis or died due to pneumoconiosis. It also specifies the procedures and requirements to be followed in conducting medical examinations and in administering various tests relevant to such determinations.

(b) This part is designed to interpret the presumptions contained in section 411(c) of the Act, evidentiary standards and criteria contained in section 413(b) of the Act and definitional requirements and standards contained in section 402(f) of the Act within a coherent framework for the adjudication of claims. It is intended that these enumerated provisions of the Act be construed as provided in this part.

§ 718.4 Definitions and use of terms.

Except as is otherwise provided by this part, the definitions and usages of terms contained in § 725.101 of subpart A of part 725 of this title shall be applicable to this part.

Subpart B—Criteria for the Development of Medical Evidence

§ 718.101 General.

(a) The Office of Workers' Compensation Programs (hereinafter OWCP or the Office) shall develop the medical evidence necessary for a determination with respect to each claimant's entitlement to benefits. Each miner who files a claim for benefits under the Act shall be provided an opportunity to substantiate his or her claim by means of a complete pulmonary evaluation including, but not limited to, a chest roentgenogram (X-ray), physical examination, pulmonary function tests and a blood-gas study.

(b) The standards for the administration of clinical tests and examinations contained in this subpart shall apply to all evidence developed by any party after [the effective date of the final rule] in connection with a claim governed by this part (see §§ 725.406(b), 725.414(a), 725.456(d)). These standards shall also apply to claims governed by part 727 (see 20 CFR 725.4(d)), but only for clinical tests or examinations conducted after [the effective date of the final rule]. Any clinical test or examination subject to these standards shall be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. Unless otherwise provided, any evidence which is not in substantial compliance with the applicable standard is insufficient to establish the fact for which it is proffered.

§ 718.102 Chest roentgenograms (X-rays).

(a) A chest roentgenogram (X-ray) shall be of suitable quality for proper classification of pneumoconiosis and shall conform to the standards for administration and interpretation of chest X-rays as described in Appendix A to this part.

(b) A chest X-ray to establish the existence of pneumoconiosis shall be classified as Category 1, 2, 3, A, B, or C, according to the International Labour Organization Union Internationale Contra Cancer/Cincinnati (1971) International Classification of Radiographs of the Pneumoconioses (ILO–U/C 1971), or subsequent revisions thereof. A chest X-ray classified as Category Z under the ILO Classification (1958) or Short Form (1968) shall be reclassified as Category O or Category 1 as appropriate, and only the latter accepted as evidence of pneumoconiosis. A chest X-ray classified under any of the foregoing classifications as Category O, including sub-categories 0—, 0/0, or 0/1 under the UICC/Cincinnati (1968) Classification or the ILO–U/C 1971 Classification does not constitute evidence of pneumoconiosis.

(c) A description and interpretation of the findings in terms of the classifications described in paragraph (b) of this section shall be submitted by the examining physician along with the film. The report shall specify the name and qualifications of the person who took the film and the name and qualifications of the physician interpreting the film. If the physician interpreting the film is a Board-certified or Board-eligible radiologist or a certified ''B'' reader (see § 718.202), he or she shall so indicate. The report shall further specify that the film was interpreted in compliance with this paragraph.

(d) The original film on which the X-ray report is based shall be supplied to the Office, unless prohibited by law, in which event the report shall be considered as evidence only if the original film is otherwise available to the Office and other parties. Where the chest X-ray of a deceased miner has been lost, destroyed or is otherwise unavailable, a report of a chest X-ray submitted by any party shall be considered in connection with the claim.

(e) No chest X-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the requirements of this section and Appendix A. In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. In the case of a deceased miner where the only available X-ray does not substantially comply with this subpart, such X-ray shall be considered and shall be accorded appropriate weight in light of all relevant evidence if it is of sufficient quality for determining the presence or absence of pneumoconiosis and such X-ray was interpreted by a Board-certified or Board-eligible radiologist or a certified ''B'' reader (see § 718.202).

§ 718.103 Pulmonary function tests.

(a) Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop). The instrument shall simultaneously provide records of volume versus time (spirometric tracing). The report shall provide the results of the forced expiratory volume in one second (FEV1) and the forced vital capacity (FVC). The report shall also provide the FEV1/FVC ratio, expressed as a percentage. If the maximum voluntary ventilation (MVV) is reported, the results of such test shall be obtained independently rather than calculated from the results of the FEV1.

(b) All pulmonary function test results submitted in connection with a claim for benefits shall be accompanied by three tracings of the flow versus volume and the electronically derived volume versus time tracings. If the MVV is reported, two tracings of the MVV whose values are within 10% of each other shall be sufficient. Pulmonary function test results submitted in connection with a claim for benefits shall also include a statement signed by the physician or technician conducting the test setting forth the following:

(1) Date and time of test;

(2) Name, DOL claim number, age, height, and weight of claimant at the time of the test;

(3) Name of technician;

(4) Name and signature of physician supervising the test;

(5) Claimant's ability to understand the instructions, ability to follow directions and degree of cooperation in performing the tests. If the claimant is unable to complete the test, the person executing the report shall set forth the reasons for such failure;

(6) Paper speed of the instrument used;

(7) Name of the instrument used;

(8) Whether a bronchodilator was administered. If a bronchodilator is administered, the physician's report must detail values obtained both before and after administration of the bronchodilator and explain the significance of the results obtained; and

(9) That the requirements of paragraphs (b) and (c) of this section have been complied with.

(c) No results of a pulmonary function study shall constitute evidence of the presence or absence of a respiratory or pulmonary impairment unless it is conducted and reported in accordance with the requirements of this section and Appendix B to this part. In the absence of evidence to the contrary, compliance with the requirements of Appendix B shall be presumed. In the case of a deceased miner, special consideration shall be given to noncomplying tests if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results obtained with good cooperation of the miner.

§ 718.104 Report of physical examinations.

(a) A report of any physical examination conducted in connection with a claim shall be prepared on a medical report form supplied by the Office or in a manner containing substantially the same information. Any such report shall include the following information and test results:

(1) The miner's medical and employment history;

(2) All manifestations of chronic respiratory disease;

(3) Any pertinent findings not specifically listed on the form;

(4) If heart disease secondary to lung disease is found, all symptoms and significant findings;

(5) The results of a chest X-ray conducted and interpreted as required by § 718.102; and

(6) The results of a pulmonary function test conducted and reported as required by § 718.103. If the miner is physically unable to perform a pulmonary function test or if the test is medically contraindicated, in the absence of evidence establishing total disability pursuant to § 718.304, the report must be based on other medically acceptable clinical and laboratory diagnostic techniques, such as a blood gas study.

(b) In addition to the requirements of paragraph (a) of this section, a report of physical examination may be based on any other procedures such as electrocardiogram, blood-gas studies conducted and reported as required by § 718.105, and other blood analyses which, in the physician's opinion, aid in his or her evaluation of the miner.

(c) In the case of a deceased miner, a report prepared by a physician who is unavailable, which fails to meet the criteria of paragraph (a), may be given appropriate consideration and weight by the adjudicator in light of all relevant

evidence provided no report which does comply with this section is available.

(d) *Treating physician.* The adjudication officer may give the medical opinion of the miner's treating physician controlling weight in weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis. The adjudication officer shall take into consideration the following factors in weighing the opinion of a treating physician:

(1) *Nature of relationship.* The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) *Duration of relationship.* The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) *Frequency of treatment.* The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) *Extent of treatment.* The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication officer shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. Whether controlling weight is given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

§ 718.105 Arterial blood-gas studies.

(a) Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. No blood-gas study shall be performed if medically contraindicated.

(b) A blood-gas study shall initially be administered at rest and in a sitting position. If the results of the blood-gas test at rest do not satisfy the requirements of Appendix C to this part, an exercise blood-gas test shall be offered to the miner unless medically contraindicated. If an exercise blood-gas test is administered, blood shall be drawn during exercise.

(c) Any report of a blood-gas study submitted in connection with a claim shall specify:

(1) Date and time of test;

(2) Altitude and barometric pressure at which the test was conducted;

(3) Name and DOL claim number of the claimant;

(4) Name of technician;

(5) Name and signature of physician supervising the study;

(6) The recorded values for PCO2, PO2, and PH, which have been collected simultaneously (specify values at rest and, if performed, during exercise);

(7) Duration and type of exercise;

(8) Pulse rate at the time the blood sample was drawn;

(9) Time between drawing of sample and analysis of sample; and

(10) Whether equipment was calibrated before and after each test.

(d) If one or more blood-gas studies producing results which meet the appropriate table in Appendix C is administered during a hospitalization which ends in the miner's death, then any such study must be accompanied by a physician's report establishing that the test results were produced by a chronic respiratory or pulmonary condition. Failure to produce such a report will prevent reliance on the blood-gas study as evidence that the miner was totally disabled at death.

§ 718.106 Autopsy; biopsy.

(a) A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen. If an autopsy has been performed, a complete copy of the autopsy report shall be submitted to the Office.

(b) In the case of a miner who died prior to March 31, 1980, an autopsy or biopsy report shall be considered even when the report does not substantially comply with the requirements of this section. A noncomplying report concerning a miner who died prior to March 31, 1980, shall be accorded the appropriate weight in light of all relevant evidence.

(c) A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.

§ 718.107 Other medical evidence.

(a) The results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis, the sequelae of pneumoconiosis or a respiratory or pulmonary impairment, may be submitted in connection with a claim and shall be given appropriate consideration.

(b) The party submitting the test or procedure pursuant to this section bears the burden to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits.

Subpart C—Determining Entitlement to Benefits

§ 718.201 Definition of pneumoconiosis.

(a) For the purpose of the Act, ''pneumoconiosis'' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or ''clinical'', pneumoconiosis and statutory, or ''legal'', pneumoconiosis.

(1) *Clinical pneumoconiosis.* ''Clinical pneumoconiosis'' consists of those diseases, recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) *Legal pneumoconiosis.* ''Legal pneumoconiosis'' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease ''arising out of coal mine employment'' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated

by, dust exposure in coal mine employment.

(c) For purposes of this definition, ''pneumoconiosis'' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.202 Determining the existence of pneumoconiosis.

(a) A finding of the existence of pneumoconiosis may be made as follows:

(1) A chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. Except as otherwise provided in this section, where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

(i) In all claims filed before January 1, 1982, where there is other evidence of pulmonary or respiratory impairment, a Board-certified or Board-eligible radiologist's interpretation of a chest X-ray shall be accepted by the Office if the X-ray is in compliance with the requirements of § 718.102 and if such X-ray has been taken by a radiologist or qualified radiologic technologist or technician and there is no evidence that the claim has been fraudulently represented. However, these limitations shall not apply to any claim filed on or after January 1, 1982.

(ii) The following definitions shall apply when making a finding in accordance with this paragraph.

(A) The term *other evidence* means medical tests such as blood-gas studies, pulmonary function studies or physical examinations or medical histories which establish the presence of a chronic pulmonary, respiratory or cardio-pulmonary condition, and in the case of a deceased miner, in the absence of medical evidence to the contrary, affidavits of persons with knowledge of the miner's physical condition.

(B) *Pulmonary or respiratory impairment* means inability of the human respiratory apparatus to perform in a normal manner one or more of the three components of respiration, namely, ventilation, perfusion and diffusion.

(C) *Board-certified* means certification in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association.

(D) *Board-eligible* means the successful completion of a formal accredited residency program in radiology or diagnostic roentgenology.

(E) *Certified 'B' reader* or *'B' reader* means a physician who has demonstrated proficiency in evaluating chest roentgenograms for roentgenographic quality and in the use of the ILO–U/C classification for interpreting chest roentgenograms for pneumoconiosis and other diseases by taking and passing a specially designed proficiency examination given on behalf of or by the Appalachian Laboratory for Occupational Safety and Health. See 42 CFR 37.51(b)(2).

(F) *Qualified radiologic technologist or technician* means an individual who is either certified as a registered technologist by the American Registry of Radiologic Technologists or licensed as a radiologic technologist by a state licensing board.

(2) A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding in an autopsy or biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis. A report of autopsy shall be accepted unless there is evidence that the report is not accurate or that the claim has been fraudulently represented.

(3) If the presumptions described in §§ 718.304, 718.305 or § 718.306 are applicable, it shall be presumed that the miner is or was suffering from pneumoconiosis.

(4) A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

(b) No claim for benefits shall be denied solely on the basis of a negative chest X-ray.

(c) A determination of the existence of pneumoconiosis shall not be made solely on the basis of a living miner's statements or testimony. Nor shall such a determination be made upon a claim involving a deceased miner filed on or after January 1, 1982, solely based upon the affidavit(s) (or equivalent sworn testimony) of the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

§ 718.203 Establishing relationship of pneumoconiosis to coal mine employment.

(a) In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. The provisions in this section set forth the criteria to be applied in making such a determination.

(b) If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

(c) If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship.

§ 718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.

(a) *General.* Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

(b)(1) *Total disability defined.* A miner shall be considered totally disabled if the irrebuttable presumption described in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

(i) From performing his or her usual coal mine work; and

(ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged

with some regularity over a substantial period of time.

(2) *Medical criteria.* In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:

(i) Pulmonary function tests showing values equal to or less than those listed in Table B1 (Males) or Table B2 (Females) in Appendix B to this part for an individual of the miner's age, sex, and height for the FEV1 test; if, in addition, such tests also reveal the values specified in either paragraph (b)(2)(i)(A) or (B) or (C) of this section:

(A) Values equal to or less than those listed in Table B3 (Males) or Table B4 (Females) in Appendix B of this part, for an individual of the miner's age, sex, and height for the FVC test, or

(B) Values equal to or less than those listed in Table B5 (Males) or Table B6 (Females) in Appendix B to this part, for an individual of the miner's age, sex, and height for the MVV test, or

(C) A percentage of 55 or less when the results of the FEV1 test are divided by the results of the FVC test (FEV1/FVC equal to or less than 55%), or

(ii) Arterial blood-gas tests show the values listed in Appendix C to this part, or

(iii) The miner has pneumoconiosis and has been shown by the medical evidence to be suffering from cor pulmonale with right-sided congestive heart failure, or

(iv) Where total disability cannot be shown under paragraphs (b)(2)(i), (ii), or (iii) of this section, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b)(1) of this section.

(c)(1) *Total disability due to pneumoconiosis defined.* A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a ''substantially contributing cause'' of the miner's disability if it:

(i) Has an adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

(2) Except as provided in § 718.305 and paragraph (b)(2)(iii) of this section, proof that the miner suffers or suffered from a totally disabling respiratory or pulmonary impairment as defined in paragraphs (b)(2)(i), (b)(2)(ii), (b)(2)(iv) and (d) of this section shall not, by itself, be sufficient to establish that the miner's impairment is or was due to pneumoconiosis. Except as provided in paragraph (d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report.

(d) *Lay evidence.* In establishing total disability, lay evidence may be used in the following cases:

(1) In a case involving a deceased miner in which the claim was filed prior to January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total (or under § 718.306 partial) disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition.

(2) In a case involving a survivor's claim filed on or after January 1, 1982, but prior to June 30, 1982, which is subject to § 718.306, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total or partial disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of the claimant and/or his or her dependents who would be eligible for augmentation of the claimant's benefits if the claim were approved.

(3) In a case involving a deceased miner whose claim was filed on or after January 1, 1982, affidavits (or equivalent sworn testimony) from persons knowledgeable of the miner's physical condition shall be sufficient to establish total disability due to pneumoconiosis if no medical or other relevant evidence exists which addresses the miner's pulmonary or respiratory condition; however, such a determination shall not be based solely upon the affidavits or testimony of any person who would be eligible for benefits (including augmented benefits) if the claim were approved.

(4) Statements made before death by a deceased miner about his or her physical condition are relevant and shall be considered in making a determination as to whether the miner was totally disabled at the time of death.

(5) In the case of a living miner's claim, a finding of total disability due to pneumoconiosis shall not be made solely on the miner's statements or testimony.

(e) In determining total disability to perform usual coal mine work, the following shall apply in evaluating the miner's employment activities:

(1) In the case of a deceased miner, employment in a mine at the time of death shall not be conclusive evidence that the miner was not totally disabled. To disprove total disability, it must be shown that at the time the miner died, there were no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(2) In the case of a living miner, proof of current employment in a coal mine shall not be conclusive evidence that the miner is not totally disabled unless it can be shown that there are no changed circumstances of employment indicative of his or her reduced ability to perform his or her usual coal mine work.

(3) Changed circumstances of employment indicative of a miner's reduced ability to perform his or her usual coal mine work may include but are not limited to:

(i) The miner's reduced ability to perform his or her customary duties without help; or

(ii) The miner's reduced ability to perform his or her customary duties at his or her usual levels of rapidity, continuity or efficiency; or

(iii) The miner's transfer by request or assignment to less vigorous duties or to duties in a less dusty part of the mine.

§ 718.205 Death due to pneumoconiosis.

(a) Benefits are provided to eligible survivors of a miner whose death was due to pneumoconiosis. In order to receive benefits, the claimant must prove that:

(1) The miner had pneumoconiosis (see § 718.202);

(2) The miner's pneumoconiosis arose out of coal mine employment (see § 718.203); and

(3) The miner's death was due to pneumoconiosis as provided by this section.

(b) For the purpose of adjudicating survivors' claims filed prior to January 1, 1982, death will be considered due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence established that the miner's death was due to pneumoconiosis, or

(2) Where death was due to multiple causes including pneumoconiosis and it is not medically feasible to distinguish which disease caused death or the extent to which pneumoconiosis contributed to the cause of death, or

(3) Where the presumption set forth at § 718.304 is applicable, or

(4) Where either of the presumptions set forth at § 718.303 or § 718.305 is applicable and has not been rebutted.

(5) Where the cause of death is significantly related to or aggravated by pneumoconiosis.

(c) For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:

(1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or

(2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or

(3) Where the presumption set forth at § 718.304 is applicable.

(4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a ''substantially contributing cause'' of a miner's death if it hastens the miner's death.

(d) To minimize the hardships to potentially entitled survivors due to the disruption of benefits upon the miner's death, survivors' claims filed on or after January 1, 1982, shall be adjudicated on an expedited basis in accordance with the following procedures. The initial burden is upon the claimant, with the assistance of the district director, to develop evidence which meets the requirements of paragraph (c) of this section. Where the initial medical evidence appears to establish that death was due to pneumoconiosis, the survivor will receive benefits unless the weight of the evidence as subsequently developed by the Department or the responsible operator establishes that the miner's death was not due to pneumoconiosis as defined in paragraph (c). However, no such benefits shall be found payable before the party responsible for the payment of such benefits shall have had a reasonable opportunity for the development of rebuttal evidence. See § 725.414 concerning the operator's opportunity to develop evidence prior to an initial determination.

§ 718.206 Effect of findings by persons or agencies.

Decisions, statements, reports, opinions, or the like, of agencies, organizations, physicians or other individuals, about the existence, cause, and extent of a miner's disability, or the cause of a miner's death, are admissible. If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

Subpart D—Presumptions Applicable to Eligibility Determinations

§ 718.301 Establishing length of employment as a miner.

The presumptions set forth in §§ 718.302, 718.303, 718.305 and 718.306 apply only if a miner worked in one or more coal mines for the number of years required to invoke the presumption. The length of the miner's coal mine work history must be computed as provided by 20 CFR 725.101(a)(32).

§ 718.302 Relationship of pneumoconiosis to coal mine employment.

If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. (See § 718.203.)

§ 718.303 Death from a respirable disease.

(a)(1) If a deceased miner was employed for ten or more years in one or more coal mines and died from a respirable disease, there shall be a rebuttable presumption that his or her death was due to pneumoconiosis.

(2) Under this presumption, death shall be found due to a respirable disease in any case in which the evidence establishes that death was due to multiple causes, including a respirable disease, and it is not medically feasible to distinguish which disease caused death or the extent to which the respirable disease contributed to the cause of death.

(b) The presumption of paragraph (a) of this section may be rebutted by a showing that the deceased miner did not have pneumoconiosis, that his or her death was not due to pneumoconiosis or that pneumoconiosis did not contribute to his or her death.

(c) This section is not applicable to any claim filed on or after January 1, 1982.

§ 718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, that a miner's death was due to pneumoconiosis or that a miner was totally disabled due to pneumoconiosis at the time of death, if such miner is suffering or suffered from a chronic dust disease of the lung which:

(a) When diagnosed by chest X-ray (see § 718.202 concerning the standards for X-rays and the effect of interpretations of X-rays by physicians) yields one or more large opacities (greater than 1 centimeter in diameter) and would be classified in Category A, B, or C in:

(1) The ILO–U/C International Classification of Radiographs of the Pneumoconioses, 1971, or subsequent revisions thereto; or

(2) The International Classification of the Radiographs of the Pneumoconioses of the International Labour Office, Extended Classification (1968) (which may be referred to as the ''ILO Classification (1968)''); or

(3) The Classification of the Pneumoconioses of the Union Internationale Contra Cancer/Cincinnati (1968) (which may be referred to as the ''UICC/Cincinnati (1968) Classification''); or

(b) When diagnosed by biopsy or autopsy, yields massive lesions in the lung; or

(c) When diagnosed by means other than those specified in paragraphs (a) and (b) of this section, would be a condition which could reasonably be expected to yield the results described in paragraph (a) or (b) of this section had diagnosis been made as therein described: *Provided, however,* That any diagnosis made under this paragraph shall accord with acceptable medical procedures.

§ 718.305 Presumption of pneumoconiosis.

(a) If a miner was employed for fifteen years or more in one or more underground coal mines, and if there is a chest X-ray submitted in connection with such miner's or his or her survivor's claim and it is interpreted as negative with respect to the requirements of § 718.304, and if other evidence demonstrates the existence of a totally disabling respiratory or pulmonary impairment, then there shall be a rebuttable presumption that such miner is totally disabled due to pneumoconiosis, that such miner's death was due to pneumoconiosis, or that at the time of death such miner was totally disabled by pneumoconiosis. In

the case of a living miner's claim, a spouse's affidavit or testimony may not be used by itself to establish the applicability of the presumption. The Secretary shall not apply all or a portion of the requirement of this paragraph that the miner work in an underground mine where it is determined that conditions of the miner's employment in a coal mine were substantially similar to conditions in an underground mine. The presumption may be rebutted only by establishing that the miner does not, or did not, have pneumoconiosis, or that his or her respiratory or pulmonary impairment did not arise out of, or in connection with, employment in a coal mine.

(b) In the case of a deceased miner, where there is no medical or other relevant evidence, affidavits of persons having knowledge of the miner's condition shall be considered to be sufficient to establish the existence of a totally disabling respiratory or pulmonary impairment for purposes of this section.

(c) The determination of the existence of a totally disabling respiratory or pulmonary impairment, for purposes of applying the presumption described in this section, shall be made in accordance with § 718.204.

(d) Where the cause of death or total disability did not arise in whole or in part out of dust exposure in the miner's coal mine employment or the evidence establishes that the miner does not or did not have pneumoconiosis, the presumption will be considered rebutted. However, in no case shall the presumption be considered rebutted on the basis of evidence demonstrating the existence of a totally disabling obstructive respiratory or pulmonary disease of unknown origin.

(e) This section is not applicable to any claim filed on or after January 1, 1982.

§ 718.306 Presumption of entitlement applicable to certain death claims.

(a) In the case of a miner who died on or before March 1, 1978, who was employed for 25 or more years in one or more coal mines prior to June 30, 1971, the eligible survivors of such miner whose claims have been filed prior to June 30, 1982, shall be entitled to the payment of benefits, unless it is established that at the time of death such miner was not partially or totally disabled due to pneumoconiosis. Eligible survivors shall, upon request, furnish such evidence as is available with respect to the health of the miner at the time of death, and the nature and duration of the miner's coal mine employment.

(b) For the purpose of this section, a miner will be considered to have been ''partially disabled'' if he or she had reduced ability to engage in work as defined in § 718.204(b).

(c) In order to rebut this presumption the evidence must demonstrate that the miner's ability to perform work as defined in § 718.204(b) was not reduced at the time of his or her death or that the miner did not have pneumoconiosis.

(d) None of the following items, by itself, shall be sufficient to rebut the presumption:

(1) Evidence that a deceased miner was employed in a coal mine at the time of death;

(2) Evidence pertaining to a deceased miner's level of earnings prior to death;

(3) A chest X-ray interpreted as negative for the existence of pneumoconiosis;

(4) A death certificate which makes no mention of pneumoconiosis.

Appendix A to Part 718—Standards for Administration and Interpretation of Chest Roentgenograms (X-rays)

The following standards are established in accordance with sections 402(f)(1)(D) and 413(b) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health. These standards are promulgated for the guidance of physicians and medical technicians to insure that uniform procedures are used in administering and interpreting X-rays and that the best available medical evidence will be submitted in connection with a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be assigned to the physician's report of an X-ray.

(1) Every chest roentgenogram shall be a single postero-anterior projection at full inspiration on a 14 by 17 inch film. Additional chest films or views shall be obtained if they are necessary for clarification and classification. The film and cassette shall be capable of being positioned both vertically and horizontally so that the chest roentgenogram will include both apices and costophrenic angles. If a miner is too large to permit the above requirements, then a projection with minimum loss of costophrenic angle shall be made.

(2) Miners shall be disrobed from the waist up at the time the roentgenogram is given. The facility shall provide a dressing area and, for those miners who wish to use one, the facility shall provide a clean gown. Facilities shall be heated to a comfortable temperature.

(3) Roentgenograms shall be made only with a diagnostic X-ray machine having a rotating anode tube with a maximum of a 2 mm source (focal spot).

(4) Except as provided in paragraph (5), roentgenograms shall be made with units having generators which comply with the following: (a) the generators of existing roentgenographic units acquired by the examining facility prior to July 27, 1973, shall have a minimum rating of 200 mA at 100 kVp; (b) generators of units acquired subsequent to that date shall have a minimum rating of 300 mA at 125 kVp.

Note: A generator with a rating of 150 kVp is recommended.

(5) Roentgenograms made with battery-powered mobile or portable equipment shall be made with units having a minimum rating of 100 mA at 110 kVp at 500 Hz, or 200 mA at 110 kVp at 60 Hz.

(6) Capacitor discharge, and field emission units may be used.

(7) Roentgenograms shall be given only with equipment having a beam-limiting device which does not cause large unexposed boundaries. The use of such a device shall be discernible from an examination of the roentgenogram.

(8) To insure high quality chest roentgenograms:

(i) The maximum exposure time shall not exceed 1/20 of a second except that with single phase units with a rating less than 300 mA at 125 kVp and subjects with chest over 28 cm postero-anterior, the exposure may be increased to not more than 1/10 of a second;

(ii) The source or focal spot to film distance shall be at least 6 feet;

(iii) Only medium-speed film and medium-speed intensifying screens shall be used;

(iv) Film-screen contact shall be maintained and verified at 6-month or shorter intervals;

(v) Intensifying screens shall be inspected at least once a month and cleaned when necessary by the method recommended by the manufacturer;

(vi) All intensifying screens in a cassette shall be of the same type and made by the same manufacturer;

(vii) When using over 90 kV, a suitable grid or other means of reducing scattered radiation shall be used;

(viii) The geometry of the radiographic system shall insure that the central axis (ray) of the primary beam is perpendicular to the plane of the film surface and impinges on the center of the film.

(9) Radiographic processing:

(i) Either automatic or manual film processing is acceptable. A constant time-temperature technique shall be meticulously employed for manual processing.

(ii) If mineral or other impurities in the processing water introduce difficulty in obtaining a high-quality roentgenogram, a suitable filter or purification system shall be used.

(10) Before the miner is advised that the examination is concluded, the roentgenogram shall be processed and inspected and accepted for quality by the physician, or if the physician is not available, acceptance may be made by the radiologic technologist. In a case of a substandard roentgenogram, another shall be made immediately.

(11) An electric power supply shall be used which complies with the voltage, current, and regulation specified by the manufacturer of the machine.

(12) A densitometric test object may be required on each roentgenogram for an objective evaluation of film quality at the discretion of the Department of Labor.

(13) Each roentgenogram made under this Appendix shall be permanently and legibly

marked with the name and address of the facility at which it is made, the miner's DOL claim number, the date of the roentgenogram, and left and right side of film. No other identifying markings shall be recorded on the roentgenogram.

Appendix B to Part 718—Standards for Administration and Interpretation of Pulmonary Function Tests—Tables B1, B2, B3, B4, B5, B6

The following standards are established in accordance with section 402(f)(1)(D) of the Act. They were developed in consultation with the National Institute for Occupational Safety and Health (NIOSH). These standards are promulgated for the guidance of physicians and medical technicians to insure that uniform procedures are used in administering and interpreting ventilatory function tests and that the best available medical evidence will be submitted in support of a claim for black lung benefits. If it is established that one or more standards have not been met, the claims adjudicator may consider such fact in determining the evidentiary weight to be given to the results of the ventilatory function tests.

(1) Instruments to be used for the administration of pulmonary function tests shall be approved by NIOSH and shall conform to the following criteria:

(i) The instrument shall be accurate within +/−50 ml or within +/−3 percent of reading, whichever is greater.

(ii) The instrument shall be capable of measuring vital capacity from 0 to 7 liters BTPS.

(iii) The instrument shall have a low inertia and offer low resistance to airflow such that the resistance to airflow at 12 liters per second must be less than 1.5 cm H_2O/liter/sec.

(iv) The instrument or user of the instrument must have a means of correcting volumes to body temperature saturated with water vapor (BTPS) under conditions of varying ambient spirometer temperatures and barometric pressures.

(v) The instrument used shall provide a tracing of flow versus volume (flow-volume loop) which displays the entire maximum inspiration and the entire maximum forced expiration. The instrument shall, in addition, provide tracings of the volume versus time tracing (spirogram) derived electronically from the flow-volume loop. Tracings are necessary to determine whether maximum inspiratory and expiratory efforts have been obtained during the FVC maneuver. If maximum voluntary ventilation is measured, the tracing shall record the individual breaths volumes versus time.

(vi) The instrument shall be capable of accumulating volume for a minimum of 10 seconds after the onset of exhalation.

(vii) The instrument must be capable of being calibrated in the field with respect to the FEV1. The volume calibration shall be accomplished with a 3 L calibrating syringe and should agree to within 1 percent of a 3 L calibrating volume. The linearity of the instrument must be documented by a record of volume calibrations at three different flow rates of approximately 3 L/6 sec, 3 L/3 sec, and 3 L/sec.

(viii) For measuring maximum voluntary ventilation (MVV) the instrument shall have a response which is flat within +/−10 percent up to 4 Hz at flow rates up to 12 liters per second over the volume range.

(ix) The spirogram shall be recorded at a speed of at least 20 mm/sec and a volume excursion of at least 10mm/L. Calculation of the FEV1 from the flow-volume loop is not acceptable. Original tracings shall be submitted.

(2) The administration of pulmonary function tests shall conform to the following criteria:

(i) Tests shall not be performed during or soon after an acute respiratory illness.

(ii) For the FEV1 and FVC, use of a nose clip is required. The procedures shall be explained in simple terms to the patient who shall be instructed to loosen any tight clothing and stand in front of the apparatus. The subject may sit, or stand, but care should be taken on repeat testing that the same position be used. Particular attention shall be given to insure that the chin is slightly elevated with the neck slightly extended. The subject shall be instructed to expire completely, momentarily hold his breath, place the mouthpiece in his mouth and close the mouth firmly about the mouthpiece to ensure no air leak. The subject will then make a maximum inspiration from the instrument and when maximum inspiration has been attained, without interruption, blow as hard, fast and completely as possible for at least 7 seconds or until a plateau has been attained in the volume-time curve with no detectable change in the expired volume during the last 2 seconds of maximal expiratory effort. A minimum of three flow-volume loops and derived spirometric tracings shall be carried out. The patient shall be observed throughout the study for compliance with instructions. Inspiration and expiration shall be checked visually for reproducibility. The effort shall be judged unacceptable when the patient:

(A) Has not reached full inspiration preceding the forced expiration; or

(B) Has not used maximal effort during the entire forced expiration; or

(C) Has not continued the expiration for at least 7 sec. or until an obvious plateau for at least 2 sec. in the volume-time curve has occurred; or

(D) Has coughed or closed his glottis; or

(E) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(F) Has an unsatisfactory start of expiration, one characterized by excessive hesitation (or false starts). Peak flow should be attained at the start of expiration and the volume-time tracing (spirogram) should have a smooth contour revealing gradually decreasing flow throughout expiration; or

(G) Has an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater.

(iii) For the MVV, the subject shall be instructed before beginning the test that he or she will be asked to breathe as deeply and as rapidly as possible for approximately 15 seconds. The test shall be performed with the subject in the standing position, if possible. Care shall be taken on repeat testing that the same position be used. The subject shall breathe normally into the mouthpiece of the apparatus for 10 to 15 seconds to become accustomed to the system. The subject shall then be instructed to breathe as deeply and as rapidly as possible, and shall be continually encouraged during the remainder of the maneuver. Subject shall continue the maneuver for 15 seconds. At least 5 minutes of rest shall be allowed between maneuvers. At least three MVV's shall be carried out. (But see § 718.103(b).) During the maneuvers the patient shall be observed for compliance with instructions. The effort shall be judged unacceptable when the patient:

(A) Has not maintained consistent effort for at least 12 to 15 seconds; or

(B) Has coughed or closed his glottis; or

(C) Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

(D) Has an excessive variability between the three acceptable curves. The variation between the two largest MVV's of the three satisfactory tracings shall not exceed 10 percent.

(iv) A calibration check shall be performed on the instrument each day before use, using a volume source of at least three liters, accurate to within +/−1 percent of full scale. The volume calibration shall be performed in accordance with the method described in paragraph (1)(vii) of this Appendix. Accuracy of the time measurement used in determining the FEV1 shall be checked using the manufacturer's stated procedure and shall be within +/−3 percent of actual. The procedure described in the Appendix shall be performed as well as any other procedures suggested by the manufacturer of the spirometer being used.

(v)(A) The first step in evaluating a spirogram for the FVC and FEV1 shall be to determine whether or not the patient has performed the test properly or as described in paragraph (2)(ii) of this Appendix. The largest recorded FVC and FEV1, corrected to BTPS, shall be used in the analysis.

(B) Only MVV maneuvers which demonstrate consistent effort for at least 12 seconds shall be considered acceptable. The largest accumulated volume for a 12 second period corrected to BTPS and multiplied by five or the largest accumulated volume for a 15 second period corrected to BTPS and multiplied by four is to be reported as the MVV.

* * * * *

Appendix C to Part 718—Blood-Gas Tables

The following tables set forth the values to be applied in determining whether total disability may be established in accordance with §§ 718.204(b)(2)(ii) and 718.305(a) and (c). The values contained in the tables are indicative of impairment only. They do not establish a degree of disability except as provided in §§ 718.204(b)(2)(ii) and 718.305

(a) and (c), nor do they establish standards for determining normal alveolar gas exchange values for any particular individual. Tests shall not be performed during or soon after an acute respiratory or cardiac illness.

A miner who meets the following medical specifications shall be found to be totally disabled, in the absence of rebutting evidence, if the values specified in one of the following tables are met:

(1) For arterial blood-gas studies performed at test sites up to 2,999 feet above sea level:

Arterial pCO2 (mm Hg)	Arterial pO2 equal to or less than (mm Hg)
25 or below	75
26	74
27	73
28	72
29	71
30	70
31	69
32	68
33	67
34	66
35	65
36	64
37	63
38	62
39	61
40–49	60
Above 50	[1]

[1] Any value.

(2) For arterial blood-gas studies performed at test sites 3,000 to 5,999 feet above sea level:

Arterial pCO2 (mm Hg)	Arterial pO2 equal to or less than (mm Hg)
25 or below	70
26	69
27	68
28	67
29	66
30	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40–49	55
Above 50	[2]

[2] Any value.

(3) For arterial blood-gas studies performed at test sites 6,000 feet or more above sea level:

Arterial pCO2 (mm Hg)	Arterial pO2 equal to or less than (mm Hg)
25 or below	65
26	64
27	63
28	62
29	61
30	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40–49	50
Above 50	[3]

[3] Any value.

3. Part 722 is proposed to be revised as follows.

PART 722—CRITERIA FOR DETERMINING WHETHER STATE WORKERS' COMPENSATION LAWS PROVIDE ADEQUATE COVERAGE FOR PNEUMOCONIOSIS AND LISTING OF APPROVED STATE LAWS

Authority: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 et seq., 921, 932, 936; 33 U.S.C. 901 et seq., Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

§ 722.1 Purpose.

Section 421 of the Black Lung Benefits Act provides that a claim for benefits based on the total disability or death of a coal miner due to pneumoconiosis must be filed under a State workers' compensation law where such law provides adequate coverage for pneumoconiosis. A State workers' compensation law may be deemed to provide adequate coverage only when it is included on a list of such laws maintained by the Secretary. The purpose of this part is to set forth the procedures and criteria for inclusion on that list, and to provide that list.

§ 722.2 Definitions.

(a) The definitions and use of terms contained in subpart A of part 725 of this title shall be applicable to this part.

(b) For purposes of this part, the following definitions apply:

(1) *State agency* means, with respect to any State, the agency, department or officer designated by the workers' compensation law of the State to administer such law. In any case in which more than one agency participates in the administration of a State workers' compensation law, the Governor of the State may designate which of the agencies shall be the State agency for purposes of this part.

(2) *The Secretary's list* means the list published by the Secretary of Labor in the **Federal Register** (see § 722.4) containing the names of those States which have in effect a workers' compensation law which provides adequate coverage for death or total disability due to pneumoconiosis.

§ 722.3 General criteria; inclusion in and removal from the Secretary's list.

(a) The Governor of any State or any duly authorized State agency may, at any time, request that the Secretary include such State's workers' compensation law on his list of those State workers' compensation laws providing adequate coverage for total disability or death due to pneumoconiosis. Each such request shall include a copy of the State workers' compensation law and any other pertinent State laws, a copy of any regulations, either proposed or promulgated, implementing such laws; and a copy of any administrative or court decision interpreting such laws or regulations, or, if such decisions are published in a readily available report, a citation to such decision.

(b) Upon receipt of a request that a State be included on the Secretary's list, the Secretary shall include the State on the list if he finds that the State's workers' compensation law guarantees the payment of monthly and medical benefits to all persons who would be entitled to such benefits under the Black Lung Benefits Act at the time of the request, at a rate no less than that provided by the Black Lung Benefits Act. The criteria used by the Secretary in making such determination shall include, but shall not be limited to, the criteria set forth in section 421(b)(2) of the Act.

(c) The Secretary may require each State included on the list to submit reports detailing the extent to which the State's workers' compensation laws, as reflected by statute, regulation, or administrative or court decision, continues to meet the requirements of paragraph (b) of this section. If the Secretary concludes that the State's workers' compensation law does not provide adequate coverage at any time, either because of changes to the State workers' compensation law or the Black Lung Benefits Act, he shall remove the State from the Secretary's list after providing the State with notice of such removal and an opportunity to be heard.

§ 722.4 The Secretary's list.

(a) The Secretary has determined that publication of the Secretary's list in the Code of Federal Regulations is appropriate. Accordingly, in addition to its publication in the **Federal Register** as required by section 421 of the Black Lung Benefits Act, the list shall also appear in paragraph (b) of this section.

(b) Upon review of all requests filed with the Secretary under section 421 of the Black Lung Benefits Act and this part, and examination of the workers' compensation laws of the States making such requests, the Secretary has determined that the workers' compensation law of each of the following listed States, for the period from the date shown in the list until such date as the Secretary may make a contrary determination, provides adequate coverage for pneumoconiosis.

State	Period commencing
None	

4. Part 725 is proposed to be revised as follows:

PART 725—CLAIMS FOR BENEFITS UNDER PART C OF TITLE IV OF THE FEDERAL MINE SAFETY AND HEALTH ACT, AS AMENDED

Subpart A—General

Subpart B—Persons Entitled to Benefits, Conditions, and Duration of Entitlement

Conditions and Duration of Entitlement: Miner

Conditions and Duration of Entitlement: Miner's Dependents (Augmented Benefits)

Conditions and Duration of Entitlement: Miner's Survivors

Terms Used in This Subpart

Subpart C—Filing of Claims

Subpart D—Adjudication Officers; Parties and Representatives

Subpart E—Adjudication of Claims by the District Director

Subpart F—Hearings

Authority: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 et seq., 921, 932, 936; 33 U.S.C. 901 et seq., 42 U.S.C. 405, Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

Subpart A—General

§ 725.1 Statutory provisions.

(a) *General.* Title IV of the Federal Mine Safety and Health Act of 1977, as amended by the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Revenue Act of 1981 and the Black Lung Benefits Amendments of 1981, provides for the payment of benefits to a coal miner who is totally disabled due to pneumoconiosis (black lung disease) and to certain survivors of a miner who dies due to pneumoconiosis. For claims filed prior to January 1, 1982, certain survivors could receive benefits if the miner was totally (or for claims filed prior to June 30, 1982, in accordance with section 411(c)(5) of the Act, partially) disabled due to pneumoconiosis, or if the miner died due to pneumoconiosis.

(b) *Part B.* Part B of title IV of the Act provided that all claims filed between December 30, 1969, and June 30, 1973, are to be filed with, processed, and paid by the Secretary of Health, Education, and Welfare through the Social Security Administration; claims filed by the survivor of a miner before January 1, 1974, or within 6 months of the miner's death if death occurred before January 1, 1974, and claims filed by the survivor of a miner who was receiving benefits under part B of title IV of the Act at the time of death, if filed within 6 months of the miner's death, are also adjudicated and paid by the Social Security Administration.

(c) *Section 415.* Claims filed by a miner between July 1 and December 31, 1973, are adjudicated and paid under section 415. Section 415 provides that a claim filed between the appropriate dates shall be filed with and adjudicated by the Secretary of Labor under certain incorporated provisions of the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 901 et seq.). A claim approved under section 415 is paid under part B of title IV of the Act for periods of eligibility occurring between July 1 and December 31, 1973, by the Secretary of Labor and for periods of eligibility thereafter, is paid by a coal mine operator which is determined liable for the claim or the Black Lung Disability Trust Fund if no operator is identified or if the miner's last coal mine employment terminated prior to January 1, 1970. An operator which may be found liable for a section 415 claim is notified of the claim and allowed to participate fully in the adjudication of such claim. A claim filed under section 415 is for all purposes considered as if it were a part C claim (see paragraph (d) of this section) and the provisions of part C of title IV of the Act are fully applicable to a section 415 claim except as is otherwise provided in section 415.

(d) *Part C.* Claims filed by a miner or survivor on or after January 1, 1974, are filed, adjudicated, and paid under the provisions of part C of title IV of the Act. Part C requires that a claim filed on or after January 1, 1974, shall be filed under an applicable approved State workers' compensation law, or if no such law has been approved by the Secretary of Labor, the claim may be filed with the Secretary of Labor under section 422 of the Act. Claims filed with the Secretary of Labor under part C are

processed and adjudicated by the Secretary and paid by a coal mine operator. If the miner's last coal mine employment terminated before January 1, 1970, or if no responsible operator can be identified, benefits are paid by the Black Lung Disability Trust Fund. Claims adjudicated under part C are subject to certain incorporated provisions of the Longshoremen's and Harbor Workers' Compensation Act.

(e) *Section 435.* Section 435 of the Act affords each person who filed a claim for benefits under part B, section 415, or part C, and whose claim had been denied or was still pending as of March 1, 1978, the effective date of the Black Lung Benefits Reform Act of 1977, the right to have his or her claim reviewed on the basis of the 1977 amendments to the Act, and under certain circumstances to submit new evidence in support of the claim.

(f) *Changes made by the Black Lung Benefits Reform Act of 1977.* In addition to those changes which are reflected in paragraphs (a) through (e) of this section, the Black Lung Benefits Reform Act of 1977 contains a number of significant amendments to the Act's standards for determining eligibility for benefits. Among these are:

(1) A provision which clarifies the definition of ''pneumoconiosis'' to include any ''chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment'';

(2) A provision which defines ''miner'' to include any person who works or has worked in or around a coal mine or coal preparation facility, and in coal mine construction or coal transportation under certain circumstances;

(3) A provision which limits the denial of a claim solely on the basis of employment in a coal mine;

(4) A provision which authorizes the Secretary of Labor to establish standards and develop criteria for determining total disability or death due to pneumoconiosis with respect to a part C claim;

(5) A new presumption which requires the payment of benefits to the survivors of a miner who was employed for 25 or more years in the mines under certain conditions;

(6) Provisions relating to the treatment to be accorded a survivor's affidavit, certain X-ray interpretations, and certain autopsy reports in the development of a claim; and

(7) Other clarifying, procedural, and technical amendments.

(g) *Changes made by the Black Lung Benefits Revenue Act of 1977.* The Black Lung Benefits Revenue Act of 1977 established the Black Lung Disability Trust Fund which is financed by a specified tax imposed upon each ton of coal (except lignite) produced and sold or used in the United States after March 31, 1978. The Secretary of the Treasury is the managing trustee of the fund and benefits are paid from the fund upon the direction of the Secretary of Labor. The fund was made liable for the payment of all claims approved under section 415, part C and section 435 of the Act for all periods of eligibility occurring on or after January 1, 1974, with respect to claims where the miner's last coal mine employment terminated before January 1, 1970, or where individual liability can not be assessed against a coal mine operator due to bankruptcy, insolvency, or the like. The fund was also authorized to pay certain claims which a responsible operator has refused to pay within a reasonable time, and to seek reimbursement from such operator. The purpose of the fund and the Black Lung Benefits Revenue Act of 1977 was to insure that coal mine operators, or the coal industry, will fully bear the cost of black lung disease for the present time and in the future. The Black Lung Benefits Revenue Act of 1977 also contained other provisions relating to the fund and authorized a coal mine operator to establish its own trust fund for the payment of certain claims.

(h) *Changes made by the Black Lung Benefits Amendments of 1981.* In addition to the change reflected in paragraph (a) of this section, the Black Lung Benefits Amendments of 1981 made a number of significant changes in the Act's standards for determining eligibility for benefits and concerning the payment of such benefits. The following changes are all applicable to claims filed on or after January 1, 1982:

(1) The Secretary of Labor may re-read any X-ray submitted in support of a claim and may rely upon a second opinion concerning such an X-ray as a means of auditing the validity of the claim;

(2) The rebuttable presumption that the death of a miner with ten or more years employment in the coal mines, who died of a respirable disease, was due to pneumoconiosis is no longer applicable;

(3) The rebuttable presumption that the total disability of a miner with fifteen or more years employment in the coal mines, who has demonstrated a totally disabling respiratory or pulmonary impairment, is due to pneumoconiosis is no longer applicable;

(4) In the case of deceased miners, where no medical or other relevant evidence is available, only affidavits from persons not eligible to receive benefits as a result of the adjudication of the claim will be considered sufficient to establish entitlement to benefits;

(5) Unless the miner was found entitled to benefits as a result of a claim filed prior to January 1, 1982, benefits are payable on survivors' claims filed on and after January 1, 1982, only when the miner's death was due to pneumoconiosis;

(6) Benefits payable under this part are subject to an offset on account of excess earnings by the miner; and

(7) Other technical amendments.

(i) *Changes made by the Black Lung Benefits Revenue Act of 1981.* The Black Lung Benefits Revenue Act of 1981 temporarily doubles the amount of the tax upon coal until the fund shall have repaid all advances received from the United States Treasury and the interest on all such advances. The fund is also made liable for the payment of certain claims previously denied under the 1972 version of the Act and subsequently approved under section 435 and for the reimbursement of operators and insurers for benefits previously paid by them on such claims. With respect to claims filed on or after January 1, 1982, the fund's authorization for the payment of interim benefits is limited to the payment of prospective benefits only. These changes also define the rates of interest to be paid to and by the fund.

(j) *Longshoremen's Act provisions.* The adjudication of claims filed under sections 415, 422 and 435 of the Act is governed by various procedural and other provisions contained in the Longshoremen's and Harbor Workers' Compensation Act (LHWCA), as amended from time to time, which are incorporated within the Act by sections 415 and 422. The incorporated LHWCA provisions are applicable under the Act except as is otherwise provided by the Act or as provided by regulations of the Secretary. Although occupational disease benefits are also payable under the LHWCA, the primary focus of the procedures set forth in that Act is upon a time definite of traumatic injury or death. Because of this and other significant differences between a black lung and longshore claim, it is determined, in accordance with the authority set forth in section 422 of the Act, that certain of the incorporated procedures prescribed by the LHWCA must be altered to fit the circumstances ordinarily confronted in the adjudication of a black lung claim. The changes made are based upon the Department's experience in processing black lung claims since July 1, 1973,

and all such changes are specified in this part or part 727 of this subchapter (see § 725.4(d)). No other departure from the incorporated provisions of the LHWCA is intended.

(k) *Social Security Act provisions.* Section 402 of the Act incorporates certain definitional provisions from the Social Security Act, 42 U.S.C. 301 et seq. Section 430 provides that the 1972, 1977 and 1981 amendments to part B of the Act shall also apply to part C ''to the extent appropriate.'' Sections 412 and 413 incorporate various provisions of the Social Security Act into part B of the Act. To the extent appropriate, these provisions also apply to part C. In certain cases, the Department has varied the terms of the Social Security Act provisions to accommodate the unique needs of the black lung benefits program. Parts of the Longshore and Harbor Workers' Compensation Act are also incorporated into part C. Where the incorporated provisions of the two acts are inconsistent, the Department has exercised its broad regulatory powers to choose the extent to which incorporation is appropriate.

§ 725.2 Purpose and applicability of this part.

(a) This part sets forth the procedures to be followed and standards to be applied in filing, processing, adjudicating, and paying claims filed under part C of title IV of the Act.

(b) This part applies to all claims filed under part C of title IV of the Act on or after August 18, 1978 and shall also apply to claims that were pending on August 18, 1978.

(c) The provisions of this part reflect revisions that became effective on [the effective date of the final rule]. This part applies to all claims filed, and all benefits payments made, after [the effective date of the final rule]. With the exception of the following sections, this part shall also apply to the adjudication of claims that were pending on [the effective date of the final rule]: §§ 725.309, 725.310, 725.351, 725.360, 725.406, 725.407, 725.408, 725.410, 725.411, 725.412, 725.413, 725.414, 725.415, 725.417, 725.418, 725.423, 725.454, 725.456, 725.457, 725.459, 725.491, 725.492, 725.493, 725.494, 725.495, 725.547. The version of those sections set forth in 20 CFR, parts 500 to end, edition revised as of April 1, 1996, apply to the adjudications of claims that were pending on [the effective date of the final rule]. For purposes of construing the provisions of this section, a claim shall be considered pending on [the effective date of the final rule] if it was not finally denied more than one year prior to that date.

§ 725.3 Contents of this part.

(a) This subpart describes the statutory provisions which relate to claims considered under this part, the purpose and scope of this part, definitions and usages of terms applicable to this part, and matters relating to the availability of information collected by the Department of Labor in connection with the processing of claims.

(b) Subpart B contains criteria for determining who may be found entitled to benefits under this part and other provisions relating to the conditions and duration of eligibility of a particular individual.

(c) Subpart C describes the procedures to be followed and action to be taken in connection with the filing of a claim under this part.

(d) Subpart D sets forth the duties and powers of the persons designated by the Secretary of Labor to adjudicate claims and provisions relating to the rights of parties and representatives of parties.

(e) Subpart E contains the procedures for developing evidence and adjudicating entitlement and liability issues by the district director.

(f) Subpart F describes the procedures to be followed if a hearing before the Office of Administrative Law Judges is required.

(g) Subpart G contains provisions governing the identification of a coal mine operator which may be liable for the payment of a claim.

(h) Subpart H contains provisions governing the payment of benefits with respect to an approved claim.

(i) Subpart I describes the statutory mechanisms provided for the enforcement of a coal mine operator's liability, sets forth the penalties which may be applied in the case of a defaulting coal mine operator, and describes the obligation of coal operators and their insurance carriers to file certain reports.

(j) Subpart J describes the right of certain beneficiaries to receive medical treatment benefits and vocational rehabilitation under the Act.

§ 725.4 Applicability of other parts in this title.

(a) *Part 718.* Part 718 of this subchapter, which contains the criteria and standards to be applied in determining whether a miner is or was totally disabled due to pneumoconiosis, or whether a miner died due to pneumoconiosis, shall be applicable to the determination of claims under this part. Claims filed after March 31, 1980, are subject to part 718 as promulgated by the Secretary in accordance with section 402(f)(1) of the Act on February 29, 1980 (see § 725.2(c)). The criteria contained in subpart C of part 727 of this subchapter are applicable in determining claims filed prior to April 1, 1980, under this part, and such criteria shall be applicable at all times with respect to claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977.

(b) *Parts 715, 717, and 720.* Pertinent and significant provisions of Parts 715, 717, and 720 of this subchapter (contained in 20 CFR, parts 500 to end, edition revised as of April 1, 1978), which established the procedures for the filing, processing, and payment of claims filed under section 415 of the Act, are included within this part as appropriate.

(c) *Part 726.* Part 726 of this subchapter, which sets forth the obligations imposed upon a coal operator to insure or self-insure its liability for the payment of benefits to certain eligible claimants, is applicable to this part as appropriate.

(d) *Part 727.* Part 727 of this subchapter, which governs the review, adjudication and payment of pending and denied claims under section 435 of the Act, is applicable with respect to such claims. The criteria contained in subpart C of part 727 for determining a claimant's eligibility for benefits are applicable under this part with respect to all claims filed before April 1, 1980, and to all claims filed under this part and under section 11 of the Black Lung Benefits Reform Act of 1977. Because the part 727 regulations affect an increasingly smaller number of claims, however, the Department has discontinued publication of the criteria in the Code of Federal Regulations. The part 727 criteria may be found at 43 FR 36818, Aug. 18, 1978 or 20 CFR, parts 500 to end, edition revised as of April 1, 1996.

(e) *Part 410.* Part 410 of this title, which sets forth provisions relating to a claim for black lung benefits under part B of title IV of the Act, is inapplicable to this part except as is provided in this part, or in part 718 of this subchapter.

§ 725.101 Definitions and use of terms.

(a) *Definitions.* For purposes of this subchapter, except where the content clearly indicates otherwise, the following definitions apply:

(1) The *Act* means the Federal Coal Mine Health and Safety Act, Public Law 91–173, 83 Stat. 742, 30 U.S.C. 801–960, as amended by the Black Lung Benefits Act of 1972, the Mine Safety and Health Act of 1977, the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Revenue Act of 1977, the Black Lung Benefits Revenue Act of 1981, and

the Black Lung Benefits Amendments of 1981.

(2) The *Longshoremen's Act* or *LHWCA* means the Longshoremen's and Harbor Workers' Compensation Act of March 4, 1927, c. 509, 44 Stat. 1424, 33 U.S.C. 901–950, as amended from time to time.

(3) The *Social Security Act* means the Social Security Act, Act of August 14, 1935, c. 531, 49 Stat. 620, 42 U.S.C. 301–431, as amended from time to time.

(4) *Administrative law judge* means a person qualified under 5 U.S.C. 3105 to conduct hearings and adjudicate claims for benefits filed pursuant to section 415 and part C of the Act. Until March 1, 1979, it shall also mean an individual appointed to conduct such hearings and adjudicate such claims under Public Law 94–504.

(5) *Beneficiary* means a miner or any surviving spouse, divorced spouse, child, parent, brother or sister, who is entitled to benefits under either section 415 or part C of title IV of the Act.

(6) *Benefits* means all money or other benefits paid or payable under section 415 or part C of title IV of the Act on account of disability or death due to pneumoconiosis, including augmented benefits (see § 725.520(c)). The term also includes any expenses related to the medical examination and testing authorized by the district director pursuant to § 725.406.

(7) *Benefits Review Board* or *Board* means the Benefits Review Board, U.S. Department of Labor, an appellate tribunal appointed by the Secretary of Labor pursuant to the provisions of section 21(b)(1) of the LHWCA. See parts 801 and 802 of this title.

(8) *Black Lung Disability Trust Fund* or the *fund* means the Black Lung Disability Trust Fund established by the Black Lung Benefits Revenue Act of 1977, as amended by the Black Lung Benefits Revenue Act of 1981, for the payment of certain claims adjudicated under this part (see subpart G of this part).

(9) *Chief Administrative Law Judge* means the Chief Administrative Law Judge of the Office of Administrative Law Judges, U.S. Department of Labor, 800 K Street, NW., suite 400, Washington, DC 20001–8002.

(10) *Claim* means a written assertion of entitlement to benefits under section 415 or part C of title IV of the Act, submitted in a form and manner authorized by the provisions of this subchapter.

(11) *Claimant* means an individual who files a claim for benefits under this part.

(12) *Coal mine* means an area of land and all structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, placed upon, under or above the surface of such land by any person, used in, or to be used in, or resulting from, the work of extracting in such area bituminous coal, lignite or anthracite from its natural deposits in the earth by any means or method, and in the work of preparing the coal so extracted, and includes custom coal preparation facilities.

(13) *Coal preparation* means the breaking, crushing, sizing, cleaning, washing, drying, mixing, storing and loading of bituminous coal, lignite or anthracite, and such other work of preparing coal as is usually done by the operator of a coal mine. For purposes of this definition, the term does not include coal preparation performed by coke oven workers.

(14) *Department* means the United States Department of Labor.

(15) *Director* means the Director, OWCP, or his or her designee.

(16) *District Director* means a person appointed as provided in sections 39 and 40 of the LHWCA, or his or her designee, who is authorized to develop and adjudicate claims as provided in this subchapter (see § 725.350). The term District Director applies instead of the term Deputy Commissioner wherever that term appears in this subchapter. This application is for administrative purposes only and in no way affects the power or authority of the position as established in the statute. Any action taken by a person under the authority of a district director will be considered the action of a deputy commissioner.

(17) *Division* or *DCMWC* means the Division of Coal Mine Workers' Compensation in the OWCP, Employment Standards Administration, United States Department of Labor.

(18) *Insurer* or *carrier* means any private company, corporation, mutual association, reciprocal or interinsurance exchange, or any other person or fund, including any State fund, authorized under the laws of a State to insure employers' liability under workers' compensation laws. The term also includes the Secretary of Labor in the exercise of his or her authority under section 433 of the Act.

(19) *Miner* or *coal miner* means any individual who works or has worked in or around a coal mine or coal preparation facility in the extraction or preparation of coal. The term also includes an individual who works or has worked in coal mine construction or transportation in or around a coal mine, to the extent such individual was exposed to coal dust as a result of such employment (see § 725.202). For purposes of this definition, the term does not include coke oven workers whose activities involve the preparation or use of coal for the coke manufacturing process.

(20) *The Nation's coal mines* means all coal mines located in any State.

(21) *Office* or *OWCP* means the Office of Workers' Compensation Programs, United States Department of Labor.

(22) *Office of Administrative Law Judges* means the Office of Administrative Law Judges, U.S. Department of Labor.

(23) *Operator* means any owner, lessee, or other person who operates, controls or supervises a coal mine, including a prior or successor operator as defined in section 422 of the Act and certain transportation and construction employers (see subpart G of this part).

(24) *Person* means an individual, partnership, association, corporation, firm, subsidiary or parent of a corporation, or other organization or business entity.

(25) *Pneumoconiosis* means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment (see part 718 of this subchapter).

(26) *Responsible operator* means an operator which has been determined to be liable for the payment of benefits to a claimant for periods of eligibility after December 31, 1973, with respect to a claim filed under section 415 or part C of title IV of the Act or reviewed under section 435 of the Act.

(27) *Secretary* means the Secretary of Labor, United States Department of Labor, or a person, authorized by him or her to perform his or her functions under title IV of the Act.

(28) *State* includes any state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, American Samoa, Guam, the Trust Territory of the Pacific Islands, and prior to January 3, 1959, and August 21, 1959, respectively, the territories of Alaska and Hawaii.

(29) *Total disability* and *partial disability*, for purposes of this part, have the meaning given them as provided in part 718 of this subchapter.

(30) *Underground coal mine* means a coal mine in which the earth and other materials which lie above and around the natural deposit of coal (i.e., overburden) are not removed in mining; including all land, structures, facilities, machinery, tools, equipment, shafts, slopes, tunnels, excavations and other property, real or personal, appurtenant thereto.

(31) A *workers' compensation law* means a law providing for payment of benefits to employees, and their dependents and survivors, for disability on account of injury, including occupational disease, or death, suffered in connection with their employment. A payment funded wholly out of general revenues shall not be considered a payment under a workers' compensation law.

(32) *Year* means a period of one calendar year (365 days, or 366 days if one of the days is February 29), or partial periods totalling one year, during which the miner worked in or around a coal mine or mines. A ''working day'' means any day or part of a day for which a miner received pay for work as a miner, including any day for which the miner received pay while on an approved absence, such as vacation or sick leave.

(i) If the evidence establishes that the miner worked in or around coal mines at least 125 working days during a calendar year or partial periods totalling one year, then the miner has worked one year in coal mine employment for all purposes under the Act. If a miner worked fewer than 125 working days in a year, he or she has worked a fractional year based on the ratio of the actual number of days worked to 125. Proof that the miner worked more than 125 working days in a calendar year or partial periods totalling a year, shall not establish more than one year.

(ii) To the extent the evidence permits, the beginning and ending dates of all periods of coal mine employment shall be ascertained. The dates and length of employment may be established by any credible evidence including (but not limited to) company records, pension records, earnings statements, coworker affidavits, and sworn testimony. If the evidence establishes that the miner's employment lasted for a calendar year, it shall be presumed, in the absence of evidence to the contrary, that the miner spent at least 125 working days in such employment.

(iii) If the evidence is insufficient to establish the beginning and ending dates of the miner's coal mine employment, or the miner's employment lasted less than a calendar year, then the adjudication officer may use the following formula: divide the miner's yearly income from work as a miner by the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics (BLS). A copy of the BLS table shall be made a part of the record if the adjudication officer uses this method to establish the length of the miner's work history.

(iv) No periods of coal mine employment occurring outside the United States shall be considered in computing the miner's work history.

(b) *Statutory terms.* The definitions contained in this section shall not be construed in derogation of terms of the Act.

(c) *Dependents and survivors.* Dependents and survivors are those persons described in subpart B of this part.

§ 725.102 Disclosure of program information.

(a) All reports, records, or other documents filed with the OWCP with respect to claims are the records of the OWCP. The Director or his or her designee shall be the official custodian of those records maintained by the OWCP at its national office. The District Director shall be the official custodian of those records maintained at a district office.

(b) The official custodian of any record sought to be inspected shall permit or deny inspection in accordance with the Department of Labor's regulations pertaining thereto (see 29 CFR part 70). The original record in any such case shall not be removed from the Office of the custodian for such inspection. The custodian may, in his or her discretion, deny inspection of any record or part thereof which is of a character specified in 5 U.S.C. 552(b) if in his or her opinion such inspection may result in damage, harm, or harassment to the beneficiary or to any other person. For special provisions concerning release of information regarding injured employees undergoing vocational rehabilitation, see § 702.508 of this chapter.

(c) Any person may request copies of records he or she has been permitted to inspect. Such requests shall be addressed to the official custodian of the records sought to be copied. The official custodian shall provide the requested copies under the terms and conditions specified in the Department of Labor's regulations relating thereto (see 29 CFR part 70).

(d) Any party to a claim (§ 725.360) or his or her duly authorized representative shall be permitted upon request to inspect the file which has been compiled in connection with such claim. Any party to a claim or representative of such party shall upon request be provided with a copy of any or all material contained in such claim file. A request for information by a party or representative made under this paragraph shall be answered within a reasonable time after receipt by the Office. Internal documents prepared by the district director which do not constitute evidence of a fact which must be established in connection with a claim shall not be routinely provided or presented for inspection in accordance with a request made under this paragraph.

§ 725.103 Burden of proof.

Except as otherwise provided in this part and part 718 of this subchapter, the burden of proving a fact alleged in connection with any provision shall rest with the party making such allegation.

Subpart B—Persons Entitled to Benefits, Conditions, and Duration of Entitlement

§ 725.201 Who is entitled to benefits; contents of this subpart.

(a) Section 415 and part C of the Act provide for the payment of periodic benefits in accordance with this part to:

(1) A miner (see § 725.202) who is determined to be totally disabled due to pneumoconiosis; or

(2) The surviving spouse or surviving divorced spouse or, where neither exists, the child of a deceased miner, where the deceased miner:

(i) Was receiving benefits under section 415 or part C of title IV of the Act as a result of a claim filed prior to January 1, 1982; or

(ii) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to pneumoconiosis at the time of death, or to have died due to pneumoconiosis. Survivors of miners whose claims are filed on or after January 1, 1982, must establish that the deceased miner's death was due to pneumoconiosis in order to establish their entitlement to benefits, except where entitlement is established under § 718.306 of this subchapter on a survivor's claim filed prior to June 30, 1982, or;

(3) The child of a miner's surviving spouse who was receiving benefits under section 415 or part C of title IV of the Act at the time of such spouse's death; or

(4) The surviving dependent parents, where there is no surviving spouse or child, or the surviving dependent brothers or sisters, where there is no surviving spouse, child, or parent, of a miner, where the deceased miner;

(i) Was receiving benefits under section 415 or part C of title IV of the Act as a result of a claim filed prior to January 1, 1982; or

(ii) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to

pneumoconiosis at the time of death, or to have died due to pneumoconiosis. Survivors of miners whose claims are filed on or after January 1, 1982, must establish that the deceased miner's death was due to pneumoconiosis in order to establish their entitlement to benefits, except where entitlement is established under § 718.306 of this subchapter on a survivor's claim filed prior to June 30, 1982.

(b) Section 411(c)(5) of the Act provides for the payment of benefits to the eligible survivors of a miner employed for 25 or more years in the mines prior to June 30, 1971, if the miner's death occurred on or before March 1, 1978, and if the claim was filed prior to June 30, 1982, unless it is established that at the time of death, the miner was not totally or partially disabled due to pneumoconiosis. For the purposes of this part the term ''total disability'' shall mean partial disability with respect to a claim for which eligibility is established under section 411(c)(5) of the Act. See § 718.306 of this subchapter which implements this provision of the Act.

(c) The provisions contained in this subpart describe the conditions of entitlement to benefits applicable to a miner, or a surviving spouse, child, parent, brother, or sister, and the events which establish or terminate entitlement to benefits.

(d) In order for an entitled miner or surviving spouse to qualify for augmented benefits because of one or more dependents, such dependents must meet relationship and dependency requirements with respect to such beneficiary prescribed by or pursuant to the Act. Such requirements are also set forth in this subpart.

Conditions and Duration of Entitlement: Miner

§ 725.202 Miner defined; condition of entitlement, miner.

(a) *Miner defined.* A ''miner'' for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:

(1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or

(2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(b) *Coal mine construction and transportation workers; special provisions.* A coal mine construction or transportation worker shall be considered a miner to the extent such individual is or was exposed to coal mine dust as a result of employment in or around a coal mine or coal preparation facility. A transportation worker shall be considered a miner to the extent that his or her work is integral to the extraction or preparation of coal. A construction worker shall be considered a miner to the extent that his or her work is integral to the building of a coal or underground mine (see § 725.101(a)(12) and (30)).

(1) There shall be a rebuttable presumption that such individual was exposed to coal mine dust during all periods of such employment occurring in or around a coal mine or coal preparation facility for purposes of:

(i) Determining whether such individual is or was a miner;

(ii) Establishing the applicability of any of the presumptions described in section 411(c) of the Act and part 718 of this subchapter; and

(iii) Determining the identity of a coal mine operator liable for the payment of benefits in accordance with § 725.495.

(2) The presumption may be rebutted by evidence which demonstrates that:

(i) The individual was not regularly exposed to coal mine dust during his or her work in or around a coal mine or coal preparation facility; or

(ii) The individual did not work regularly in or around a coal mine or coal preparation facility.

(c) A person who is or was a self-employed miner or independent contractor, and who otherwise meets the requirements of this paragraph, shall be considered a miner for the purposes of this part.

(d) *Conditions of entitlement; miner.* An individual is eligible for benefits under this subchapter if the individual:

(1) Is a miner as defined in this section; and

(2) Has met the requirements for entitlement to benefits by establishing that he or she:

(i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

(3) Has filed a claim for benefits in accordance with the provisions of this part.

§ 725.203 Duration and cessation of entitlement; miner.

(a) An individual is entitled to benefits as a miner for each month beginning with the first month on or after January 1, 1974, in which the miner is totally disabled due to pneumoconiosis arising out of coal mine employment.

(b) The last month for which such individual is entitled to benefits is the month before the month during which either of the following events first occurs:

(1) The miner dies; or

(2) The miner's total disability ceases (see § 725.504).

(c) An individual who has been finally adjudged to be totally disabled due to pneumoconiosis and is receiving benefits under the Act shall promptly notify the Office and the responsible coal mine operator, if any, if he or she engages in his or her usual coal mine work or comparable and gainful work.

(d) Upon reasonable notice, an individual who has been finally adjudged entitled to benefits shall submit to any additional tests or examinations the Office deems appropriate if an issue arises pertaining to the validity of the original award.

Conditions and Duration of Entitlement: Miner's Dependents (Augmented Benefits)

§ 725.204 Determination of relationship; spouse.

(a) For the purpose of augmenting benefits, an individual will be considered to be the spouse of a miner if:

(1) The courts of the State in which the miner is domiciled would find that such individual and the miner validly married; or

(2) The courts of the State in which the miner is domiciled would find, under the law they would apply in determining the devolution of the miner's intestate personal property, that the individual is the miner's spouse; or

(3) Under State law, such individual would have the right of a spouse to share in the miner's intestate personal property; or

(4) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which, but for a legal impediment, would have been a valid marriage, unless the individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the

miner were not living in the same household in the month in which a request is filed that the miner's benefits be augmented because such individual qualifies as the miner's spouse.

(b) The qualification of an individual for augmentation purposes under this section shall end with the month before the month in which:

(1) The individual dies, or

(2) The individual who previously qualified as a spouse for purposes of § 725.520(c), entered into a valid marriage without regard to this section, with a person other than the miner.

§ 725.205 Determination of dependency; spouse.

For the purposes of augmenting benefits, an individual who is the miner's spouse (see § 725.204) will be determined to be dependent upon the miner if:

(a) The individual is a member of the same household as the miner (see § 725.232); or

(b) The individual is receiving regular contributions from the miner for support (see § 725.233(c)); or

(c) The miner has been ordered by a court to contribute to such individual's support (see § 725.233(e)); or

(d) The individual is the natural parent of the son or daughter of the miner; or

(e) The individual was married to the miner (see § 725.204) for a period of not less than 1 year.

§ 725.206 Determination of relationship; divorced spouse.

For the purposes of augmenting benefits with respect to any claim considered or reviewed under this part or part 727 of this subchapter (see § 725.4(d)), an individual will be considered to be the divorced spouse of a miner if the individual's marriage to the miner has been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to the miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final.

§ 725.207 Determination of dependency; divorced spouse.

For the purpose of augmenting benefits, an individual who is the miner's divorced spouse (§ 725.206) will be determined to be dependent upon the miner if:

(a) The individual is receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual is receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order requires the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.208 Determination of relationship; child.

As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of death (see § 725.212), or a miner. An individual will be considered to be the child of a beneficiary if:

(a) The courts of the State in which the beneficiary is domiciled (see § 725.231) would find, under the law they would apply, that the individual is the beneficiary's child; or

(b) The individual is the legally adopted child of such beneficiary; or

(c) The individual is the stepchild of such beneficiary by reason of a valid marriage of the individual's parent or adopting parent to such beneficiary; or

(d) The individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section if the beneficiary and the mother or the father, as the case may be, of the individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) The individual is the natural son or daughter of a beneficiary but is not a child under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of the beneficiary if:

(1) The beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the parent of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(e)) because the individual is his or her son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or mother of the individual and was living with or contributing to the support of the individual at the time the beneficiary became entitled to benefits.

§ 725.209 Determination of dependency; child.

(a) For purposes of augmenting the benefits of a miner or surviving spouse, the term ''beneficiary'' as used in this section means only a miner or surviving spouse entitled to benefits (see § 725.202 and § 725.212). An individual who is the beneficiary's child (§ 725.208) will be determined to be, or to have been, dependent on the beneficiary, if the child:

(1) Is unmarried; and

(2)(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d); or

(iii) Is 18 years of age or older and is a student.

(b)(1) The term ''student'' means a ''full-time student'' as defined in section 202(d)(7) of the Social Security Act, 42 U.S.C. 402(d)(7) (see §§ 404.367 through 404.369 of this title), or an individual under 23 years of age who has not completed 4 years of education beyond the high school level and who is regularly pursuing a full-time course of study or training at an institution which is:

(i) A school, college, or university operated or directly supported by the United States, or by a State or local government or political subdivision thereof; or

(ii) A school, college, or university which has been accredited by a State or by a State-recognized or nationally-recognized accrediting agency or body; or

(iii) A school, college, or university not so accredited but whose credits are accepted, on transfer, by at least three institutions which are so accredited; or

(iv) A technical, trade, vocational, business, or professional school accredited or licensed by the Federal or a state government or any political subdivision thereof, providing courses of not less than 3 months' duration that prepare the student for a livelihood in a trade, industry, vocation, or profession.

(2) A student will be considered to be ''pursuing a full-time course of study or training at an institution'' if the student is enrolled in a noncorrespondence course of at least 13 weeks duration and is carrying a subject load which is considered full-time for day students under the institution's standards and practices. A student beginning or ending a full-time course of study or training in part of any month will be considered to

be pursuing such course for the entire month.

(3) A child is considered not to have ceased to be a student:

(i) During any interim between school years, if the interim does not exceed 4 months and the child shows to the satisfaction of the Office that he or she has a bona fide intention of continuing to pursue a full-time course of study or training; or

(ii) During periods of reasonable duration in which, in the judgment of the Office, the child is prevented by factors beyond the child's control from pursuing his or her education.

(4) A student whose 23rd birthday occurs during a semester or the enrollment period in which such student is pursuing a full-time course of study or training shall continue to be considered a student until the end of such period, unless eligibility is otherwise terminated.

§ 725.210 Duration of augmented benefits.

Augmented benefits payable on behalf of a spouse or divorced spouse, or a child, shall begin with the first month in which the dependent satisfies the conditions of relationship and dependency set forth in this subpart. Augmentation of benefits on account of a dependent continues through the month before the month in which the dependent ceases to satisfy these conditions, except in the case of a child who qualifies as a dependent because such child is a student. In the latter case, benefits continue to be augmented through the month before the first month during no part of which such child qualifies as a student.

§ 725.211 Time of determination of relationship and dependency of spouse or child for purposes of augmentation of benefits.

With respect to the spouse or child of a miner entitled to benefits, and with respect to the child of a surviving spouse entitled to benefits, the determination as to whether an individual purporting to be a spouse or child is related to or dependent upon such miner or surviving spouse shall be based on the facts and circumstances present in each case, at the appropriate time.

Conditions and Duration of Entitlement: Miner's Survivors

§ 725.212 Condition of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual who is the surviving spouse or surviving divorced spouse of a miner is eligible for benefits if such individual:

(1) Is not married;

(2) Was dependent on the miner at the pertinent time; and

(3) The deceased miner either:

(i) Was receiving benefits under section 415 or part C of title IV of the Act at the time of death as a result of a claim filed prior to January 1, 1982; or

(ii) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to pneumoconiosis at the time of death or to have died due to pneumoconiosis. A surviving spouse or surviving divorced spouse of a miner whose claim is filed on or after January 1, 1982, must establish that the deceased miner's death was due to pneumoconiosis in order to establish entitlement to benefits, except where entitlement is established under § 718.306 of this subchapter on a claim filed prior to June 30, 1982.

(b) If more than one spouse meets the conditions of entitlement prescribed in paragraph (a) of this section, then each spouse will be considered a beneficiary for purposes of section 412(a)(2) of the Act without regard to the existence of any other entitled spouse or spouses.

§ 725.213 Duration of entitlement; surviving spouse or surviving divorced spouse.

(a) An individual is entitled to benefits as a surviving spouse, or as a surviving divorced spouse, for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.212 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which either of the following events first occurs:

(1) The surviving spouse or surviving divorced spouse marries; or

(2) The surviving spouse or surviving divorced spouse dies.

(c) A surviving spouse or surviving divorced spouse whose entitlement to benefits has been terminated pursuant to § 725.213(b)(1) may thereafter again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after the marriage ends and such individual meets the requirements of § 725.212. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.212(a)(3)(i)) or the miner's death due to pneumoconiosis (§ 725.212(a)(3)(ii)).

§ 725.214 Determination of relationship; surviving spouse.

An individual shall be considered to be the surviving spouse of a miner if:

(a) The courts of the State in which the miner was domiciled (see § 725.231) at the time of his or her death would find that the individual and the miner were validly married; or

(b) The courts of the State in which the miner was domiciled (see § 725.231) at the time of the miner's death would find that the individual was the miner's surviving spouse; or

(c) Under State law, such individual would have the right of the spouse to share in the miner's interstate personal property; or

(d) Such individual went through a marriage ceremony with the miner resulting in a purported marriage between them and which but for a legal impediment (see § 725.230) would have been a valid marriage, unless such individual entered into the purported marriage with knowledge that it was not a valid marriage, or if such individual and the miner were not living in the same household at the time of the miner's death.

§ 725.215 Determination of dependency; surviving spouse.

An individual who is the miner's surviving spouse (see § 725.214) shall be determined to have been dependent on the miner if, at the time of the miner's death:

(a) The individual was living with the miner (see § 725.232); or

(b) The individual was dependent upon the miner for support or the miner has been ordered by a court to contribute to such individual's support (see § 725.233); or

(c) The individual was living apart from the miner because of the miner's desertion or other reasonable cause; or

(d) The individual is the natural parent of the miner's son or daughter;

(e) The individual had legally adopted the miner's son or daughter while the individual was married to the miner and while such son or daughter was under the age of 18; or

(f) The individual was married to the miner at the time both of them legally adopted a child under the age of 18; or

(g) (1) The individual was married to the miner for a period of not less than 9 months immediately before the day on which the miner died, unless the miner's death:

(i) Is accidental (as defined in paragraph (g)(2) of this section), or

(ii) Occurs in line of duty while the miner is a member of a uniformed service serving on active duty (as defined in § 404.1019 of this title), and the surviving spouse was married to the miner for a period of not less than 3 months immediately prior to the day on which such miner died.

(2) For purposes of paragraph (g)(l)(i) of this section, the death of a miner is accidental if such individual received bodily injuries solely through violent, external, and accidental means, and as a direct result of the bodily injuries and independently of all other causes, dies not later than 3 months after the day on which such miner receives such bodily injuries. The term ''accident'' means an event that was unpremeditated and unforeseen from the standpoint of the deceased individual. To determine whether the death of an individual did, in fact, result from an accident the adjudication officer will consider all the circumstances surrounding the casualty. An intentional and voluntary suicide will not be considered to be death by accident; however, suicide by an individual who is so incompetent as to be incapable of acting intentionally and voluntarily will be considered to be a death by accident. In no event will the death of an individual resulting from violent and external causes be considered a suicide unless there is direct proof that the fatal injury was self-inflicted.

(3) The provisions of this paragraph (g) shall not apply if the adjudication officer determines that at the time of the marriage involved, the miner would not reasonably have been expected to live for 9 months.

§ 725.216 Determination of relationship; surviving divorced spouse.

An individual will be considered to be the surviving divorced spouse of a deceased miner in a claim considered under this part or reviewed under part 727 of this subchapter (see § 725.4(d)), if such individual's marriage to the miner had been terminated by a final divorce on or after the 10th anniversary of the marriage unless, if such individual was married to and divorced from the miner more than once, such individual was married to such miner in each calendar year of the period beginning 10 years immediately before the date on which any divorce became final and ending with the year in which the divorce became final.

§ 725.217 Determination of dependency; surviving divorced spouse.

An individual who is the miner's surviving divorced spouse (see § 725.216) shall be determined to have been dependent on the miner if, for the month before the month in which the miner died:

(a) The individual was receiving at least one-half of his or her support from the miner (see § 725.233(g)); or

(b) The individual was receiving substantial contributions from the miner pursuant to a written agreement (see § 725.233(c) and (f)); or

(c) A court order required the miner to furnish substantial contributions to the individual's support (see § 725.233(c) and (e)).

§ 725.218 Conditions of entitlement; child.

(a) An individual is entitled to benefits where he or she meets the required standards of relationship and dependency under this subpart (see § 725.220 and § 725.221) and is the child of a deceased miner who:

(1) Was receiving benefits under section 415 or part C of title IV of the Act as a result of a claim filed prior to January 1, 1982, or

(2) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to pneumoconiosis at the time of death, or to have died due to pneumoconiosis. A surviving dependent child of a miner whose claim is filed on or after January 1, 1982, must establish that the miner's death was due to pneumoconiosis in order to establish entitlement to benefits, except where entitlement is established under § 718.306 of this subchapter on a claim filed prior to June 30, 1982.

(b) A child is not entitled to benefits for any month for which a miner, or the surviving spouse or surviving divorced spouse of a miner, establishes entitlement to benefits.

§ 725.219 Duration of entitlement; child.

(a) An individual is entitled to benefits as a child for each month beginning with the first month in which all of the conditions of entitlement prescribed in § 725.218 are satisfied.

(b) The last month for which such individual is entitled to such benefits is the month before the month in which any one of the following events first occurs:

(1) The child dies;

(2) The child marries;

(3) The child attains age 18; and

(i) Is not a student (as defined in § 725.209(b)) during any part of the month in which the child attains age 18; and

(ii) Is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(4) If the child's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the child is a student; or

(ii) The month in which the child attains age 23 and is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(5) If the child's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

(c) A child whose entitlement to benefits terminated with the month before the month in which the child attained age 18, or later, may thereafter (provided such individual is not married) again become entitled to such benefits upon filing application for such reentitlement, beginning with the first month after termination of benefits in which such individual is a student and has not attained the age of 23.

§ 725.220 Determination of relationship; child.

For purposes of determining whether an individual may qualify for benefits as the child of a deceased miner, the provisions of § 725.208 shall be applicable. As used in this section, the term ''beneficiary'' means only a surviving spouse entitled to benefits at the time of such surviving spouse's death (see § 725.212), or a miner. For purposes of a survivor's claim, an individual will be considered to be a child of a beneficiary if:

(a) The courts of the State in which such beneficiary is domiciled (see § 725.231) would find, under the law they would apply in determining the devolution of the beneficiary's intestate personal property, that the individual is the beneficiary's child; or

(b) Such individual is the legally adopted child of such beneficiary; or

(c) Such individual is the stepchild of such beneficiary by reason of a valid marriage of such individual's parent or adopting parent to such beneficiary; or

(d) Such individual does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, but would, under State law, have the same right as a child to share in the beneficiary's intestate personal property; or

(e) Such individual is the natural son or daughter of a beneficiary but does not bear the relationship of child to such beneficiary under paragraph (a), (b), or (c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if the beneficiary and the mother or father, as the case may be, of such individual went through a marriage ceremony resulting in a purported marriage between them which but for a legal impediment (see § 725.230) would have been a valid marriage; or

(f) Such individual is the natural son or daughter of a beneficiary but does not have the relationship of child to such beneficiary under paragraph (a), (b), or

(c) of this section, and is not considered to be the child of the beneficiary under paragraph (d) or (e) of this section, such individual shall nevertheless be considered to be the child of such beneficiary if:

(1) Such beneficiary, prior to his or her entitlement to benefits, has acknowledged in writing that the individual is his or her son or daughter, or has been decreed by a court to be the father or mother of the individual, or has been ordered by a court to contribute to the support of the individual (see § 725.233(a)) because the individual is a son or daughter; or

(2) Such beneficiary is shown by satisfactory evidence to be the father or mother of the individual and was living with or contributing to the support of the individual at the time such beneficiary became entitled to benefits.

§ 725.221 Determination of dependency; child.

For the purposes of determining whether a child was dependent upon a deceased miner, the provisions of § 725.209 shall be applicable, except that for purposes of determining the eligibility of a child who is under a disability as defined in section 223(d) of the Social Security Act, such disability must have begun before the child attained age 22, or in the case of a student, before the child ceased to be a student.

§ 725.222 Conditions of entitlement; parent, brother, or sister.

(a) An individual is eligible for benefits as a surviving parent, brother or sister if all of the following requirements are met:

(1) The individual is the parent, brother, or sister of a deceased miner;

(2) The individual was dependent on the miner at the pertinent time;

(3) Proof of support is filed within 2 years after the miner's death, unless the time is extended for good cause (§ 725.226);

(4) In the case of a brother or sister, such individual also:

(i) Is under 18 years of age; or

(ii) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), which began before such individual attained age 22, or in the case of a student, before the student ceased to be a student; or

(iii) Is a student (see § 725.209(b)); or

(iv) Is under a disability as defined in section 223(d) of the Social Security Act, 42 U.S.C. 423(d), at the time of the miner's death;

(5) The deceased miner:

(i) Was entitled to benefits under section 415 or part C of title IV of the Act as a result of a claim filed prior to January 1, 1982; or

(ii) Is determined as a result of a claim filed prior to January 1, 1982, to have been totally disabled due to pneumoconiosis at the time of death or to have died due to pneumoconiosis. A surviving dependent parent, brother or sister of a miner whose claim is filed on or after January 1, 1982, must establish that the miner's death was due to pneumoconiosis in order to establish entitlement to benefits, except where entitlement is established under § 718.306 of this subchapter on a claim filed prior to June 30, 1982.

(b)(1) A parent is not entitled to benefits if the deceased miner was survived by a spouse or child at the time of such miner's death.

(2) A brother or sister is not entitled to benefits if the deceased miner was survived by a spouse, child, or parent at the time of such miner's death.

§ 725.223 Duration of entitlement; parent, brother, or sister.

(a) A parent, sister, or brother is entitled to benefits beginning with the month all the conditions of entitlement described § 725.222 are met.

(b) The last month for which such parent is entitled to benefits is the month in which the parent dies.

(c) The last month for which such brother or sister is entitled to benefits is the month before the month in which any of the following events first occurs:

(1) The individual dies;

(2)(i) The individual marries or remarries; or

(ii) If already married, the individual received support in any amount from his or her spouse;

(3) The individual attains age 18; and

(i) Is not a student (as defined in § 725.209(b)) during any part of the month in which the individual attains age 18; and

(ii) is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(4) If the individual's entitlement beyond age 18 is based on his or her status as a student, the earlier of:

(i) The first month during no part of which the individual is a student; or

(ii) The month in which the individual attains age 23 and is not under a disability (as defined in § 725.209(a)(2)(ii)) at that time;

(5) If the individual's entitlement beyond age 18 is based on disability, the first month in no part of which such individual is under a disability.

§ 725.224 Determination of relationship; parent, brother, or sister.

(a) An individual will be considered to be the parent, brother, or sister of a miner if the courts of the State in which the miner was domiciled (see § 225.231) at the time of death would find, under the law they would apply, that the individual is the miner's parent, brother, or sister.

(b) Where, under State law, the individual is not the miner's parent, brother, or sister, but would, under State law, have the same status (i.e., right to share in the miner's intestate personal property) as a parent, brother, or sister, the individual will be considered to be the parent, brother, or sister as appropriate.

§ 725.225 Determination of dependency; parent, brother, or sister.

An individual who is the miner's parent, brother, or sister will be determined to have been dependent on the miner if, during the 1-year period immediately prior to the miner's death:

(a) The individual and the miner were living in the same household (see § 725.232); and

(b) The individual was totally dependent on the miner for support (see § 725.233(h)).

§ 725.226 ''Good cause'' for delayed filing of proof of support.

(a) *What constitutes ''good cause.''* ''Good cause'' may be found for failure to file timely proof of support where the parent, brother, or sister establishes to the satisfaction of the Office that such failure to file was due to:

(1) Circumstances beyond the individual's control, such as extended illness, mental, or physical incapacity, or communication difficulties; or

(2) Incorrect or incomplete information furnished the individual by the Office; or

(3) Efforts by the individual to secure supporting evidence without a realization that such evidence could be submitted after filing proof of support.

(b) *What does not constitute ''good cause.''* ''Good cause'' for failure to file timely proof of support (see § 725.222(a)(3)) does not exist when there is evidence of record in the Office that the individual was informed that he or she should file within the prescribed period and he or she failed to do so deliberately or through negligence.

§ 725.227 Time of determination of relationship and dependency of survivors.

The determination as to whether an individual purporting to be an entitled survivor of a miner or beneficiary was related to, or dependent upon, the miner is made after such individual files a claim for benefits as a survivor. Such determination is based on the facts and circumstances with respect to a reasonable period of time ending with

the miner's death. A prior determination that such individual was, or was not, a dependent for the purposes of augmenting the miner's benefits for a certain period, is not determinative of the issue of whether the individual is a dependent survivor of such miner.

§ 725.228 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

An individual who has been convicted of the felonious and intentional homicide of a miner or other beneficiary shall not be entitled to receive any benefits payable because of the death of such miner or other beneficiary, and such person shall be considered nonexistent in determining the entitlement to benefits of other individuals.

Terms Used in this Subpart

§ 725.229 Intestate personal property.

References in this subpart to the ''same right to share in the intestate personal property'' of a deceased miner (or surviving spouse) refer to the right of an individual to share in such distribution in the individual's own right and not the right of representation.

§ 725.230 Legal impediment.

For purposes of this subpart, ''legal impediment'' means an impediment resulting from the lack of dissolution of a previous marriage or otherwise arising out of such previous marriage or its dissolution or resulting from a defect in the procedure followed in connection with the purported marriage ceremony—for example, the solemnization of a marriage only through a religious ceremony in a country which requires a civil ceremony for a valid marriage.

§ 725.231 Domicile.

(a) For purposes of this subpart, the term ''domicile'' means the place of an individual's true, fixed, and permanent home.

(b) The domicile of a deceased miner or surviving spouse is determined as of the time of death.

(c) If an individual was not domiciled in any State at the pertinent time, the law of the District of Columbia is applied.

§ 725.232 Member of the same household—''living with,'' ''living in the same household,'' and ''living in the miner's household,'' defined.

(a) *Defined.* (1) The term ''member of the same household'' as used in section 402(a)(2) of the Act (with respect to a spouse); the term ''living with'' as used in section 402(e) of the Act (with respect to a surviving spouse); and the term ''living in the same household'' as used in this subpart, means that a husband and wife were customarily living together as husband and wife in the same place.

(2) The term ''living in the miner's household'' as used in section 412(a)(5) of the Act (with respect to a parent, brother, or sister) means that the miner and such parent, brother, or sister were sharing the same residence.

(b) *Temporary absence.* The temporary absence from the same residence of either the miner, or the miner's spouse, parent, brother, or sister (as the case may be), does not preclude a finding that one was ''living with'' the other, or that they were ''members of the same household.'' The absence of one such individual from the residence in which both had customarily lived shall, in the absence of evidence to the contrary, be considered temporary:

(1) If such absence was due to service in the Armed Forces of the United States; or

(2) If the period of absence from his or her residence did not exceed 6 months and the absence was due to business or employment reasons, or because of confinement in a penal institution or in a hospital, nursing home, or other curative institution; or

(3) In any other case, if the evidence establishes that despite such absence they nevertheless reasonably expected to resume physically living together.

(c) *Relevant period of time.* (1) The determination as to whether a surviving spouse had been ''living with'' the miner shall be based upon the facts and circumstances as of the time of the death of the miner.

(2) The determination as to whether a spouse is a ''member of the same household'' as the miner shall be based upon the facts and circumstances with respect to the period or periods of time as to which the issue of membership in the same household is material.

(3) The determination as to whether a parent, brother, or sister was ''living in the miner's household'' shall take account of the 1-year period immediately prior to the miner's death.

§ 725.233 Support and contributions.

(a) *Support* defined. The term ''support'' includes food, shelter, clothing, ordinary medical expenses, and other ordinary and customary items for the maintenance of the person supported.

(b) *Contributions* defined. The term ''contributions'' refers to contributions actually provided by the contributor from such individual's property, or the use thereof, or by the use of such individual's own credit.

(c) *Regular contributions* and *substantial contributions* defined. The terms ''regular contributions'' and ''substantial contributions'' mean contributions that are customary and sufficient to constitute a material factor in the cost of the individual's support.

(d) *Contributions and community property.* When a spouse receives and uses for his or her support income from services or property, and such income, under applicable State law, is the community property of the wife and her husband, no part of such income is a ''contribution'' by one spouse to the other's support regardless of the legal interest of the donor. However, when a spouse receives and uses for support, income from the services and the property of the other spouse and, under applicable State law, such income is community property, all of such income is considered to be a contribution by the donor to the spouse's support.

(e) *Court order for support* defined. References to a support order in this subpart means any court order, judgment, or decree of a court of competent jurisdiction which requires regular contributions that are a material factor in the cost of the individual's support and which is in effect at the applicable time. If such contributions are required by a court order, this condition is met whether or not the contributions were actually made.

(f) *Written agreement* defined. The term ''written agreement'' in the phrase ''substantial contributions pursuant to a written agreement'', as used in this subpart means an agreement signed by the miner providing for substantial contributions by the miner for the individual's support. It must be in effect at the applicable time but it need not be legally enforceable.

(g) *One-half support* defined. The term ''one-half support'' means that the miner made regular contributions, in cash or in kind, to the support of a divorced spouse at the specified time or for the specified period, and that the amount of such contributions equalled or exceeded one-half the total cost of such individual's support at such time or during such period.

(h) *Totally dependent for support* defined. The term ''totally dependent for support'' as used in § 725.225(b) means that the miner made regular contributions to the support of the miner's parents, brother, or sister, as the case may be, and that the amount of such contributions at least equalled the total cost of such individual's support.

Subpart C—Filing of Claims

§ 725.301 Who may file a claim.

(a) Any person who believes he or she may be entitled to benefits under the Act may file a claim in accordance with this subpart.

(b) A claimant who has attained the age of 18, is mentally competent and physically able, may file a claim on his or her own behalf.

(c) If a claimant is unable to file a claim on his or her behalf because of a legal or physical impairment, the following rules shall apply:

(1) A claimant between the ages of 16 and 18 years who is mentally competent and not under the legal custody or care of another person, or a committee or institution, may upon filing a statement to the effect, file a claim on his or her own behalf. In any other case where the claimant is under 18 years of age, only a person, or the manager or principal officer of an institution having legal custody or care of the claimant may file a claim on his or her behalf.

(2) If a claimant over 18 years of age has a legally appointed guardian or committee, only the guardian or committee may file a claim on his or her behalf.

(3) If a claimant over 18 years of age is mentally incompetent or physically unable to file a claim and is under the care of another person, or an institution, only the person, or the manager or principal officer of the institution responsible for the care of the claimant, may file a claim on his or her behalf.

(4) For good cause shown, the Office may accept a claim executed by a person other than one described in paragraphs (c)(2) or (3) of this section.

(d) Except as provided in § 725.305, in order for a claim to be considered, the claimant must be alive at the time the claim is filed.

§ 725.302 Evidence of authority to file a claim on behalf of another.

A person filing a claim on behalf of a claimant shall submit evidence of his or her authority to so act at the time of filing or at a reasonable time thereafter in accordance with the following:

(a) A legally appointed guardian or committee shall provide the Office with certification of appointment by a proper official of the court.

(b) Any other person shall provide a statement describing his or her relationship to the claimant, the extent to which he or she has care of the claimant, or his or her position as an officer of the institution of which the claimant is an inmate. The Office may, at any time, require additional evidence to establish the authority of any such person.

§ 725.303 Date and place of filing of claims.

(a)(1) Claims for benefits shall be delivered, mailed to, or presented at, any of the various district offices of the Social Security Administration, or any of the various offices of the Department of Labor authorized to accept claims, or, in the case of a claim filed by or on behalf of a claimant residing outside the United States, mailed or presented to any office maintained by the Foreign Service of the United States. A claim shall be considered filed on the day it is received by the office in which it is first filed.

(2) A claim submitted to a Foreign Service Office or any other agency or subdivision of the U.S. Government shall be forwarded to the Office and considered filed as of the date it was received at the Foreign Service Office or other governmental agency or unit.

(b) A claim submitted by mail shall be considered filed as of the date of delivery unless a loss or impairment of benefit rights would result, in which case a claim shall be considered filed as of the date of its postmark. In the absence of a legible postmark, other evidence may be used to establish the mailing date.

§ 725.304 Forms and initial processing.

(a) Claims shall be filed on forms prescribed and approved by the Office. The district office at which the claim is filed will assist claimants in completing their forms.

(b) If the place at which a claim is filed is an office of the Social Security Administration, such office shall forward the completed claim form to an office of the DCMWC, which is authorized to process the claim.

§ 725.305 When a written statement is considered a claim.

(a) The filing of a statement signed by an individual indicating an intention to claim benefits shall be considered to be the filing of a claim for the purposes of this part under the following circumstances:

(1) The claimant or a proper person on his or her behalf (see § 725.301) executes and files a prescribed claim form with the Office during the claimant's lifetime within the period specified in paragraph (b) of this section.

(2) Where the claimant dies within the period specified in paragraph (b) of this section without filing a prescribed claim form, and a person acting on behalf of the deceased claimant's estate executes and files a prescribed claim form within the period specified in paragraph (c) of this section.

(b) Upon receipt of a written statement indicating an intention to claim benefits, the Office shall notify the signer in writing that to be considered the claim must be executed by the claimant or a proper party on his or her behalf on the prescribed form and filed with the Office within six months from the date of mailing of the notice.

(c) If before the notice specified in paragraph (b) of this section is sent, or within six months after such notice is sent, the claimant dies without having executed and filed a prescribed form, or without having had one executed and filed in his or her behalf, the Office shall upon receipt of notice of the claimant's death advise his or her estate, or those living at his or her last known address, in writing that for the claim to be considered, a prescribed claim form must be executed and filed by a person authorized to do so on behalf of the claimant's estate within six months of the date of the later notice.

(d) Claims based upon written statements indicating an intention to claim benefits not perfected in accordance with this section shall not be processed.

§ 725.306 Withdrawal of a claim.

(a) A claimant or an individual authorized to execute a claim on a claimant's behalf or on behalf of claimant's estate under § 725.305, may withdraw a previously filed claim provided that:

(1) He or she files a written request with the appropriate adjudication officer indicating the reasons for seeking withdrawal of the claim;

(2) The appropriate adjudication officer approves the request for withdrawal on the grounds that it is in the best interests of the claimant or his or her estate, and;

(3) Any payments made to the claimant in accordance with § 725.522 are reimbursed.

(b) When a claim has been withdrawn under paragraph (a) of this section, the claim will be considered not to have been filed.

§ 725.307 Cancellation of a request for withdrawal.

At any time prior to approval, a request for withdrawal may be canceled by a written request of the claimant or a person authorized to act on the claimant's behalf or on behalf of the claimant's estate.

§ 725.308 Time limits for filing claims.

(a) A claim for benefits filed under this part by, or on behalf of, a miner shall be filed within three years after a medical determination of total disability

due to pneumoconiosis which has been communicated to the miner or a person responsible for the care of the miner, or within three years after the date of enactment of the Black Lung Benefits Reform Act of 1977, whichever is later. There is no time limit on the filing of a claim by the survivor of a miner.

(b) A miner who is receiving benefits under part B of title IV of the Act and who is notified by HEW of the right to seek medical benefits may file a claim for medical benefits under part C of title IV of the Act and this part. The Secretary of Health, Education, and Welfare is required to notify each miner receiving benefits under part B of this right. Notwithstanding the provisions of paragraph (a) of this section, a miner notified of his or her rights under this paragraph may file a claim under this part on or before December 31, 1980. Any claim filed after that date shall be untimely unless the time for filing has been enlarged for good cause shown.

(c) There shall be a rebuttable presumption that every claim for benefits is timely filed. However, except as provided in paragraph (b) of this section, the time limits in this section are mandatory and may not be waived or tolled except upon a showing of extraordinary circumstances.

§ 725.309 Additional claims; effect of a prior denial of benefits.

(a) A claimant whose claim for benefits was previously approved under part B of title IV of the Act may file a claim for benefits under this part as provided in §§ 725.308(b) and 725.702.

(b) If a claimant files a claim under this part while another claim filed by the claimant under this part is still pending, the later claim shall be merged with the earlier claim for all purposes. For purposes of this section, a claim shall be considered pending if it has not yet been finally denied.

(c) If a claimant files a claim under this part within one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a request for modification of the prior denial and shall be processed and adjudicated under § 725.310.

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see §§ 725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

(e) Notwithstanding any other provision of this part or part 727 of this subchapter (see § 725.4(d)), a person may exercise the right of review provided in paragraph (c) of § 727.103 at the same time such person is pursuing an appeal of a previously denied part B claim under the law as it existed prior to March 1, 1978. If the part B claim is ultimately approved as a result of the appeal, the claimant must immediately notify the Secretary of Labor and, where appropriate, the coal mine operator, and all duplicate payments made under part C shall be considered an overpayment and arrangements shall be made to insure the repayment of such overpayments to the fund or an operator, as appropriate.

(f) In any case involving more than one claim filed by the same claimant, under no circumstances are duplicate benefits payable for concurrent periods of eligibility. Any duplicate benefits paid shall be subject to collection or offset under subpart H of this part.

§ 725.310 Modification of awards and denials.

(a) Upon his or her own initiative, or upon the request of any party on grounds of a change in conditions or because of a mistake in a determination of fact, the district director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

(b) Modification proceedings shall be conducted in accordance with the provisions of this part as appropriate, except that the claimant and the operator, or group of operators or the fund, as appropriate, shall each be entitled to submit no more than one additional chest X-ray interpretation, one additional pulmonary function test, one additional arterial blood gas study, and one additional medical report in support of its affirmative case along with such rebuttal evidence and additional statements as are authorized by paragraphs (a)(2)(ii) and (a)(3)(ii) of § 725.414. Modification proceedings shall not be initiated before an administrative law judge or the Benefits Review Board.

(c) At the conclusion of modification proceedings before the district director, the district director may issue a proposed decision and order (§ 725.418) or, if appropriate, deny the claim by reason of abandonment (§ 725.409). In any case in which the district director has initiated modification proceedings on his own initiative to alter the terms of an award or denial of benefits issued by an administrative law judge, the

district director shall, at the conclusion of modification proceedings, forward the claim for a hearing (§ 725.421). In any case forwarded for a hearing, the administrative law judge assigned to hear such case shall consider whether any additional evidence submitted by the parties demonstrates a change in condition and, regardless of whether the parties have submitted new evidence, whether the evidence of record demonstrates a mistake in a determination of fact.

(d) An order issued following the conclusion of modification proceedings may terminate, continue, reinstate, increase or decrease benefit payments or award benefits. Such order shall not affect any benefits previously paid, except that an order increasing the amount of benefits payable based on a finding of a mistake in a determination of fact may be made effective on the date from which benefits were determined payable by the terms of an earlier award. In the case of an award which is decreased, no payment made in excess of the decreased rate prior to the date upon which the party requested reconsideration under paragraph (a) of this section shall be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by § 725.543. In the case of an award which is decreased following the initiation of modification by the district director, no payment made in excess of the decreased rate prior to the date upon which the district director initiated modification proceedings under paragraph (a) shall be subject to collection or offset under subpart H of this part, provided the claimant is without fault as defined by § 725.543. In the case of an award which has become final and is thereafter terminated, no payment made prior to the date upon which the party requested reconsideration under paragraph (a) shall be subject to collection or offset under subpart H of this part. In the case of an award which has become final and is thereafter terminated following the initiation of modification by the district director, no payment made prior to the date upon which the district director initiated modification proceedings under paragraph (a) shall be subject to collection or offset under subpart H of this part.

§ 725.311 Communications with respect to claims; time computations.

(a) Unless otherwise specified by this part, all requests, responses, notices, decisions, orders, or other communications required or permitted by this part shall be in writing.

(b) If required by this part, any document, brief, or other statement submitted in connection with the adjudication of a claim under this part shall be sent to each party to the claim by the submitting party. If proof of service is required with respect to any communication, such proof of service shall be submitted to the appropriate adjudication officer and filed as part of the claim record.

(c) In computing any period of time described in this part, by any applicable statute, or by the order of any adjudication officer, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday, in which event the period extends until the next day which is not a Saturday, Sunday, or legal holiday. ''Legal holiday'' includes New Year's Day, Birthday of Martin Luther King, Jr., Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veterans Day, Thanksgiving Day, Christmas Day and any other day appointed as a holiday by the President or the Congress of the United States.

(d) In any case in which a provision of this part requires a document to be sent to a person or party by certified mail, and the document is not sent by certified mail, but the person or party actually received the document, the document shall be deemed to have been sent in compliance with the provisions of this part. In such a case, any time period which commences upon the service of the document shall commence on the date the document was received.

Subpart D—Adjudication Officers; Parties and Representatives

§ 725.350 Who are the adjudication officers.

(a) *General.* The persons authorized by the Secretary of Labor to accept evidence and decide claims on the basis of such evidence are called ''adjudication officers.'' This section describes the status of black lung claims adjudication officers.

(b) *District Director.* The district director is that official of the DCMWC or his designee who is authorized to perform functions with respect to the development, processing, and adjudication of claims in accordance with this part.

(c) *Administrative law judge.* An administrative law judge is that official appointed pursuant to 5 U.S.C. 3105 (or Public Law 94–504) who is qualified to preside at hearings under 5 U.S.C. 557 and is empowered by the Secretary to conduct formal hearings with respect to, and adjudicate, claims in accordance with this part. A person appointed under Public Law 94–504 shall not be considered an administrative law judge for purposes of this part for any period after March 1, 1979.

§ 725.351 Powers of adjudication officers.

(a) *District Director.* The district director is authorized to:

(1) Make determinations with respect to claims as is provided in this part;

(2) Conduct conferences and informal discovery proceedings as provided in this part;

(3) Compel the production of documents by the issuance of a subpoena;

(4) Prepare documents for the signature of parties;

(5) Issue appropriate orders as provided in this part; and

(6) Do all other things necessary to enable him or her to discharge the duties of the office.

(b) *Administrative Law Judge.* An administrative law judge is authorized to:

(1) Conduct formal hearings in accordance with the provisions of this part;

(2) Administer oaths and examine witnesses;

(3) Compel the production of documents and appearance of witnesses by the issuance of subpoenas;

(4) Issue decisions and orders with respect to claims as provided in this part; and

(5) Do all other things necessary to enable him or her to discharge the duties of the office.

(c) If any person in proceedings before an adjudication officer disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the district director, or the administrative law judge responsible for the adjudication of the claim, shall certify the facts to the Federal district court having jurisdiction in the place in which he or she is sitting (or to the U.S. District Court for the District of Columbia if he or she is sitting in the District) which shall thereupon in a summary manner hear the evidence as to the acts complained of, and, if the evidence so warrants, punish such person in the same manner and to the

same extent as for a contempt committed before the court, or commit such person upon the same condition as if the doing of the forbidden act had occurred with reference to the process or in the presence of the court.

§ 725.352 Disqualification of adjudication officer.

(a) No adjudication officer shall conduct any proceedings in a claim in which he or she is prejudiced or partial, or where he or she has any interest in the matter pending for decision. A decision to withdraw from the consideration of a claim shall be within the discretion of the adjudication officer. If that adjudication officer withdraws, another officer shall be designated by the Director or the Chief Administrative Law Judge, as the case may be, to complete the adjudication of the claim.

(b) No adjudication officer shall be permitted to appear or act as a representative of a party under this part while such individual is employed as an adjudication officer. No adjudication officer shall be permitted at any time to appear or act as a representative in connection with any case or claim in which he or she was personally involved. No fee or reimbursement shall be awarded under this part to an individual who acts in violation of this paragraph.

(c) No adjudication officer shall act in any claim involving a party which employed such adjudication officer within one year before the adjudication of such claim.

(d) Notwithstanding paragraph (a) of this section, no adjudication officer shall be permitted to act in any claim involving a party who is related to the adjudication officer by consanguinity or affinity within the third degree as determined by the law of the place where such party is domiciled. Any action taken by an adjudication officer in knowing violation of this paragraph shall be void.

§ 725.360 Parties to proceedings.

(a) Except as provided in § 725.361, no person other than the Secretary of Labor and authorized personnel of the Department of Labor shall participate at any stage in the adjudication of a claim for benefits under this part, unless such person is determined by the appropriate adjudication officer to qualify under the provisions of this section as a party to the claim. The following persons shall be parties:

(1) The claimant;

(2) A person other than a claimant, authorized to execute a claim on such claimant's behalf under § 725.301;

(3) Any coal mine operator notified under § 725.407 of its possible liability for the claim;

(4) Any insurance carrier of such operator; and

(5) The Director in all proceedings relating to a claim for benefits under this part.

(b) A widow, child, parent, brother, or sister, or the representative of a decedent's estate, who makes a showing in writing that his or her rights with respect to benefits may be prejudiced by a decision of an adjudication officer, may be made a party.

(c) Any coal mine operator or prior operator or insurance carrier which has not been notified under § 725.407 and which makes a showing in writing that its rights may be prejudiced by a decision of an adjudication officer may be made a party.

(d) Any other individual may be made a party if that individual's rights with respect to benefits may be prejudiced by a decision to be made.

§ 725.361 Party amicus curiae.

At the discretion of the Chief Administrative Law Judge or the administrative law judge assigned to the case, a person or entity which is not a party may be allowed to participate amicus curiae in a formal hearing only as to an issue of law. A person may participate amicus curiae in a formal hearing upon written request submitted with supporting arguments prior to the hearing. If the request is granted, the administrative law judge hearing the case will inform the party of the extent to which participation will be permitted. The request may, however, be denied summarily and without explanation.

§ 725.362 Representation of parties.

(a) Except for the Secretary of Labor, whose interests shall be represented by the Solicitor of Labor or his or her designee, each of the parties may appoint an individual to represent his or her interest in any proceeding for determination of a claim under this part. Such appointment shall be made in writing or on the record at the hearing. An attorney qualified in accordance with § 725.363(a) shall file a written declaration that he or she is authorized to represent a party, or declare his or her representation on the record at a formal hearing. Any other person (see § 725.363(b)) shall file a written notice of appointment signed by the party or his or her legal guardian, or enter his or her appearance on the record at a formal hearing if the party he or she seeks to represent is present and consents to the representation. Any written declaration or notice required by this section shall include the OWCP number assigned by the Office and shall be sent to the Office or, for representation at a formal hearing, to the Chief Administrative Law Judge. In any case, such representative must be qualified under § 725.363. No authorization for representation or agreement between a claimant and representative as to the amount of a fee, filed with the Social Security Administration in connection with a claim under part B of title IV of the Act, shall be valid under this part. A claimant who has previously authorized a person to represent him or her in connection with a claim originally filed under part B of title IV may renew such authorization by filing a statement to such effect with the Office or appropriate adjudication officer.

(b) Any party may waive his or her right to be represented in the adjudication of a claim. If an adjudication officer determines, after an appropriate inquiry has been made, that a claimant who has been informed of his or her right to representation does not wish to obtain the services of a representative, such adjudication officer shall proceed to consider the claim in accordance with this part, unless it is apparent that the claimant is, for any reason, unable to continue without the help of a representative. However, it shall not be necessary for an adjudication officer to inquire as to the ability of a claimant to proceed without representation in any adjudication taking place without a hearing. The failure of a claimant to obtain representation in an adjudication taking place without a hearing shall be considered a waiver of the claimant's right to representation. However, at any time during the processing or adjudication of a claim, any claimant may revoke such waiver and obtain a representative.

§ 725.363 Qualification of representative.

(a) *Attorney.* Any attorney in good standing who is admitted to practice before a court of a State, territory, district, or insular possession, or before the Supreme Court of the United States or other Federal court and is not, pursuant to any provision of law, prohibited from acting as a representative, may be appointed as a representative.

(b) *Other person.* With the approval of the adjudication officer, any other person may be appointed as a representative so long as that person is not, pursuant to any provision of law, prohibited from acting as a representative.

§ 725.364 Authority of representative.

A representative, appointed and qualified as provided in §§ 725.362 and 725.363, may make or give on behalf of the party he or she represents, any request or notice relative to any proceeding before an adjudication officer, including formal hearing and review, except that such representative may not execute a claim for benefits, unless he or she is a person designated in § 725.301 as authorized to execute a claim. A representative shall be entitled to present or elicit evidence and make allegations as to facts and law in any proceeding affecting the party represented and to obtain information with respect to the claim of such party to the same extent as such party. Notice given to any party of any administrative action, determination, or decision, or request to any party for the production of evidence shall be sent to the representative of such party and such notice or request shall have the same force and effect as if it had been sent to the party represented.

§ 725.365 Approval of representative's fees; lien against benefits.

No fee charged for representation services rendered to a claimant with respect to any claim under this part shall be valid unless approved under this subpart. No contract or prior agreement for a fee shall be valid. In cases where the obligation to pay the attorney's fee is upon the claimant, the amount of the fee awarded may be made a lien upon the benefits due under an award and the adjudication officer shall fix, in the award approving the fee, such lien and the manner of payment of the fee. Any representative who is not an attorney may be awarded a fee for services under this subpart, except that no lien may be imposed with respect to such representative's fee.

§ 725.366 Fees for representatives.

(a) A representative seeking a fee for services performed on behalf of a claimant shall make application therefor to the district director, administrative law judge, or appropriate appellate tribunal, as the case may be, before whom the services were performed. The application shall be filed and served upon the claimant and all other parties within the time limits allowed by the district director, administrative law judge, or appropriate appellate tribunal. The application shall be supported by a complete statement of the extent and character of the necessary work done, and shall indicate the professional status (e.g., attorney, paralegal, law clerk, lay representative or clerical) of the person performing such work, and the customary billing rate for each such person. The application shall also include a listing of reasonable unreimbursed expenses, including those for travel, incurred by the representative or an employee of a representative in establishing the claimant's case. Any fee requested under this paragraph shall also contain a description of any fee requested, charged, or received for services rendered to the claimant before any State or Federal court or agency in connection with a related matter.

(b) Any fee approved under paragraph (a) of this section shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the qualifications of the representative, the complexity of the legal issues involved, the level of proceedings to which the claim was raised, the level at which the representative entered the proceedings, and any other information which may be relevant to the amount of fee requested. No fee approved shall include payment for time spent in preparation of a fee application. No fee shall be approved for work done on claims filed between December 30, 1969, and June 30, 1973, under part B of title IV of the Act, except for services rendered on behalf of the claimant in regard to the review of the claim under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

(c) In awarding a fee, the appropriate adjudication officer shall consider, and shall add to the fee, the amount of reasonable and unreimbursed expenses incurred in establishing the claimant's case. Reimbursement for travel expenses incurred by an attorney shall be determined in accordance with the provisions of § 725.459(a). No reimbursement shall be permitted for expenses incurred in obtaining medical or other evidence which has previously been submitted to the Office in connection with the claim.

(d) Upon receipt of a request for approval of a fee, such request shall be reviewed and evaluated by the appropriate adjudication officer and a fee award issued. Any party may request reconsideration of a fee awarded by the adjudication officer. A revised or modified fee award may then be issued, if appropriate.

(e) Each request for reconsideration or review of a fee award shall be in writing and shall contain supporting statements or information pertinent to any increase or decrease requested. If a fee awarded by a district director is disputed, such award shall be appealable directly to the Benefits Review Board. In such a fee dispute case, the record before the Board shall consist of the order of the district director awarding or denying the fee, the application for a fee, any written statement in opposition to the fee and the documentary evidence contained in the file which verifies or refutes any item claimed in the fee application.

§ 725.367 Payment of a claimant's attorney's fee by responsible operator or fund.

(a) An attorney who represents a claimant in the successful prosecution of a claim for benefits may be entitled to collect a reasonable attorney's fee from the responsible operator that is ultimately found liable for the payment of benefits, or, in a case in which there is no operator who is liable for the payment of benefits, from the fund. Generally, the operator or fund liable for the payment of benefits shall be liable for the payment of the claimant's attorney's fees where the operator or fund, as appropriate, took action, or acquiesced in action, that created an adversarial relationship between itself and the claimant. The fees payable under this section shall include fees for reasonable and necessary services performed prior to the creation of the adversarial relationship. Circumstances in which a successful attorney's fees shall be payable by the responsible operator or the fund include, but are not limited to, the following:

(1) The responsible operator initially found to be liable for the payment of benefits by the district director (see § 725.410(a)) contests the claimant's eligibility for benefits, either by filing a response pursuant to § 725.411(b)(1), or, in a case in which the district director issues an initial finding that the claimant is not eligible for benefits, by failing to file a response. The operator that is ultimately determined to be liable for benefits shall be liable for an attorney's fee with respect to all reasonable services performed by the claimant's attorney;

(2) There is no operator that may be held liable for the payment of benefits, and the district director issues an initial finding that the claimant is not eligible for benefits. The fund shall be liable for an attorney's fee with respect to all reasonable services performed by the claimant's attorney;

(3) The claimant submits a bill for medical treatment, and the party liable for the payment of benefits declines to pay the bill on the grounds that the treatment is unreasonable, or is for a condition that is not compensable. The responsible operator or fund, as appropriate, shall be liable for an attorney's fee with respect to all reasonable services performed by the claimant's attorney;

(4) A beneficiary seeks an increase in the amount of benefits payable, and the responsible operator or fund issues a notice of controversion contesting the claimant's right to that increase. If the beneficiary is successful in securing an increase in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all reasonable services performed by the beneficiary's attorney;

(5) The responsible operator or fund seeks a decrease in the amount of benefits payable. If the beneficiary is successful in resisting the request for a decrease in the amount of benefits payable, the operator or fund shall be liable for an attorney's fee with respect to all reasonable services performed by the beneficiary's attorney. A request for information clarifying the amount of benefits payable shall not be considered a request to decrease that amount.

(b) Any fee awarded under this section shall be in addition to the award of benefits, and shall be awarded, in an order, by the district director, administrative law judge, Board or court, before whom the work was performed. The operator or fund shall pay such fee promptly and directly to the claimant's attorney in a lump sum after the award of benefits becomes final.

(c) Section 205(a) of the Black Lung Benefits Amendments of 1981, Public Law 97–119, amended section 422 of the Act and relieved operators and carriers from liability for the payment of benefits on certain claims. Payment of benefits on those claims was made the responsibility of the fund. The claims subject to this transfer of liability are described in § 725.496. On claims subject to the transfer of liability described in this paragraph the fund will pay all fees and costs which have been or will be awarded to claimant's attorneys which were or would have become the liability of an operator or carrier but for the enactment of the 1981 Amendments and which have not already been paid by such operator or carrier. Section 9501(d)(7) of the Internal Revenue Code (26 U.S.C.), which was also enacted as a part of the 1981 Amendments to the Act, expressly prohibits the fund from reimbursing an operator or carrier for any attorney fees or costs which it has paid on cases subject to the transfer of liability provisions.

Subpart E—Adjudication of Claims by the District Director

§ 725.401 Claims development—general.

After a claim has been received by the district director, the district director shall take such action as is necessary to develop, process, and make determinations with respect to the claim as provided in this subpart.

§ 725.402 Approved State workers' compensation law.

If a district director determines that any claim filed under this part is one subject to adjudication under a workers' compensation law approved under part 722 of this subchapter, he or she shall advise the claimant of this determination and of the Act's requirement that the claim must be filed under the applicable State workers' compensation law. The district director shall then prepare a proposed decision and order dismissing the claim for lack of jurisdiction pursuant to § 725.418 and proceed as appropriate.

§ 725.403 [Reserved]

§ 725.404 Development of evidence—general.

(a) *Employment history.* Each claimant shall furnish the district director with a complete and detailed history of the coal miner's employment and, upon request, supporting documentation.

(b) *Matters of record.* Where it is necessary to obtain proof of age, marriage or termination of marriage, death, family relationship, dependency (see subpart B of this part), or any other fact which may be proven as a matter of public record, the claimant shall furnish such proof to the district director upon request.

(c) *Documentary evidence.* If a claimant is required to submit documents to the district director, the claimant shall submit either the original, a certified copy or a clear readable copy thereof. The district director or administrative law judge may require the submission of an original document or certified copy thereof, if necessary.

(d) *Submission of insufficient evidence.* In the event a claimant submits insufficient evidence regarding any matter, the district director shall inform the claimant of what further evidence is necessary and request that such evidence be submitted within a specified reasonable time which may, upon request, be extended for good cause.

§ 725.405 Development of medical evidence; scheduling of medical examinations and tests.

(a) Upon receipt of a claim, the district director shall ascertain whether the claim was filed by or on account of a miner as defined in § 725.202, and in the case of a claim filed on account of a deceased miner, whether the claim was filed by an eligible survivor of such miner as defined in subpart B of this part.

(b) In the case of a claim filed by or on behalf of a miner, the district director shall, where necessary, schedule the miner for a medical examination and testing under § 725.406.

(c) In the case of a claim filed by or on behalf of a survivor of a miner, the district director shall obtain whatever medical evidence is necessary and available for the development and evaluation of the claim.

(d) The district director shall, where appropriate, collect other evidence necessary to establish:

(1) The nature and duration of the miner's employment; and

(2) All other matters relevant to the determination of the claim.

(e) If at any time during the processing of the claim by the district director, the evidence establishes that the claimant is not entitled to benefits under the Act, the district director may terminate evidentiary development of the claim and proceed as appropriate.

§ 725.406 Medical examinations and tests.

(a) The Act requires the Department to provide each miner who applies for benefits with the opportunity to undergo a complete pulmonary evaluation at no expense to the miner. A complete pulmonary evaluation includes a report of physical examination, a pulmonary function study, a chest roentgenogram and, unless medically contraindicated, a blood gas study.

(b) As soon as possible after a miner files an application for benefits, the district director will provide the miner with a list of medical facilities and physicians in the state of the miner's residence and states contiguous to the state of the miner's residence that the Office has authorized to perform complete pulmonary evaluations. The miner shall select one of the facilities or physicians on the list, and the district director will make arrangements for the miner to be given a complete pulmonary evaluation by that facility or physician. The results of the complete pulmonary evaluation shall not be counted as evidence submitted by the miner under § 725.414.

(c) If any medical examination or test conducted under paragraph (a) of this section is not administered or reported in substantial compliance with the provisions of part 718 of this subchapter, or does not provide sufficient information to allow the district director to decide whether the miner is eligible for benefits, the district

director shall schedule the miner for further examination and testing. Where the deficiencies in the report are the result of a lack of effort on the part of the miner, the miner will be afforded one additional opportunity to produce a satisfactory result. In order to determine whether any medical examination or test was administered and reported in substantial compliance with the provisions of part 718 of this subchapter, the district director may have any component of such examination or test reviewed by a physician selected by the district director.

(d) After the physician completes the report authorized by paragraph (a), the district director will inform the miner that he may elect to have the results of the objective testing sent to his treating physician for use in preparing a medical opinion. The district director will also inform the claimant that any medical opinion submitted by his treating physician will count as one of the two medical opinions that the miner may submit under § 725.414.

(e) If, at any time after the completion of the initial complete pulmonary evaluation, the district director believes that unresolved medical questions remain, he may require the claimant to be examined by a physician or medical facility selected by the district director from the list of physicians and facilities authorized to perform complete pulmonary evaluations. If additional medical evidence is obtained in accordance with this paragraph, the district director may order the physician selected to retest or reexamine the miner to do so without the presence or participation of any other physician who previously examined the miner, and without benefit of the conclusions of any other physician who has examined the miner. Any evidence obtained under this paragraph shall be considered a part of the complete pulmonary evaluation obtained under paragraph (b) of this section for purposes of the limitations established in § 725.414, except that any additional chest X-ray, pulmonary function test, or blood gas study performed in connection with a request for re-examination under this paragraph shall be substituted for the chest X-ray, pulmonary function test, or blood gas study performed in connection with the original evaluation.

(f) The cost of any medical examination or test authorized under this section, including the cost of travel to and from the examination, shall be paid by the fund. No reimbursement for overnight accommodations shall be authorized unless the district director determines that an adequate testing facility is unavailable within one day's round trip travel by automobile from the miner's residence. The fund shall be reimbursed for such payments by an operator, if any, found liable for the payment of benefits to the claimant. If an operator fails to repay such expenses, with interest, upon request of the Office, the entire amount may be collected in an action brought under section 424 of the Act and § 725.603.

§ 725.407 Identification and notification of responsible operator.

(a) Upon receipt of the miner's employment history, the district director shall investigate whether any operator may be held liable for the payment of benefits as a responsible operator in accordance with the criteria contained in subpart G of this part.

(b) Prior to issuing an initial finding pursuant to § 725.410, the district director may identify one or more operators potentially liable for the payment of benefits in accordance with the criteria set forth in § 725.495. The district director shall notify each such operator of the existence of the claim. Where the records maintained by the Office pursuant to part 726 of this subchapter indicate that the operator had obtained a policy of insurance, and the claim falls within such policy, the notice provided pursuant to this section shall also be sent to the operator's carrier. Any operator or carrier notified of the claim shall thereafter be considered a party to the claim in accordance with § 725.360 unless it is dismissed by an adjudication officer and is not thereafter notified again of its potential liability.

(c) The notification issued pursuant to this section shall include a copy of the claimant's application and a copy of all evidence obtained by the district director relating to the miner's employment. The district director may request the operator to answer specific questions, including, but not limited to, questions related to the nature of its operations, its relationship with the miner, its financial status, including any insurance obtained to secure its obligations under the Act, and its relationship with other potentially liable operators. A copy of any notification issued pursuant to this section shall be sent to the claimant by regular mail.

(d) If at any time before a case is referred to the Office of Administrative Law Judges, the district director determines that an operator which may be liable for the payment of benefits has not been notified under this section or has been incorrectly dismissed pursuant to § 725.413(c)(1), the district director shall give such operator notice of its potential liability in accordance with this section. The adjudication officer shall then take such further action on the claim as may be appropriate. There shall be no time limit applicable to a later identification of an operator under this paragraph if the operator fraudulently concealed its identity as an employer of the miner. The district director may not notify additional operators of their potential liability after a case has been referred to the Office of Administrative Law Judges, unless the case was referred for a hearing to determine whether the claim was properly denied as abandoned pursuant to § 725.409.

§ 725.408 Operator's response to notification.

(a)(1) An operator which receives notification under § 725.407 shall, within 30 days of receipt, file a response, and shall indicate its intent to accept or contest its identification as a potentially liable operator. The operator's response shall also be sent to the claimant by regular mail.

(2) If the operator contests its identification, it shall, on a form supplied by the district director, state the precise nature of its disagreement by admitting or denying each of the following assertions. In answering these assertions, the term ''operator'' shall include any operator for which the identified operator may be considered a successor operator pursuant to § 725.492.

(i) That the named operator was an operator for any period after June 30, 1973;

(ii) That the operator employed the miner as a miner for a cumulative period of not less than one year;

(iii) That the miner was exposed to coal mine dust while working for the operator;

(iv) That the miner's employment with the operator included at least one working day after December 31, 1969; and

(v) That the operator is capable of assuming liability for the payment of benefits.

(3) An operator which receives notification under § 725.407, and which fails to file a response within the time limit provided by this section, shall not be allowed to contest its liability for the payment of benefits on the grounds set forth in paragraph (a)(2) of this section.

(b)(1) Within 90 days of the date on which it receives notification under § 725.407, an operator may submit documentary evidence in support of its position.

(2) No documentary evidence relevant to the grounds set forth in paragraph (a)(2) may be admitted in any further proceedings unless it is submitted within the time limits set forth in this section.

§ 725.409 Denial of a claim by reason of abandonment.

(a) A claim may be denied at any time by the district director by reason of abandonment where the claimant fails:

(1) To undergo a required medical examination without good cause; or,

(2) To submit evidence sufficient to make a determination of the claim; or,

(3) To pursue the claim with reasonable diligence; or,

(4) To attend an informal conference without good cause.

(b)(1) If the district director determines that a denial by reason of abandonment under paragraphs (a)(1) through (3) of this section is appropriate, he or she shall notify the claimant of the reasons for such denial and of the action which must be taken to avoid a denial by reason of abandonment. If the claimant completes the action requested within the time allowed, the claim shall be developed, processed and adjudicated as specified in this part. If the claimant does not fully comply with the action requested by the district director, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Any request for a hearing prior to the issuance of such notification shall be considered invalid and of no effect. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(2) In any case in which a claimant has failed to attend an informal conference and has not provided the district director with his reasons for failing to attend, the district director shall ask the claimant to explain his absence. In considering whether the claimant had good cause for his failure to attend the conference, the district director shall consider all relevant circumstances, including the age, education, and health of the claimant, as well as the distance between the claimant's residence and the location of the conference. If the district director concludes that the claimant had good cause for failing to attend the conference, he may continue processing the claim, including, where appropriate under § 725.416, the scheduling of an informal conference. If the claimant does not supply the district director with his reasons for failing to attend the conference within 30 days of the date of the district director's request, or the district director concludes that the reasons supplied by the claimant do not establish good cause, the district director shall notify the claimant that the claim has been denied by reason of abandonment. Any request for a hearing prior to the issuance of such notification shall be considered invalid and of no effect. Such notification shall be served on the claimant and all other parties to the claim by certified mail.

(c) The denial of a claim by reason of abandonment shall become effective and final unless, within 30 days after the denial is issued, the claimant requests a hearing. Following the expiration of the 30-day period, a new claim may be filed at any time pursuant to § 725.309. If the claimant timely requests a hearing, the district director shall refer the case to the Office of Administrative Law Judges in accordance with § 725.421. The hearing will be limited to the issue of whether the claim was properly denied by reason of abandonment. If the administrative law judge determines that the claim was not properly denied by reason of abandonment, he shall remand the claim to the district director for the completion of administrative processing.

§ 725.410 Initial findings by the district director.

(a) Based upon the evidence developed, the district director shall make an initial finding with respect to the claim. The initial finding shall include a determination with respect to the claimant's eligibility and a determination with respect to whether any of the operators notified of potential liability under § 725.407 of this part is the responsible operator in accordance with § 725.495.

(b) The district director shall serve the initial finding, together with a copy of all of the evidence developed, on the claimant, the responsible operator, and all other operators which received notification pursuant to § 725.407. The initial finding shall be served on each party by certified mail.

(c) If the evidence submitted does not support a finding of eligibility, the initial finding shall specify the reasons why the claim cannot be approved and the additional evidence necessary to establish entitlement. The initial finding shall notify the claimant that he has the right to obtain further adjudication of his eligibility in accordance with this subpart, that he has the right to submit additional evidence in accordance with this subpart, and that he has the right to obtain counsel, under the terms set forth in subpart D of this part, in order to assist him. The initial finding shall further notify the claimant that, if he establishes his entitlement to benefits, the cost of obtaining additional evidence, along with a reasonable attorney's fee, shall be reimbursed by the responsible operator, or, if no operator can be held liable, the fund.

§ 725.411 Initial finding—eligibility.

(a) *Claimant response.*

(1) *Finding that the claimant is not eligible for benefits.*

(i) Within one year after the district director issues an initial finding that the claimant is not eligible for benefits, the claimant may request further adjudication of the claim. Any statement filed during the applicable time period demonstrating the claimant's intention to pursue his or her claim shall be considered a request for further adjudication in accordance with this section. The claimant may not request a hearing at this point. Any request for a hearing prior to the issuance of a proposed decision and order shall be considered invalid and of no effect.

(ii) If the claimant does not request further adjudication of the claim within the time limits set forth in this section, the claim shall be deemed to have been denied, effective as of the date of the issuance of the initial finding. Any submission by the claimant after the time limits set forth in this section will be treated as an intent to file a new claim for benefits in accordance with § 725.305. Such a claim may be approved only if it meets the conditions of § 725.309.

(2) *Finding that the claimant is eligible for benefits.* If the district director issues an initial finding that the evidence submitted supports a finding of eligibility, the claimant may, within 30 days of the issuance of the initial finding, request revision of any of the terms of the initial finding. If the claimant does not file a timely request pursuant to this paragraph, he shall be deemed to have accepted the district director's initial finding.

(b) *Operator response.* (1) Within 30 days of the issuance of an initial finding, the responsible operator initially found liable for the payment of benefits shall file a response with regard to the claimant's eligibility for benefits. The response shall specifically indicate whether the operator agrees or disagrees with the initial finding of eligibility. A response that the operator is not liable for benefits shall not be sufficient to contest the claimant's eligibility under this section. A response to the initial finding of eligibility shall be filed regardless of whether the district director finds the claimant eligible for benefits.

(2) If the operator initially found liable for the payment of benefits does not file a timely response, it shall be deemed to have accepted the district director's initial finding with respect to the claimant's eligibility, and shall not, except as provided in § 725.463, be permitted to raise issues or present evidence with respect to issues inconsistent with the initial findings in any further proceeding conducted with respect to the claim.

§ 725.412 Initial finding-liability.

(a) Within 30 days of the issuance of an initial finding, the responsible operator initially found liable for the payment of benefits shall file a response with regard to its liability for benefits. The response shall specifically indicate whether the operator agrees or disagrees with the initial finding of liability. A response that the operator is not liable for benefits under this section shall not be sufficient to contest the claimant's eligibility. A response to the initial finding of liability shall be filed regardless of whether or not the district director finds the claimant eligible for benefits.

(b) If the responsible operator initially found liable for the payment of benefits does not file a timely response, it shall be deemed to have accepted the district director's initial finding with respect to its liability, and to have waived its right to contest its liability in any further proceeding conducted with respect to the claim.

§ 725.413 Initial adjudication by the district director.

(a) If the district director issues an initial finding that the evidence submitted supports a finding of eligibility, and

(1) The responsible operator does not file a timely response under either § 725.411 or § 725.412, or

(2) There is no operator responsible for the payment of benefits, the district director shall, after considering any request filed by the claimant pursuant to § 725.411(a)(2), issue a proposed decision and order in accordance with § 725.418.

(b) If the district director issues an initial finding that the evidence submitted does not support a finding of eligibility, and the claimant does not file a timely response pursuant to § 725.411, the claim shall be considered to have been denied, effective as of the date of the issuance of the initial finding. Any later submission by the claimant will be treated as an intent to file a claim for benefits in accordance with § 725.305. Such a claim may be approved only if it meets the conditions of § 725.309.

(c)(1) In all other cases, the district director shall, following the expiration of all applicable time periods for filing responses, or the receipt of responses, notify all parties of any responses received from the claimant and the responsible operator. The district director may, in his discretion, dismiss as parties any of the operators notified of their potential liability pursuant to § 725.407. If the district director thereafter determines that the participation of a party dismissed pursuant to this section is required, he may once again notify the operator in accordance with § 725.407(d).

(2) The district director shall notify the parties of a schedule for submitting documentary evidence. Such schedule shall allow the parties not less than 60 days within which to submit evidence in support of their contentions, and shall provide not less than an additional 30 days within which the parties may respond to evidence submitted by other parties. Any such evidence must meet the requirements set forth in § 725.414 in order to be admitted into the record.

§ 725.414 Development of evidence.

(a) *Medical evidence.* (1) For purposes of this section, a medical report shall consist of a physician's written assessment of the miner's respiratory or pulmonary condition. A medical report may be prepared by a physician who examined the miner and/or reviewed the available admissible evidence. A physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, shall not be considered a medical report for purposes of this section.

(2)(i) The claimant shall be entitled to submit, in support of his affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section.

(ii) The claimant shall be entitled to submit, in rebuttal of the case presented by the party or parties opposing entitlement, no more than one physician's interpretation of each chest X-ray, pulmonary function test, or arterial blood gas study submitted by any potentially liable operator or the fund, as appropriate, under paragraph (a)(3)(i) or (a)(3)(iii) of this section and by the Director pursuant to § 725.406. In any case in which the party opposing entitlement has submitted the results of other testing pursuant to § 718.107, the claimant shall be entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the responsible operator or fund has submitted rebuttal evidence under paragraph (a)(3)(ii) or (a)(3)(iii) of this section with respect to medical testing submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the claimant, the claimant shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(3) The Department intends that all parties to a claim, including all operators notified of their potential liability under § 725.407 that have not been dismissed, shall be bound by a final adjudication of the claimant's eligibility. Accordingly, any operator notified of its potential liability in accordance with § 725.407 shall not be entitled to require the claimant to re-adjudicate his eligibility in the event the district director's initial finding with respect to the responsible operator is determined to have been erroneous.

(i) The responsible operator and any other operators that remain parties to the case shall collectively be entitled to obtain and submit, in support of their affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section. In obtaining such evidence, neither the responsible operator, nor any other operator permitted to submit evidence under paragraph (a)(3)(iv) of this section, may require the miner to travel more than 100 miles from his or her place of residence, or the distance traveled by the miner in obtaining the complete pulmonary evaluation provided by § 725.406, whichever is greater, unless a trip of greater distance is authorized in writing by the district director. If a miner unreasonably refuses—

(A) To provide the Office or a coal mine operator with a complete statement of his or her medical history

and/or to authorize access to his or her medical records, or

(B) To submit to an evaluation or test requested by the district director or a potentially liable operator, the miner's claim may be denied by reason of abandonment (See § 725.409).

(ii) The responsible operator and any other operators that remain parties to the case shall be entitled to submit, in rebuttal of the case presented by the claimant, no more than one physician's interpretation of each chest X-ray, pulmonary function test, or arterial blood gas study submitted by the claimant under paragraph (a)(2)(i) of this section and by the Director pursuant to § 725.406. In any case in which the claimant has submitted the results of other testing pursuant to § 718.107, the responsible operator and other operators that remain parties to the case shall collectively be entitled to submit one physician's assessment of each piece of such evidence in rebuttal. In addition, where the claimant has submitted rebuttal evidence under paragraph (a)(2)(ii) of this section, the responsible operator and other operators that remain parties to the case shall collectively be entitled to submit an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing. Where the rebuttal evidence tends to undermine the conclusion of a physician who prepared a medical report submitted by the responsible operator, the responsible operator shall be entitled to submit an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence.

(iii) In a case in which the district director has not identified any potentially liable operators, the district director shall be entitled to exercise the rights of a responsible operator under this section, except that the evidence obtained in connection with the complete pulmonary evaluation performed pursuant to § 725.406 shall be considered evidence obtained and submitted by the Director, OWCP, for purposes of paragraph (a)(3)(i) of this section.

(iv) Except for the responsible operator, any operator notified of its potential liability pursuant to § 725.407, and which has not been dismissed as a party by the district director, must request permission of the adjudication officer to obtain and submit a medical report or the results of any objective medical testing. Such permission shall be granted only upon a showing that the responsible operator has not undertaken a full development of the evidence, and that without such permission, the potentially liable operator will be unable to secure a full and fair litigation of the claimant's eligibility. In granting such permission, the adjudication officer shall take such action as is necessary to prevent the miner from undergoing unnecessary testing, and shall ensure that the record contains, in support of the operators' affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, and no more than two medical reports submitted by the operators opposing the claimant's eligibility. The adjudication officer shall also ensure that the record contains, in rebuttal of the affirmative case presented by the claimant, no more than one physician's interpretation of each chest X-ray, pulmonary function test, and arterial blood gas study submitted by the claimant under paragraph (a)(2)(ii) of this section and by the Director pursuant to § 725.406.

(4) Notwithstanding the limitations in paragraphs (a)(2) and (a)(3) of this section, any record of a miner's hospitalization for a respiratory or pulmonary or related disease, medical treatment for a respiratory or pulmonary or related disease, or a biopsy or autopsy may be received into evidence.

(5) A copy of any documentary evidence submitted by a party must be served on all other parties to the claim. If the claimant is not represented by an attorney, the district director shall mail a copy of all documentary evidence submitted by the claimant to all other parties to the claim. Following the development and submission of affirmative medical evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(6) The district director shall admit into the record all evidence submitted in accordance with this section, and shall also admit the results of any medical examination or test conducted pursuant to § 725.406.

(b) *Evidence pertaining to liability.* (1) Except as provided by § 725.408(b)(2), the potential responsible operator may submit evidence to demonstrate that it is not the potentially liable operator that most recently employed the claimant. Failure to submit such evidence shall be deemed an acceptance of the district director's initial finding of liability.

(2) Any other party may submit evidence regarding the liability of the potential responsible operator or any other operator.

(3) A copy of any documentary evidence submitted under this paragraph must be mailed to all other parties to the claim. Following the submission of affirmative evidence, the parties may submit rebuttal evidence in accordance with the schedule issued by the district director.

(c) *Testimony.* A physician who prepared a medical report admitted under this section may testify with respect to the claim at any formal hearing conducted in accordance with subpart F of this part, or by deposition. If a party has submitted fewer than two medical reports as part of that party's affirmative case under this section, a physician who did not prepare a medical report may testify in lieu of such a medical report. The testimony of such a physician shall be considered a medical report for purposes of the limitations provided by this section. A party may offer the testimony of no more than two physicians under the provisions of this section unless the adjudication officer finds good cause under paragraph (b)(1) of § 725.456. In accordance with the schedule issued by the district director, all parties shall notify the district director of the name and current address of any potential witness whose testimony pertains to the liability of a potentially liable operator or the responsible operator. Absent such notice, the testimony of a witness relevant to the liability of a potentially liable operator or the responsible operator shall not be admitted in any hearing conducted with respect to the claim unless the administrative law judge finds that the lack of notice should be excused due to extraordinary circumstances.

(d) Except to the extent permitted by § 725.456 and § 725.310(b), the limitations set forth in this section shall apply to all proceedings conducted with respect to a claim, and no documentary evidence pertaining to liability shall be admitted in any further proceeding conducted with respect to a claim unless it is submitted to the district director in accordance with this section.

(e) Any documentary evidence obtained by a party during the time a claim is pending before a district director, which is withheld from the district director or any other party to the claim, shall not be admitted into the record in any later proceedings held with respect to the claim in the absence of extraordinary circumstances, unless the admission of such evidence is requested by the Director or such other party.

§ 725.415 Action by the district director after development of operator's evidence.

(a) At the end of the period permitted under § 725.413(c)(2) for the submission

of evidence, the district director shall review the claim on the basis of all evidence submitted in accordance with § 725.414.

(b) After review of all evidence submitted, the district director may schedule a conference in accordance with § 725.416, issue a proposed decision and order in accordance with § 725.418, or take such other action as the district director considers appropriate.

§ 725.416 Conferences.

(a) At the conclusion of the period permitted by § 725.413(c)(2) for the submission of evidence, the district director may conduct an informal conference in any claim where it appears that such conference will assist in the voluntary resolution of any issue raised with respect to the claim. The conference proceedings shall not be stenographically reported and sworn testimony shall not be taken.

(b) The district director shall notify the parties of a definite time and place for the conference. The notification shall set forth the specific reasons why the district director believes that a conference will assist in the voluntary resolution of any issue raised with respect to the claim. No sanction may be imposed under paragraph (c) of this section unless the record contains a notification that meets the requirements of this section. The district director may in his or her discretion, or on the motion of any party, cancel or reschedule a conference, and allow any or all of the parties to participate by telephone.

(c) The unexcused failure of any party to appear at an informal conference shall be grounds for the imposition of sanctions. If the claimant fails to appear, the district director may take such steps as are authorized by § 725.409(b)(2) to deny the claim by reason of abandonment. If the responsible operator fails to appear, it shall be deemed to have waived its right to contest its potential liability for an award of benefits and, in the discretion of the district director, its right to contest any issue related to the claimant's eligibility.

(d) Any representative of an operator, of an operator's insurance carrier, or of a claimant, authorized to represent such party in accordance with § 725.362, shall be deemed to have sufficient authority to stipulate facts or issues or agree to a final disposition of the claim.

(e) Procedures to be followed at a conference shall be within the discretion of the district director. In the case of a conference involving an unrepresented claimant, the district director shall fully inform the claimant of the consequences of any agreement the claimant is asked to sign. If it is apparent that the unrepresented claimant does not understand the nature or effect of the proceedings, the district director shall not permit the execution of any stipulation or agreement in the claim unless it is clear that the best interests of the claimant are served thereby.

§ 725.417 Action at the conclusion of conference.

(a) At the conclusion of a conference, the district director shall prepare a stipulation of contested and uncontested issues which shall be signed by the parties and the district director. If a hearing is conducted with respect to the claim, this stipulation shall be submitted to the Office of Administrative Law Judges and placed in the claim record.

(b) In any case, where appropriate, the district director may permit a reasonable time for the submission of additional evidence following a conference, provided that such evidence does not exceed the limits set forth in § 725.414.

(c) Within 20 days after the termination of all conference proceedings, the district director shall prepare and send to the parties by certified mail a memorandum of conference, on a form prescribed by the Office, summarizing the conference and including the following:

(1) Date, time and place of conference;

(2) Names, addresses, telephone numbers, and status (i.e., claimant, attorney, operator, carrier's representative, etc.);

(3) Issues discussed at conference;

(4) Additional material presented (i.e., medical reports, employment reports, marriage certificates, birth certificates, etc.);

(5) Issues resolved at conference; and

(6) District director's recommendation.

(d) Each party shall, in writing, either accept or reject, in whole or in part, the district director's recommendation, stating the reasons for such rejection. If no reply is received within 30 days from the date on which the recommendation was sent to parties, the recommendation shall be deemed accepted.

§ 725.418 Proposed decision and order.

(a) After evaluating the parties' responses to the district director's recommendation pursuant to § 725.417, or, if no informal conference is to be held, at the conclusion of the period permitted by § 725.413(c)(2) for the submission of evidence, the district director shall issue a proposed decision and order. A proposed decision and order is a document, issued by the district director after the evidentiary development of the claim is completed and all contested issues, if any, are joined, which purports to resolve a claim on the basis of the evidence submitted to or obtained by the district director. A proposed decision and order shall be considered a final adjudication of a claim only as provided in § 725.419. A proposed decision and order may be issued by the district director in any claim and at any time during the adjudication of a claim if:

(1) Issuance is authorized or required by this part; or,

(2) The district director determines that its issuance will expedite the adjudication of the claim.

(b) A proposed decision and order shall contain findings of fact and conclusions of law and an appropriate order shall be served on all parties to the claim by certified mail.

§ 725.419 Response to proposed decision and order.

(a) Within 30 days after the date of issuance of a proposed decision and order, any party may, in writing, request a revision of the proposed decision and order or a hearing. If a hearing is requested, the district director shall refer the claim to the Office of Administrative Law Judges (see § 725.421).

(b) Any response made by a party to a proposed decision and order shall specify the findings and conclusions with which the responding party disagrees, and shall be served on the district director and all other parties to the claim.

(c) If a timely request for revision of a proposed decision and order is made, the district director may amend the proposed decision and order, as circumstances require, and serve the revised proposed decision and order on all parties or take such other action as is appropriate. If a revised proposed decision and order is issued, each party to the claim shall have 30 days from the date of issuance of that revised proposed decision and order within which to request a hearing.

(d) If no response to a proposed decision and order is sent to the district director within the period described in paragraph (a) of this section, or if no response to a revised proposed decision and order is sent to the district director within the period described in paragraph (c) of this section, the proposed decision and order shall become a final decision and order, which is effective upon the expiration of the applicable 30-day period. Once a

proposed decision and order or revised proposed decision and order becomes final and effective, all rights to further proceedings with respect to the claim shall be considered waived, except as provided in § 725.310.

§ 725.420 Initial determinations.

(a) Section 9501(d)(1)(A)(1) of the Internal Revenue Code (26 U.S.C.) provides that the Black Lung Disability Trust Fund shall begin the payment of benefits on behalf of an operator in any case in which the operator liable for such payments has not commenced payment of such benefits within 30 days after the date of an initial determination of eligibility by the Secretary. For claims filed on or after January 1, 1982, the payment of such interim benefits from the fund is limited to benefits accruing after the date of such initial determination.

(b) Except as provided in § 725.415, after the district director has determined that a claimant is eligible for benefits, on the basis of all evidence submitted by a claimant and operator, and has determined that a hearing will be necessary to resolve the claim, the district director shall in writing so inform the parties and direct the operator to begin the payment of benefits to the claimant in accordance with § 725.522. The date on which this writing is sent to the parties shall be considered the date of initial determination of the claim.

(c) If a notified operator refuses to commence payment of a claim within 30 days from the date on which an initial determination is made under this section, benefits shall be paid by the fund to the claimant in accordance with § 725.522, and the operator shall be liable to the fund, if such operator is determined liable for the claim, for all benefits paid by the fund on behalf of such operator, and, in addition, such penalties and interest as are appropriate.

§ 725.421 Referral of a claim to the Office of Administrative Law Judges.

(a) In any claim for which a formal hearing is requested or ordered, and with respect to which the district director has completed development and adjudication without having resolved all contested issues in the claim, the district director shall refer the claim to the Office of Administrative Law Judges for a hearing.

(b) In any case referred to the Office of Administrative Law Judges under this section, the district director shall transmit to that office the following documents, which shall be placed in the record at the hearing subject to the objection of any party:

(1) Copies of the claim form or forms;

(2) Any statement, document, or pleading submitted by a party to the claim;

(3) A copy of the notification to an operator of its possible liability for the claim;

(4) All evidence submitted to the district director under this part;

(5) Any written stipulation of law or fact or stipulation of contested and uncontested issues entered into by the parties;

(6) Any pertinent forms submitted to the district director;

(7) The statement by the district director of contested and uncontested issues in the claim; and

(8) The district director's initial determination of eligibility or other documents necessary to establish the right of the fund to reimbursement, if appropriate. Copies of the transmittal notice shall also be sent to all parties to the claim by regular mail.

(c) A party may at any time request and obtain from the district director copies of documents transmitted to the Office of Administrative Law Judges under paragraph (b) of this section. If the party has previously been provided with such documents, additional copies may be sent to the party upon the payment of a copying fee to be determined by the district director.

§ 725.422 Legal assistance.

The Secretary or his or her designee may, upon request, provide a claimant with legal assistance in processing a claim under the Act. Such assistance may be made available to a claimant in the discretion of the Solicitor of Labor or his or her designee at any time prior to or during the time in which the claim is being adjudicated and shall be furnished without charge to the claimant. Representation of a claimant in adjudicatory proceedings shall not be provided by the Department of Labor unless it is determined by the Solicitor of Labor that such representation is in the best interests of the black lung benefits program. In no event shall representation be provided to a claimant in a claim with respect to which the claimant's interests are adverse to those of the Secretary of Labor or the fund.

§ 725.423 Extensions of time.

Except for the one-year time limit set forth in § 725.411(a)(1)(i) and the 30-day time limit set forth in § 725.419, any of the time periods set forth in this subpart may be extended, for good cause shown, by filing a request for an extension with the district director prior to the expiration of the time period.

Subpart F—Hearings

§ 725.450 Right to a hearing.

Any party to a claim (see § 725.360) shall have a right to a hearing concerning any contested issue of fact or law unresolved by the district director. There shall be no right to a hearing until the processing and adjudication of the claim by the district director has been completed. There shall be no right to a hearing in a claim with respect to which a determination of the claim made by the district director has become final and effective in accordance with this part.

§ 725.451 Request for hearing.

After the completion of proceedings before the district director, or as is otherwise indicated in this part, any party may in writing request a hearing on any contested issue of fact or law (see § 725.419). A district director may on his or her own initiative refer a case for hearing. If a hearing is requested, or if a district director determines that a hearing is necessary to the resolution of any issue, the claim shall be referred to the Chief Administrative Law Judge for a hearing under § 725.421.

§ 725.452 Type of hearing; parties.

(a) A hearing held under this part shall be conducted by an administrative law judge designated by the Chief Administrative Law Judge. Except as otherwise provided by this part, all hearings shall be conducted in accordance with the provisions of 5 U.S.C. 554 *et seq.*

(b) All parties to a claim shall be permitted to participate fully at a hearing held in connection with such claim.

(c) A full evidentiary hearing need not be conducted if a party moves for summary judgment and the administrative law judge determines that there is no genuine issue as to any material fact and that the moving party is entitled to the relief requested as a matter of law. All parties shall be entitled to respond to the motion for summary judgment prior to decision thereon.

(d) If the administrative law judge believes that an oral hearing is not necessary (for any reason other than on motion for summary judgment), the judge shall notify the parties by written order and allow at least 30 days for the parties to respond. The administrative law judge shall hold the oral hearing if any party makes a timely request in response to the order.

§ 725.453 Notice of hearing.

All parties shall be given at least 30 days written notice of the date and place

of a hearing and the issues to be resolved at the hearing. Such notice shall be sent to each party or representative by certified mail.

§ 725.454 Time and place of hearing; transfer of cases.

(a) The Chief Administrative Law Judge shall assign a definite time and place for a formal hearing, and shall, where possible, schedule the hearing to be held at a place within 75 miles of the claimant's residence unless an alternate location is requested by the claimant.

(b) If the claimant's residence is not in any State, the Chief Administrative Law Judge may, in his or her discretion, schedule the hearing in the country of the claimant's residence.

(c) The Chief Administrative Law Judge or the administrative law judge assigned the case may in his or her discretion direct that a hearing with respect to a claim shall begin at one location and then later be reconvened at another date and place.

(d) The Chief Administrative Law Judge or administrative law judge assigned the case may change the time and place for a hearing, either on his or her own motion or for good cause shown by a party. The administrative law judge may adjourn or postpone the hearing for good cause shown, at any time prior to the mailing to the parties of the decision in the case. Unless otherwise agreed, at least 10 days notice shall be given to the parties of any change in the time or place of hearing.

(e) The Chief Administrative Law Judge may for good cause shown transfer a case from one administrative law judge to another.

§ 725.455 Hearing procedures; generally.

(a) *General.* The purpose of any hearing conducted under this subpart shall be to resolve contested issues of fact or law. Except as provided in § 725.421(b)(8), any findings or determinations made with respect to a claim by a district director shall not be considered by the administrative law judge.

(b) *Evidence.* The administrative law judge shall at the hearing inquire fully into all matters at issue, and shall not be bound by common law or statutory rules of evidence, or by technical or formal rules of procedure, except as provided by 5 U.S.C. 554 and this subpart. The administrative law judge shall receive into evidence the testimony of the witnesses and parties, the evidence submitted to the Office of Administrative Law Judges by the district director under § 725.421, and such additional evidence as may be submitted in accordance with the provisions of this subpart. The administrative law judge may entertain the objections of any party to the evidence submitted under this section.

(c) *Procedure.* The conduct of the hearing and the order in which allegations and evidence shall be presented shall be within the discretion of the administrative law judge and shall afford the parties an opportunity for a fair hearing.

(d) *Oral argument and written allegations.* The parties, upon request, may be allowed a reasonable time for the presentation of oral argument at the hearing. Briefs or other written statements or allegations as to facts or law may be filed by any party with the permission of the administrative law judge. Copies of any brief or other written statement shall be filed with the administrative law judge and served on all parties by the submitting party.

§ 725.456 Introduction of documentary evidence.

(a) All documents transmitted to the Office of Administrative Law Judges under § 725.421 shall be placed into evidence by the administrative law judge, subject to objection by any party.

(b)(1) Documentary evidence pertaining to the liability of a potentially liable operator and/or the identification of a responsible operator which was not submitted to the district director shall not be admitted into the hearing record in the absence of extraordinary circumstances. Medical evidence in excess of the limitations contained in § 725.414 shall not be admitted into the hearing record in the absence of good cause.

(2) Subject to the limitations in paragraph (b)(1) of this section, any other documentary material, including medical reports, which was not submitted to the district director, may be received in evidence subject to the objection of any party, if such evidence is sent to all other parties at least 20 days before a hearing is held in connection with the claim.

(3) Documentary evidence, which is not exchanged with the parties in accordance with this paragraph, may be admitted at the hearing with the written consent of the parties or on the record at the hearing, or upon a showing of good cause why such evidence was not exchanged in accordance with this paragraph. If documentary evidence is not exchanged in accordance with paragraph (b)(2) of this section and the parties do not waive the 20-day requirement or good cause is not shown, the administrative law judge shall either exclude the late evidence from the record or remand the claim to the district director for consideration of such evidence.

(4) A medical report which is not made available to the parties in accordance with paragraph (b)(2) of this section shall not be admitted into evidence in any case unless the hearing record is kept open for at least 30 days after the hearing to permit the parties to take such action as each considers appropriate in response to such evidence. If, in the opinion of the administrative law judge, evidence is withheld from the parties for the purpose of delaying the adjudication of the claim, the administrative law judge may exclude such evidence from the hearing record and close the record at the conclusion of the hearing.

(c) Documentary evidence which is obtained by any party during the time a claim is pending before the district director, and which is withheld from the district director or any other party until the claim is forwarded to the Office of Administrative Law Judges shall, notwithstanding paragraph (b) of this section, not be admitted into the hearing record in the absence of extraordinary circumstances, unless such admission is requested by any opposing party (see § 725.414(e)).

(d) Subject to paragraph (b) of this section, documentary evidence which the district director excludes from the record, and the objections to such evidence, may be submitted by the parties to the administrative law judge, who shall independently determine whether the evidence shall be admitted.

(1) If the evidence is admitted, the administrative law judge may, in his or her discretion, remand the claim to the district director for further consideration.

(2) If the evidence is admitted, the administrative law judge shall afford the opposing party or parties the opportunity to develop such additional documentary evidence as is necessary to protect the right of cross-examination.

(e) All medical records and reports submitted by any party shall be considered by the administrative law judge in accordance with the quality standards contained in part 718 of this subchapter.

(f) If the administrative law judge concludes that the complete pulmonary evaluation provided pursuant to § 725.406, or any part thereof, fails to comply with the applicable quality standards, or fails to address the relevant conditions of entitlement (see § 725.202(d)(2)(i) through (iv)) in a manner which permits resolution of the claim, the administrative law judge shall, in his or her discretion, remand the claim to the district director with

instructions to develop only such additional evidence as is required, or allow the parties a reasonable time to obtain and submit such evidence, before the termination of the hearing.

§ 725.457 Witnesses.

(a) Witnesses at the hearing shall testify under oath or affirmation. The administrative law judge and the parties may question witnesses with respect to any matters relevant and material to any contested issue. Any party who intends to present the testimony of an expert witness at a hearing shall so notify all other parties to the claim at least 10 days before the hearing. The failure to give notice of the appearance of an expert witness in accordance with this paragraph, unless notice is waived by all parties, shall preclude the presentation of testimony by such expert witness.

(b) No person shall be required to appear as a witness in any proceeding before an administrative law judge at a place more than 100 miles from his or her place of residence, unless the lawful mileage and witness fee for 1 day's attendance is paid in advance of the hearing date.

(c) No person shall be permitted to testify as a witness at the hearing, or pursuant to deposition or interrogatory under § 725.458, unless that person meets the requirements of § 725.414(c).

(1) In the case of a witness offering testimony relevant to the liability of a potentially liable operator and/or the identification of the responsible operator, the witness must have been identified as a potential hearing witness while the claim was pending before the district director.

(2) In the case of a physician offering testimony relevant to the physical condition of the miner, such physician must have prepared a medical report. Alternatively, a physician may offer testimony relevant to the physical condition of the miner only to the extent that the party offering the physician's testimony has submitted fewer medical reports than permitted by § 725.414. Such physician's opinion shall be considered a medical report subject to the limitations of § 725.414. This provision shall apply to any testimony by a physician, whether at a formal hearing or a deposition, or by interrogatories.

(d) A physician whose testimony is permitted under this section may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner's condition that is not admissible.

§ 725.458 Depositions; interrogatories.

The testimony of any witness or party may be taken by deposition or interrogatory according to the rules of practice of the Federal district court for the judicial district in which the case is pending (or of the U.S. District Court for the District of Columbia if the case is pending in the District or outside the United States), except that at least 30 days prior notice of any deposition shall be given to all parties unless such notice is waived. No post-hearing deposition or interrogatory shall be permitted unless authorized by the administrative law judge upon the motion of a party to the claim. The testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of the testimony contained in § 725.457(d).

§ 725.459 Witness fees.

(a) A witness testifying at a hearing before an administrative law judge, or whose deposition is taken, shall receive the same fees and mileage as witnesses in courts of the United States. If the witness is an expert, he or she shall be entitled to an expert witness fee. Except as provided in paragraphs (b) and (c) of this section, such fees shall be paid by the proponent of the witness.

(b) If the witness' proponent does not intend to call the witness to appear at a hearing or deposition, any other party may subpoena the witness for cross-examination. The administrative law judge shall authorize the least intrusive and expensive means of cross-examination as he deems appropriate and necessary to the full and true disclosure of facts. If such witness is required to attend the hearing, give a deposition or respond to interrogatories for cross-examination purposes, the proponent of the witness shall pay the witness' fee. If the claimant is the proponent of the witness whose cross-examination is sought, and demonstrates, within time limits established by the administrative law judge, that he would be deprived of ordinary and necessary living expenses if required to pay the witness fee and mileage necessary to produce that witness for cross-examination, the administrative law judge may apportion the costs of such cross-examination among the parties to the case. The administrative law judge may not apportion any costs against the fund in a case in which the district director has designated a responsible operator, except that the fund shall remain liable for any costs associated with the cross-examination of the physician who performed the complete pulmonary evaluation pursuant to § 725.406.

(c) If a claimant is determined entitled to benefits, there may be assessed as costs against a responsible operator, if any, or the fund, fees and mileage for necessary witnesses attending the hearing at the request of the claimant. Both the necessity for the witness and the reasonableness of the fees of any expert witness shall be approved by the administrative law judge. The amounts awarded against a responsible operator or the fund as attorney's fees, or costs, fees and mileage for witnesses, shall not in any respect affect or diminish benefits payable under the Act.

(d) A claimant shall be considered to be deprived of funds required for ordinary and necessary living expenses for purposes of paragraph (b) of this section where payment of the projected fee and mileage would meet the standards set forth at 20 CFR 404.508.

§ 725.460 Consolidated hearings.

When two or more hearings are to be held, and the same or substantially similar evidence is relevant and material to the matters at issue at each such hearing, the Chief Administrative Law Judge may, upon motion by any party or on his or her own motion, order that a consolidated hearing be conducted. Where consolidated hearings are held, a single record of the proceedings shall be made and the evidence introduced in one claim may be considered as introduced in the others, and a separate or joint decision shall be made, as appropriate.

§ 725.461 Waiver of right to appear and present evidence.

(a) If all parties waive their right to appear before the administrative law judge, it shall not be necessary for the administrative law judge to give notice of, or conduct, an oral hearing. A waiver of the right to appear shall be made in writing and filed with the Chief Administrative Law Judge or the administrative law judge assigned to hear the case. Such waiver may be withdrawn by a party for good cause shown at any time prior to the mailing of the decision in the claim. Even though all of the parties have filed a waiver of the right to appear, the administrative law judge may, nevertheless, after giving notice of the time and place, conduct a hearing if he or she believes that the personal appearance and testimony of the party or parties would assist in ascertaining the facts in issue in the claim. Where a waiver has been filed by all parties, and they do not appear before the administrative law judge personally or by representative, the administrative law judge shall make a record of the

relevant documentary evidence submitted in accordance with this part and any further written stipulations of the parties. Such documents and stipulations shall be considered the evidence of record in the case and the decision shall be based upon such evidence.

(b) Except as provided in § 725.456(a), the unexcused failure of any party to attend a hearing shall constitute a waiver of such party's right to present evidence at the hearing, and may result in a dismissal of the claim (see § 725.465).

§ 725.462 Withdrawal of controversion of issues set for formal hearing; effect.

A party may, on the record, withdraw his or her controversion of any or all issues set for hearing. If a party withdraws his or her controversion of all issues, the administrative law judge shall remand the case to the district director for the issuance of an appropriate order.

§ 725.463 Issues to be resolved at hearing; new issues.

(a) Except as otherwise provided in this section, the hearing shall be confined to those contested issues which have been identified by the district director (see § 725.421) or any other issue raised in writing before the district director.

(b) An administrative law judge may consider a new issue only if such issue was not reasonably ascertainable by the parties at the time the claim was before the district director. Such new issue may be raised upon application of any party, or upon an administrative law judge's own motion, with notice to all parties, at any time after a claim has been transmitted by the district director to the Office of Administrative Law Judges and prior to decision by an administrative law judge. If a new issue is raised, the administrative law judge may, in his or her discretion, either remand the case to the district director with instructions for further proceedings, hear and resolve the new issue, or refuse to consider such new issue.

(c) If a new issue is to be considered by the administrative law judge, a party may, upon request, be granted an appropriate continuance.

§ 725.464 Record of hearing.

All hearings shall be open to the public and shall be mechanically or stenographically reported. All evidence upon which the administrative law judge relies for decision shall be contained in the transcript of testimony, either directly or by appropriate reference. All medical reports, exhibits, and any other pertinent document or record, either in whole or in material part, introduced as evidence, shall be marked for identification and incorporated into the record.

§ 725.465 Dismissals for cause.

(a) The administrative law judge may, at the request of any party, or on his or her own motion, dismiss a claim:

(1) Upon the failure of the claimant or his or her representative to attend a hearing without good cause;

(2) Upon the failure of the claimant to comply with a lawful order of the administrative law judge; or

(3) Where there has been a prior final adjudication of the claim or defense to the claim under the provisions of this subchapter and no new evidence is submitted (except as provided in part 727 of this subchapter; see § 725.4(d)).

(b) A party who is not a proper party to the claim (see § 725.360) shall be dismissed by the administrative law judge. The administrative law judge shall not dismiss any operator named as a potentially liable operator pursuant to § 725.407, except upon the motion or written agreement of the Director.

(c) In any case where a dismissal of a claim, defense, or party is sought, the administrative law judge shall issue an order to show cause why the dismissal should not be granted and afford all parties a reasonable time to respond to such order. After the time for response has expired, the administrative law judge shall take such action as is appropriate to rule on the dismissal, which may include an order dismissing the claim, defense or party.

(d) No claim shall be dismissed in a case with respect to which payments prior to final adjudication have been made to the claimant in accordance with § 725.522, except upon the motion or written agreement of the Director.

§ 725.466 Order of dismissal.

(a) An order dismissing a claim shall be served on the parties in accordance with § 725.478. The dismissal of a claim shall have the same effect as a decision and order disposing of the claim on its merits, except as provided in paragraph (b) of this section. Such order shall advise the parties of their right to request review by the Benefits Review Board.

(b) Where the Chief Administrative Law Judge or the presiding administrative law judge issues a decision and order dismissing the claim after a show cause proceeding, the district director shall terminate any payments being made to the claimant under § 725.522, and the order of dismissal shall, if appropriate, order the claimant to reimburse the fund for all benefits paid to the claimant.

§ 725.475 Termination of hearings.

Hearings are officially terminated when all the evidence has been received, witnesses heard, pleadings and briefs submitted to the administrative law judge, and the transcript of the proceedings has been printed and delivered to the administrative law judge.

§ 725.476 Issuance of decision and order.

Within 20 days after the official termination of the hearing (see § 725.475), the administrative law judge shall issue a decision and order with respect to the claim making an award to the claimant, rejecting the claim, or taking such other action as is appropriate.

§ 725.477 Form and contents of decision and order.

(a) Orders adjudicating claims for benefits shall be designated by the term ''decision and order'' or ''supplemental decision and order'' as appropriate, followed by a descriptive phrase designating the particular type of order, such as ''award of benefits,'' ''rejection of claim,'' ''suspension of benefits,'' ''modification of award.''

(b) A decision and order shall contain a statement of the basis of the order, the names of the parties, findings of fact, conclusions of law, and an award, rejection or other appropriate paragraph containing the action of the administrative law judge, his or her signature and the date of issuance. A decision and order shall be based upon the record made before the administrative law judge.

§ 725.478 Filing and service of decision and order.

On the date of issuance of a decision and order under § 725.477, the administrative law judge shall serve the decision and order on all parties to the claim by certified mail. On the same date, the original record of the claim shall be sent to the DCMWC in Washington, D.C. Upon receipt by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

§ 725.479 Finality of decisions and orders.

(a) A decision and order shall become effective when filed in the office of the district director (see § 725.478), and unless proceedings for suspension or setting aside of such order are instituted within 30 days of such filing, the order shall become final at the expiration of

the 30th day after such filing (see § 725.481).

(b) Any party may, within 30 days after the filing of a decision and order under § 725.478, request a reconsideration of such decision and order by the administrative law judge. The procedures to be followed in the reconsideration of a decision and order shall be determined by the administrative law judge.

(c) The time for appeal to the Benefits Review Board shall be suspended during the consideration of a request for reconsideration. After the administrative law judge has issued and filed a denial of the request for reconsideration, or a revised decision and order in accordance with this part, any dissatisfied party shall have 30 days within which to institute proceedings to set aside the decision and order on reconsideration.

(d) Regardless of any defect in service, actual receipt of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

§ 725.480 Modification of decisions and orders.

A party who is dissatisfied with a decision and order which has become final in accordance with § 725.479 may request a modification of the decision and order if the conditions set forth in § 725.310 are met.

§ 725.481 Right to appeal to the Benefits Review Board.

Any party dissatisfied with a decision and order issued by an administrative law judge may, before the decision and order becomes final (see § 725.479), appeal the decision and order to the Benefits Review Board. A notice of appeal shall be filed with the Board. Proceedings before the Board shall be conducted in accordance with part 802 of this title.

§ 725.482 Judicial review.

(a) Any person adversely affected or aggrieved by a final order of the Benefits Review Board may obtain a review of that order in the U.S. court of appeals for the circuit in which the injury occurred by filing in such court within 60 days following the issuance of such Board order a written petition praying that the order be modified or set aside. The payment of the amounts required by an award shall not be stayed pending final decision in any such proceeding unless ordered by the court. No stay shall be issued unless the court finds that irreparable injury would otherwise ensue to an operator or carrier.

(b) The Director, Office of Workers' Compensation Program, as designee of the Secretary of Labor responsible for the administration and enforcement of the Act, shall be considered the proper party to appear and present argument on behalf of the Secretary of Labor in all review proceedings conducted pursuant to this part and the Act, either as petitioner or respondent.

§ 725.483 Costs in proceedings brought without reasonable grounds.

If a United States court having jurisdiction of proceedings regarding any claim or final decision and order, determines that the proceedings have been instituted or continued before such court without reasonable ground, the costs of such proceedings shall be assessed against the party who has so instituted or continued such proceedings.

Subpart G—Responsible Coal Mine Operators

General Provisions

§ 725.490 Statutory provisions and scope.

(a) One of the major purposes of the black lung benefits amendments of 1977 was to provide a more effective means of transferring the responsibility for the payment of benefits from the Federal government to the coal industry with respect to claims filed under this part. In furtherance of this goal, a Black Lung Disability Trust Fund financed by the coal industry was established by the Black Lung Benefits Revenue Act of 1977. The primary purpose of the Fund is to pay benefits with respect to all claims in which the last coal mine employment of the miner on whose account the claim was filed occurred before January 1, 1970. With respect to most claims in which the miner's last coal mine employment occurred after January 1, 1970, individual coal mine operators will be liable for the payment of benefits. The 1981 amendments to the Act relieved individual coal mine operators from the liability for payment of certain special claims involving coal mine employment on or after January 1, 1970, where the claim was previously denied and subsequently approved under section 435 of the Act. See § 725.496 for a detailed description of these special claims. Where no such operator exists or the operator determined to be liable is in default in any case, the fund shall pay the benefits due and seek reimbursement as is appropriate. See also § 725.420 for the fund's role in the payment of interim benefits in certain contested cases. In addition, the Black Lung Benefits Reform Act of 1977 amended certain provisions affecting the scope of coverage under the Act and describing the effects of particular corporate transactions on the liability of operators.

(b) The provisions of this subpart define the term ''operator'' and prescribe the manner in which the identity of an operator which may be liable for the payment of benefits—referred to herein as a ''responsible operator''—will be determined.

§ 725.491 Operator defined.

(a) For purposes of this part, the term ''operator'' shall include:

(1) Any owner, lessee, or other person who operates, controls, or supervises a coal mine, or any independent contractor performing services or construction at such mine; or

(2) Any other person who:

(i) Employs an individual in the transportation of coal or in coal mine construction in or around a coal mine, to the extent such individual was exposed to coal mine dust as a result of such employment (see § 725.202);

(ii) In accordance with the provisions of § 725.492, may be considered a successor operator; or

(iii) Paid wages or a salary, or provided other benefits, to an individual in exchange for work as a miner (see § 725.202).

(b) The terms ''owner,'' ''lessee,'' and ''person'' shall include any individual, partnership, association, corporation, firm, subsidiary of a corporation, or other organization, as appropriate, except that an officer of a corporation shall not be considered an ''operator'' for purposes of this part. Following the issuance of an order awarding benefits against a corporation that has not secured its liability for benefits in accordance with section 423 of the Act and § 726.4, such order may be enforced against the president, secretary, or treasurer of the corporation in accordance with subpart I of this part.

(c) The term ''independent contractor'' shall include any person who contracts to perform services. Such contractor's status as an operator shall not be contingent upon the amount or percentage of its work or business related to activities in or around a mine, nor upon the number or percentage of its employees engaged in such activities.

(d) For the purposes of determining whether a person is or was an operator that may be found liable for the payment of benefits under this part, there shall be a rebuttable presumption that during the course of an individual's employment with such employer, such individual was regularly and continuously exposed to coal mine dust during the course of employment. The presumption may be rebutted by a showing that the employee was not

exposed to coal mine dust for significant periods during such employment.

(e) The operation, control, or supervision referred to in paragraph (a)(1) of this section may be exercised directly or indirectly. Thus, for example, where a coal mine is leased, and the lease empowers the lessor to make decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor may be considered an operator. Similarly, any parent entity or other controlling business entity may be considered an operator for purposes of this part, regardless of the nature of its business activities.

(f) Neither the United States, nor any State, nor any instrumentality or agency of the United States or any State, shall be considered an operator.

§ 725.492 Successor operator defined.

(a) Any person who, on or after January 1, 1970, acquired a mine or mines, or substantially all of the assets thereof, from a prior operator, or acquired the coal mining business of such prior operator, or substantially all of the assets thereof, shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(b) The following transactions shall also be deemed to create successor operator liability:

(1) If an operator ceases to exist by reason of a reorganization which involves a change in identity, form, or place of business or organization, however effected;

(2) If an operator ceases to exist by reason of a liquidation into a parent or successor corporation; or

(3) If an operator ceases to exist by reason of a sale of substantially all its assets, or as a result of merger, consolidation, or division.

(c) In any case in which a transaction specified in paragraph (b), or substantially similar to a transaction specified in paragraph (b) took place, the resulting entity shall be considered a ''successor operator'' with respect to any miners previously employed by such prior operator.

(d) This section shall not be construed to relieve a prior operator of any liability if such prior operator meets the conditions set forth in § 725.494. If the prior operator does not meet the conditions set forth in § 725.494, the following provisions shall apply:

(1) In any case in which a prior operator transferred a mine or mines, or substantially all of the assets thereof, to a successor operator, or sold its coal mining business or substantially all of the assets thereof, to a successor operator, and then ceased to exist, within the terms of paragraph (b), the successor operator as identified in paragraph (a) shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(2) In any case in which a prior operator transferred mines, or substantially all of the assets thereof, to more than one successor operator, the successor operator that most recently acquired a mine or mines or assets from the prior operator shall be primarily liable for the payment of benefits to any miners previously employed by such prior operator.

(3) In any case in which a mine or mines, or substantially all the assets thereof, have been transferred more than once, the successor operator that most recently acquired such mine or mines or assets shall be primarily liable for the payment of benefits to any miners previously employed by the original prior operator. If the most recent successor operator does not meet the criteria for a potentially liable operator set forth in § 725.494, the next most recent successor operator shall be liable.

(e) An ''acquisition,'' for purposes of this section, shall include any transaction by which title to the mine or mines, or substantially all of the assets thereof, or the right to extract or prepare coal at such mine or mines, becomes vested in a person other than the prior operator.

§ 725.493 Employment relationship defined.

(a)(1) In determining the identity of a responsible operator under this part, the terms ''employ'' and ''employment'' shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

(2) The payment of wages or salary shall be prima facie evidence of the right to direct, control, or supervise an individual's work. The Department intends that where the operator who paid a miner's wages or salary meets the criteria for a potentially liable operator set forth in § 725.494, that operator shall be primarily liable for the payment of any benefits due the miner as a result of such employment. The absence of such payment, however, will not negate the existence of an employment relationship. Thus, the Department also intends that where the person who paid a miner's wages may not be considered a potentially liable operator, any other operator who retained the right to direct, control or supervise the work performed by the miner, or who benefitted from such work, may be considered a potentially liable operator.

(b) This paragraph contains examples of relationships that shall be considered employment relationships for purposes of this part. The list is not intended to be exclusive.

(1) In any case in which an operator may be considered a successor operator, as determined in accordance with § 725.492, any employment with a prior operator shall also be deemed to be employment with the successor operator. In a case in which the miner was not independently employed by the successor operator, the prior operator shall remain primarily liable for the payment of any benefits based on the miner's employment with the prior operator. In a case in which the miner was independently employed by the successor operator after the transaction giving rise to successor operator liability, the successor operator shall be primarily liable for the payment of any benefits.

(2) In any case in which the operator which directed, controlled or supervised the miner is no longer in business and such operator was a subsidiary of a parent company, a member of a joint venture, a partner in a partnership, or was substantially owned or controlled by another business entity, such parent entity or other member of a joint venture or partner or controlling business entity may be considered the employer of any employees of such operator.

(3) In any claim in which the operator which directed, controlled or supervised the miner is a lessee, the lessee shall be considered primarily liable for the claim. The liability of the lessor may be established only after it has been determined that the lessee is unable to provide for the payment of

benefits to a successful claimant. In any case involving the liability of a lessor for a claim arising out of employment with a lessee, any determination of lessor liability shall be made on the basis of the facts present in the case in accordance with the following considerations:

(i) Where a coal mine is leased, and the lease empowers the lessor to make decisions with respect to the terms and conditions under which coal is to be extracted or prepared, such as, but not limited to, the manner of extraction or preparation or the amount of coal to be produced, the lessor shall be considered the employer of any employees of the lessee.

(ii) Where a coal mine is leased to a self-employed operator, the lessor shall be considered the employer of such self-employed operator and its employees if the lease or agreement is executed or renewed after August 18, 1978 and such lease or agreement does not require the lessee to guarantee the payment of benefits which may be required under this part and part 726 of this subchapter.

(iii) Where a lessor previously operated a coal mine, it may be considered an operator with respect to employees of any lessee of such mine, particularly where the leasing arrangement was executed or renewed after August 18, 1978 and does not require the lessee to secure benefits provided by the Act.

(4) A self-employed operator, depending upon the facts of the case, may be considered an employee of any other operator, person, or business entity which substantially controls, supervises, or is financially responsible for the activities of the self-employed operator.

§ 725.494 Potentially liable operators.

An operator may be considered a ''potentially liable operator'' with respect to a claim for benefits under this part if each of the following conditions is met:

(a) The miner's disability or death arose at least in part out of employment in or around a mine or other facility during a period when the mine or facility was operated by such operator, or by a person with respect to which the operator may be considered a successor operator. For purposes of this section, there shall be a rebuttable presumption that the miner's disability or death arose in whole or in part out of his or her employment with such operator. Unless this presumption is rebutted, the responsible operator shall be liable to pay benefits to the claimant on account of the disability or death of the miner in accordance with this part. A miner's pneumoconiosis, or disability or death therefrom, shall be considered to have arisen in whole or in part out of work in or around a mine if such work caused, contributed to or aggravated the progression or advancement of a miner's loss of ability to perform his or her regular coal mine employment or comparable employment.

(b) The operator, or any person with respect to which the operator may be considered a successor operator, was an operator for any period after June 30, 1973.

(c) The miner was employed by the operator, or any person with respect to which the operator may be considered a successor operator, for a cumulative period of not less than one year (§ 725.101(a)(32)).

(d) The miner's employment with the operator, or any person with respect to which the operator may be considered a successor operator, included at least one working day (§ 725.101(a)(32)) after December 31, 1969.

(e) The operator is capable of assuming its liability for the payment of continuing benefits under this part. An operator will be deemed capable of assuming its liability for a claim if one of the following three conditions is met:

(1) The operator obtained a policy or contract of insurance under section 423 of the Act and part 726 of this subchapter that covers the claim, except that such policy shall not be considered sufficient to establish the operator's capability of assuming liability if the insurance company has been declared insolvent and its obligations for the claim are not otherwise guaranteed;

(2) The operator qualified as a self-insurer under section 423 of the Act and part 726 of this subchapter during the period in which the miner was last employed by the operator, provided that the operator still qualifies as a self-insurer or the security given by the operator pursuant to § 726.104(b) is sufficient to secure the payment of benefits in the event the claim is awarded; or

(3) The operator possesses sufficient assets to secure the payment of benefits in the event the claim is awarded in accordance with § 725.606.

§ 725.495 Criteria for determining a responsible operator.

(a)(1) The operator responsible for the payment of benefits in a claim adjudicated under this part (the ''responsible operator'') shall be the potentially liable operator, as determined in accordance with § 725.494, that most recently employed the miner.

(2) If more than one potentially liable operator may be deemed to have employed the miner most recently, then the liability for any benefits payable as a result of such employment shall be assigned as follows:

(i) First, to the potentially liable operator that directed, controlled, or supervised the miner;

(ii) Second, to any potentially liable operator that may be considered a successor operator with respect to miners employed by the operator identified in paragraph (a)(2)(i) of this section; and

(iii) Third, to any other potentially liable operator which may be deemed to have been the miner's most recent employer pursuant to § 725.493.

(3) If the operator that most recently employed the miner may not be considered a potentially liable operator, as determined in accordance with § 725.494, the responsible operator shall be the potentially liable operator that next most recently employed the miner. Any potentially liable operator that employed the miner for at least one day after December 31, 1969 may be deemed the responsible operator if no more recent employer may be considered a potentially liable operator.

(b) Except as provided in this section and § 725.408(a)(3), with respect to the adjudication of the identity of a responsible operator, the Director shall bear the burden of proving that the responsible operator initially found liable for the payment of benefits pursuant to § 725.410 (the ''designated responsible operator'') is a potentially liable operator. It shall be presumed, in the absence of evidence to the contrary, that the designated responsible operator is capable of assuming liability for the payment of benefits in accordance with § 725.494(e).

(c) The designated responsible operator shall bear the burden of proving either:

(1) That it does not possess sufficient assets to secure the payment of benefits in accordance with § 725.606; or

(2) That it is not the potentially liable operator that most recently employed the miner. Such proof must include evidence that the miner was employed as a miner after he or she stopped working for the designated responsible operator and that the person by whom he or she was employed is a potentially liable operator within the meaning of § 725.494. In order to establish that a more recent employer is a potentially liable operator, the designated responsible operator must demonstrate that the more recent employer possesses sufficient assets to secure the payment of benefits in accordance with

§ 725.606. The designated responsible operator may satisfy its burden by presenting evidence that the owner, if the more recent employer is a sole proprietorship; the partners, if the more recent employer is a partnership; or the president, secretary, and treasurer, if the more recent employer is a corporation that failed to secure the payment of benefits pursuant to part 726 of this subchapter, possess assets sufficient to secure the payment of benefits, provided such assets may be reached in a proceeding brought under subpart I of this part.

(d) In any case referred to the Office of Administrative Law Judges pursuant to § 725.421 in which the responsible operator initially found liable for the payment of benefits pursuant to § 725.410 is not the operator that most recently employed the miner, the record shall contain a statement from the district director explaining the reasons for such initial finding. If the reasons include the most recent employer's failure to meet the conditions of § 725.494(e), the record shall also contain a statement that the Office has searched the files it maintains pursuant to part 726, and that the Office has no record of insurance coverage for that employer, or of authorization to self-insure, that meets the conditions of § 725.494(e)(1) or (e)(2). Such a statement shall be prima facie evidence that the most recent employer is not financially capable of assuming its liability for a claim. In the absence of such a statement, it shall be presumed that the most recent employer is financially capable of assuming its liability for a claim.

§ 725.496 Special claims transferred to the fund.

(a) The 1981 amendments to the Act amended section 422 of the Act and transferred liability for payment of certain special claims from operators and carriers to the fund. These provisions apply to claims which were denied before March 1, 1978, and which have been or will be approved in accordance with section 435 of the Act.

(b) Section 402(i) of the Act defines three classes of denied claims subject to the transfer provisions:

(1) Claims filed with and denied by the Social Security Administration before March 1, 1978;

(2) Claims filed with the Department of Labor in which the claimant was notified by the Department of an administrative or informal denial before March 1, 1977, and in which the claimant did not within one year of such notification either:

(i) Request a hearing; or

(ii) Present additional evidence; or

(iii) Indicate an intention to present additional evidence; or

(iv) Request a modification or reconsideration of the denial on the ground of a change in conditions or because of a mistake in a determination of fact;

(3) Claims filed with the Department of Labor and denied under the law in effect prior to the enactment of the Black Lung Benefits Reform Act of 1977, that is, before March 1, 1978, following a formal hearing before an administrative law judge or administrative review before the Benefits Review Board or review before a United States Court of Appeals.

(c) Where more than one claim was filed with the Social Security Administration and/or the Department of Labor prior to March 1, 1978, by or on behalf of a miner or a surviving dependent of a miner, unless such claims were required to be merged by the agency's regulations, the procedural history of each such claim must be considered separately to determine whether the claim is subject to the transfer of liability provisions.

(d) For a claim filed with and denied by the Social Security Administration prior to March 1, 1978, to come within the transfer provisions, such claim must have been or must be approved under the provisions of section 435 of the Act. No claim filed with and denied by the Social Security Administration is subject to the transfer of liability provisions unless a request was made by or on behalf of the claimant for review of such denied claim under section 435. Such review must have been requested by the filing of a valid election card or other equivalent document with the Social Security Administration in accordance with section 435(a) and its implementing regulations at 20 CFR 410.700 through 410.707.

(e) Where a claim filed with the Department of Labor prior to March 1, 1977, was subjected to repeated administrative or informal denials, the last such denial issued during the pendency of the claim determines whether the claim is subject to the transfer of liability provisions.

(f) Where a miner's claim comes within the transfer of liability provisions of the 1981 amendments the fund is also liable for the payment of any benefits to which the miner's dependent survivors are entitled after the miner's death. However, if the survivor's entitlement was established on a separate claim not subject to the transfer of liability provisions prior to approval of the miner's claim under section 435, the party responsible for the payment of such survivors' benefits shall not be relieved of that responsibility because the miner's claim was ultimately approved and found subject to the transfer of liability provisions.

§ 725.497 Procedures in special claims transferred to the fund.

(a) *General.* It is the purpose of this section to define procedures to expedite the handling and disposition of claims affected by the benefit liability transfer provisions of Section 205 of the Black Lung Benefits Amendments of 1981.

(b) *Action by the Department.* The OWCP shall, in accordance with the criteria contained in § 725.496, review each claim which is or may be affected by the provisions of Section 205 of the Black Lung Benefits Amendments of 1981. Any party to a claim, adjudication officer, or adjudicative body may request that such a review be conducted and that the record be supplemented with any additional documentation necessary for an informed consideration of the transferability of the claim. Where the issue of the transferability of the claim can not be resolved by agreement of the parties and the evidence of record is not sufficient for a resolution of the issue, the hearing record may be reopened or the case remanded for the development of the additional evidence concerning the procedural history of the claim necessary to such resolution. Such determinations shall be made on an expedited basis.

(c) *Dismissal of operators.* If it is determined that a coal mine operator or insurance carrier which previously participated in the consideration or adjudication of any claim, may no longer be found liable for the payment of benefits to the claimant by reason of section 205 of the Black Lung Benefits Amendments of 1981, such operator or carrier shall be promptly dismissed as a party to the claim. The dismissal of an operator or carrier shall be concluded at the earliest possible time and in no event shall an operator or carrier participate as a necessary party in any claim for which only the fund may be liable.

(d) *Procedure following dismissal of an operator.* After it has been determined that an operator or carrier must be dismissed as a party in any claim in accordance with this section, the Director shall take such action as is authorized by the Act to bring about the proper and expeditious resolution of the claim in light of all relevant medical and other evidence. Action to be taken in this regard by the Director may include, but is not limited to, the assignment of the claim to the Black

Lung Disability Trust Fund for the payment of benefits, the reimbursement of benefits previously paid by an operator or carrier if appropriate, the defense of the claim on behalf of the fund, or proceedings authorized by § 725.310.

(e) Any claimant whose claim has been subsequently denied in a modification proceeding will be entitled to expedited review of the modification decision. Where a formal hearing was previously held, the claimant may waive his right to a further hearing and ask that a decision be made on the record of the prior hearing, as supplemented by any additional documentary evidence which the parties wish to introduce and briefs of the parties, if desired. In any case in which the claimant waives his right to a second hearing, a decision and order must be issued within 30 days of the date upon which the parties agree the record has been completed.

Subpart H—Payment of Benefits

General Provisions

§ 725.501 Payment provisions generally.

The provisions of this subpart govern the payment of benefits to claimants whose claims are approved for payment under section 415 and part C of title IV of the Act or approved after review under section 435 of the Act and part 727 of this subchapter (see § 725.4(d)).

§ 725.502 When benefit payments are due; manner of payment.

(a)(1) Except with respect to benefits paid by the fund pursuant to an initial determination issued in accordance with § 725.418 (see § 725.522), benefits under the Act shall be paid when they become due. Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated by an administrative law judge on reconsideration, or, upon review under section 21 of the LHWCA, by the Benefits Review Board or an appropriate court, or is superseded by an effective order issued pursuant to § 725.310.

(2) A proposed order issued by a district director pursuant to § 725.418 becomes effective at the expiration of the thirtieth day thereafter if no party timely requests revision of the proposed decision and order or a hearing (see § 725.419). An order issued by an administrative law judge becomes effective when it is filed in the office of the district director (see § 725.479). An order issued by the Benefits Review Board shall become effective when it is issued. An order issued by a court shall become effective in accordance with the rules of the court.

(b)(1) While an effective order requiring the payment of benefits remains in effect, monthly benefits, at the rates set forth in § 725.520, shall be due on the fifteenth day of the month following the month for which the benefits are payable. For example, benefits payable for the month of January shall be due on the fifteenth day of February.

(2) Within 30 days after the issuance of an effective order requiring the payment of benefits, the district director shall compute the amount of benefits payable for periods prior to the effective date of the order, in addition to any interest payable for such periods (see § 725.608), and shall so notify the parties. Any computation made by the district director under this paragraph shall strictly observe the terms of the order. Benefits and interest payable for such periods shall be due on the thirtieth day following issuance of the district director's computation. A copy of the current table of applicable interest rates shall be attached.

(c) Benefits are payable for monthly periods and shall be paid directly to an eligible claimant or his or her representative payee (see § 725.510) beginning with the month during which eligibility begins. Benefits payments shall terminate with the month before the month during which eligibility terminates. If a claimant dies in the first month during which all requirements are met, benefits shall be paid for that month.

§ 725.503 Date from which benefits are payable.

(a) In accordance with the provisions of section 6(a) of the Longshore Act as incorporated by section 422(a) of the Act, and except as provided in § 725.504, the provisions of this section shall be applicable in determining the date from which benefits are payable to an eligible claimant for any claim filed after March 31, 1980. Except as provided in paragraph (d) of this section, the date from which benefits are payable for any claim approved under part 727 of this subchapter, shall be determined in accordance with § 727.302 (see § 725.4(d).

(b) *Miner's claim.* In the case of a miner who is entitled to benefits, benefits are payable to such miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. Where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed. In the case of a miner who filed a claim before January 1, 1982, benefits shall be payable to the miner's eligible survivor (if any) beginning with the month in which the miner died.

(c) *Survivor's claim.* In the case of an eligible survivor, benefits shall be payable beginning with the month of the miner's death, or January 1, 1974, whichever is later.

(d) If a claim is awarded pursuant to section 22 of the Longshore Act and § 725.310, then the date from which benefits are payable shall be determined as follows:

(1) *Mistake in fact.* The provisions of paragraphs (b) or (c) of this section, as applicable, shall govern the determination of the date from which benefits are payable.

(2) *Change in conditions.* Benefits are payable to a miner beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, provided that no benefits shall be payable for any month prior to the effective date of the most recent denial of the claim by a district director or administrative law judge. Where the evidence does not establish the month of onset, benefits shall be payable to such miner from the month in which the claimant requested modification.

(e) In the case of a claim filed between July 1, 1973, and December 31, 1973, benefits shall be payable as provided by this section, except to the extent prohibited by § 727.303 (see § 725.4(d)).

(f) No benefits shall be payable with respect to a claim filed after December 31, 1973 (a part C claim), for any period of eligibility occurring before January 1, 1974.

(g) Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant.

§ 725.504 Payments to a claimant employed as a miner.

(a) In the case of a claimant who is employed as a miner (see § 725.202) at the time of a final determination of such miner's eligibility for benefits, no benefits shall be payable unless:

(1) The miner's eligibility is established under section 411(c)(3) of the Act; or

(2) The miner terminates his or her coal mine employment within 1 year from the date of the final determination of the claim.

(b) If the eligibility of a working miner is established under section 411(c)(3) of the Act, benefits shall be payable as is otherwise provided in this part. If eligibility cannot be established under section 411(c)(3), and the miner continues to be employed as a miner in any capacity for a period of less than 1 year after a final determination of the claim, benefits shall be payable beginning with the month during which the miner ends his or her coal mine employment. If the miner's employment continues for more than 1 year after a final determination of eligibility, such determination shall be considered a denial of benefits on the basis of the miner's continued employment, and the miner may seek benefits only as provided in § 725.310, if applicable, or by filing a new claim under this part. The provisions of subparts E and F of this part shall be applicable to claims considered under this section as is appropriate.

(c) In any case where the miner returns to coal mine or comparable and gainful work, the payments to such miner shall be suspended and no benefits shall be payable (except as provided in section 411(c)(3) of the Act) for the period during which the miner continues to work. If the miner again terminates employment, the district director may require the miner to submit to further medical examination before authorizing the payment of benefits.

§ 725.505 Payees.

Benefits may be paid, as appropriate, to a beneficiary, to a qualified dependent, or to a representative authorized under this subpart to receive payments on behalf of such beneficiary or dependent.

§ 725.506 Payment on behalf of another; ''legal guardian'' defined.

Benefits are paid only to the beneficiary, his or her representative payee (see § 725.510) or his or her legal guardian. As used in this section, ''legal guardian'' means an individual who has been appointed by a court of competent jurisdiction or otherwise appointed pursuant to law to assume control of and responsibility for the care of the beneficiary, the management of his or her estate, or both.

§ 725.507 Guardian for minor or incompetent.

An adjudication officer may require that a legal guardian or representative be appointed to receive benefit payments payable to any person who is mentally incompetent or a minor and to exercise the powers granted to, or to perform the duties otherwise required of such person under the Act.

§ 725.510 Representative payee.

(a) If the district director determines that the best interests of a beneficiary are served thereby, the district director may certify the payment of such beneficiary's benefits to a representative payee.

(b) Before any amount shall be certified for payment to any representative payee for or on behalf of a beneficiary, such representative payee shall submit to the district director such evidence as may be required of his or her relationship to, or his or her responsibility for the care of, the beneficiary on whose behalf payment is to be made, or of his or her authority to receive such a payment. The district director may, at any time thereafter, require evidence of the continued existence of such relationship, responsibility, or authority. If a person requesting representative payee status fails to submit the required evidence within a reasonable period of time after it is requested, no further payments shall be certified to him or her on behalf of the beneficiary unless the required evidence is thereafter submitted.

(c) All benefit payments made to a representative payee shall be available only for the use and benefit of the beneficiary, as defined in § 725.511.

§ 725.511 Use and benefit defined.

(a) Payments certified to a representative payee shall be considered as having been applied for the use and benefit of the beneficiary when they are used for the beneficiary's current maintenance—*i.e.*, to replace current income lost because of the disability of the beneficiary. Where a beneficiary is receiving care in an institution, current maintenance shall include the customary charges made by the institution and charges made for the current and foreseeable needs of the beneficiary which are not met by the institution.

(b) Payments certified to a representative payee which are not needed for the current maintenance of the beneficiary, except as they may be used under § 725.512, shall be conserved or invested on the beneficiary's behalf. Preferred investments are U.S. savings bonds which shall be purchased in accordance with applicable regulations of the U.S. Treasury Department (31 CFR part 315). Surplus funds may also be invested in accordance with the rules applicable to investment of trust estates by trustees. For example, surplus funds may be deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association if the account is either federally insured or is otherwise insured in accordance with State law requirements. Surplus funds deposited in an interest or dividend bearing account in a bank or trust company or in a savings and loan association must be in a form of account which clearly shows that the representative payee has only a fiduciary, and not a personal, interest in the funds. The preferred forms of such accounts are as follows:

Name of beneficiary _____
by (Name of representative payee)
representative payee,
or (Name of beneficiary)
by (Name of representative payee) trustee,

U.S. savings bonds purchased with surplus funds by a representative payee for an incapacitated adult beneficiary should be registered as follows: (Name of beneficiary) (Social Security No.), for whom (Name of payee) is representative payee for black lung benefits.

§ 725.512 Support of legally dependent spouse, child, or parent.

If current maintenance needs of a beneficiary are being reasonably met, a relative or other person to whom payments are certified as representative payee on behalf of the beneficiary may use part of the payments so certified for the support of the legally dependent spouse, a legally dependent child, or a legally dependent parent of the beneficiary.

§ 725.513 Accountability; transfer.

(a) The district director may require a representative payee to submit periodic reports including a full accounting of the use of all benefit payments certified to a representative payee. If a requested report or accounting is not submitted within the time allowed, the district director shall terminate the certification of the representative payee and thereafter payments shall be made directly to the beneficiary. A certification which is terminated under this section may be reinstated for good cause, provided that all required reports are supplied to the district director.

(b) A representative payee who has conserved or invested funds from payments under this part shall, upon the direction of the district director, transfer any such funds (including interest) to a successor payee appointed by the district director or, at the option of the district director, shall transfer such funds to the Office for

recertification to a successor payee or the beneficiary.

§ 725.514 Certification to dependent of augmentation portion of benefit.

(a) If the basic benefit of a miner or of a surviving spouse is augmented because of one or more dependents, and it appears to the district director that the best interests of such dependent would be served thereby, or that the augmented benefit is not being used for the use and benefit (as defined in this subpart) of the augmentee, the district director may certify payment of the amount of such augmentation (to the extent attributable to such dependent) to such dependent directly, or to a legal guardian or a representative payee for the use and benefit of such dependent.

(b) Any request to the district director to certify separate payment of the amount of an augmentation in accordance with paragraph (a) of this section shall be in writing on such form and in accordance with such instructions as are prescribed by the Office.

(c) The district director shall specify the terms and conditions of any certification authorized under this section and may terminate any such certification where appropriate.

(d) Any payment made under this section, if otherwise valid under the Act, is a complete settlement and satisfaction of all claims, rights, and interests in and to such payment, except that such payment shall not be construed to abridge the rights of any party to recoup any overpayment made.

§ 725.515 Assignment and exemption from claims of creditors.

(a) Except as provided by the Act and this part, no assignment, release, or commutation of benefits due or payable under this part by a responsible operator shall be valid, and all benefits shall be exempt from claims of creditors and from levy, execution, and attachment or other remedy or recovery or collection of a debt, which exemption may not be waived.

(b) Notwithstanding any other provision of law, benefits due from, or payable by, the Black Lung Disability Trust Fund under the Act and this part to a claimant shall be subject to legal process brought for the enforcement against the claimant of his or her legal obligations to provide child support or make alimony payments to the same extent as if the fund was a private person.

Benefit Rates

§ 725.520 Computation of benefits.

(a) *Basic rate.* The amount of benefits payable to a beneficiary for a month is determined, in the first instance, by computing the ''basic rate.'' The basic rate is equal to 37½ percent of the monthly pay rate for Federal employees in GS–2, step 1. That rate for a month is determined by:

(1) Ascertaining the lowest annual rate of pay (step 1) for Grade GS–2 of the General Schedule applicable to such month (see 5 U.S.C. 5332);

(2) Ascertaining the monthly rate thereof by dividing the amount determined in paragraph (a)(1) of this section by 12; and

(3) Ascertaining the basic rate under the Act by multiplying the amount determined in paragraph (a)(2) of this section by 0.375 (that is, by 37½ percent).

(b) *Basic benefit.* When a miner or surviving spouse is entitled to benefits for a month for which he or she has no dependents who qualify under this part and when a surviving child of a miner or spouse, or a parent, brother, or sister of a miner, is entitled to benefits for a month for which he or she is the only beneficiary entitled to benefits, the amount of benefits to which such beneficiary is entitled is equal to the basic rate as computed in accordance with this section (raised, if not a multiple of 10 cents, to the next high multiple of 10 cents). This amount is referred to as the ''basic benefit.''

(c) *Augmented benefit.* (1) When a miner or surviving spouse is entitled to benefits for a month for which he or she has one or more dependents who qualify under this part, the amount of benefits to which such miner or surviving spouse is entitled is increased. This increase is referred to as an ''augmentation.''

(2) The benefits of a miner or surviving spouse are augmented to take account of a particular dependent beginning with the first month in which such dependent satisfies the conditions set forth in this part, and continues to be augmented through the month before the month in which such dependent ceases to satisfy the conditions set forth in this part, except in the case of a child who qualifies as a dependent because he or she is a student. In the latter case, such benefits continue to be augmented through the month before the first month during no part of which he or she qualifies as a student.

(3) The basic rate is augmented by 50 percent for one such dependent, 75 percent for two such dependents, and 100 percent for three or more such dependents.

(d) *Survivor benefits.* As used in this section, ''survivor'' means a surviving child of a miner or surviving spouse, or a surviving parent, brother, or sister of a miner, who establishes entitlement to benefits under this part.

(e) *Computation and rounding.* (1) Any computation prescribed by this section is made to the third decimal place.

(2) Monthly benefits are payable in multiples of 10 cents. Therefore, a monthly payment of amounts derived under paragraph (c)(3) of this section which is not a multiple of 10 cents is increased to the next higher multiple of 10 cents.

(3) Since a fraction of a cent is not a multiple of 10 cents, such an amount which contains a fraction in the third decimal place is raised to the next higher multiple of 10 cents.

(f) *Eligibility based on the coal mine employment of more than one miner.* Where an individual, for any month, is entitled (and/or qualifies as a dependent for purposes of augmentation of benefits) based on the disability or death due to pneumoconiosis arising out of the coal mine employment of more than one miner, the benefit payable to or on behalf of such individual shall be at a rate equal to the highest rate of benefits for which entitlement is established by reason of eligibility as a beneficiary, or by reason of his or her qualification as a dependent for augmentation of benefit purposes.

§ 725.521 Commutation of payments; lump sum awards.

(a) Whenever the district director determines that it is in the interest of justice, the liability for benefits or any part thereof as determined by a final adjudication, may, with the approval of the Director, be discharged by the payment of a lump sum equal to the present value of future benefit payments commuted, computed at 4 percent true discount compounded annually.

(b) Applications for commutation of future payments of benefits shall be made to the district director in the manner prescribed by the district director. If the district director determines that an award of a lump sum payment of such benefits would be in the interest of justice, he or she shall refer such application, together with the reasons in support of such determination, to the Director for consideration.

(c) The Director shall, in his or her discretion, grant or deny the application for commutation of payments. Such

decision may be appealed to the Benefits Review Board.

(d) The computation of all commutations of such benefits shall be made by the OWCP. For this purpose the file shall contain the date of birth of the person on whose behalf commutation is sought, as well as the date upon which such commutation shall be effective.

(e) For purposes of determining the amount of any lump sum award, the probability of the death of the disabled miner and/or other persons entitled to benefits before the expiration of the period during which he or she is entitled to benefits, shall be determined in accordance with the most current United States Life Tables, as developed by the Department of Health, Education, and Welfare, and the probability of the remarriage of a surviving spouse shall be determined in accordance with the remarriage tables of the Dutch Royal Insurance Institution. The probability of the happening of any other contingency affecting the amount or duration of the compensation shall be disregarded.

(f) In the event that an operator or carrier is adjudicated liable for the payment of benefits, such operator or carrier shall be notified of and given an opportunity to participate in the proceedings to determine whether a lump sum award shall be made. Such operator or carrier shall, in the event a lump sum award is made, tender full and prompt payment of such award to the claimant as though such award were a final payment of monthly benefits. Except as provided in paragraph (g) of this section, such lump sum award shall forever discharge such operator or carrier from its responsibility to make monthly benefit payments under the Act to the person who has requested such lump-sum award. In the event that an operator or carrier is adjudicated liable for the payment of benefits, such operator or carrier shall not be liable for any portion of a commuted or lump sum award predicated upon benefits due any claimant prior to January 1, 1974.

(g) In the event a lump-sum award is approved under this section, such award shall not operate to discharge an operator carrier, or the fund from any responsibility imposed by the Act for the payment of medical benefits to an eligible miner.

§ 725.522 Payments prior to final adjudication.

(a) If an operator or carrier fails or refuses to commence the payment of benefits within 30 days of issuance of an initial determination of eligibility by the district director (see § 725.420), or fails or refuses to commence the payment of any benefits due pursuant to an effective order by a district director, administrative law judge, Benefits Review Board, or court, the fund shall commence the payment of such benefits and shall continue such payments as appropriate. In the event that the fund undertakes the payment of benefits on behalf of an operator or carrier, the provisions of §§ 725.601 through 725.609 shall be applicable to such operator or carrier.

(b) If benefit payments are commenced prior to the final adjudication of the claim and it is later determined by an administrative law judge, the Board, or court that the claimant was ineligible to receive such payments, such payments shall be considered overpayments pursuant to § 725.540 and may be recovered in accordance with the provisions of this subpart.

Special Provisions for Operator Payments

§ 725.530 Operator payments; generally.

(a) Benefits payable by an operator or carrier pursuant to an effective order issued by a district director, administrative law judge, Benefits Review Board, or court, or by an operator that has agreed that it is liable for the payment of benefits to a claimant, shall be paid by the operator or carrier immediately when they become due (see § 725.502(b)). An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 shall be applicable. In addition, a claimant who does not receive any benefits within 10 days of the date they become due is entitled to additional compensation equal to twenty percent of those benefits (see § 725.607). Arrangements for the payment of medical costs shall be made by such operator or carrier in accordance with the provisions of subpart J of this part.

(b) Benefit payments made by an operator or carrier shall be made directly to the person entitled thereto or a representative payee if authorized by the district director. The payment of a claimant's attorney's fee, if any is awarded, shall be made directly to such attorney. Reimbursement of the fund, including interest, shall be paid directly to the Secretary on behalf of the fund.

§ 725.531 Receipt for payment.

Any individual receiving benefits under the Act in his or her own right, or as a representative payee, or as the duly appointed agent for the estate of a deceased beneficiary, shall execute receipts for benefits paid by any operator which shall be produced by such operator for inspection whenever the district director requires. A canceled check shall be considered adequate receipt of payment for purposes of this section. No operator or carrier shall be required to retain receipts for payments made for more than 5 years after the date on which such receipt was executed.

§ 725.532 Suspension, reduction, or termination of payments.

(a) No suspension, reduction, or termination in the payment of benefits is permitted unless authorized by the district director, administrative law judge, Board, or court. No suspension, reduction, or termination shall be authorized except upon the occurrence of an event which terminates a claimant's eligibility for benefits (see subpart B of this part) or as is otherwise provided in subpart C of this part, §§ 725.306 and 725.310, or this subpart (see also §§ 725.533 through 725.546).

(b) Any unauthorized suspension in the payment of benefits by an operator or carrier shall be treated as provided in subpart I.

(c) Unless suspension, reduction, or termination of benefits payments is required by an administrative law judge, the Benefits Review Board or a court, the district director, after receiving notification of the occurrence of an event that would require the suspension, reduction, or termination of benefits, shall follow the procedures for the determination of claims set forth in subparts E and F.

Increases and Reductions of Benefits

§ 725.533 Modification of benefits amounts; general.

(a) Under certain circumstances the amount of monthly benefits as computed in § 725.520 or lump-sum award (§ 725.521) shall be modified to determine the amount actually to be paid to a beneficiary. With respect to any benefits payable for all periods of eligibility after January 1, 1974, a reduction of the amount of benefits payable shall be required on account of:

(1) Any compensation or benefits received under any State workers' compensation law because of death or partial or total disability due to pneumoconiosis; or

(2) Any compensation or benefits received under or pursuant to any Federal law including part B of title IV of the Act because of death or partial or total disability due to pneumoconiosis; or

(3) In the case of benefits to a parent, brother, or sister as a result of a claim

filed at any time or benefits payable on a miner's claim which was filed on or after January 1, 1982, the excess earnings from wages and from net earnings from self-employment (see § 410.530 of this title) of such parent, brother, sister, or miner, respectively; or

(4) The fact that a claim for benefits from an additional beneficiary is filed, or that such claim is effective for a payment during the month of filing, or a dependent qualifies under this part for an augmentation portion of a benefit of a miner or widow for a period in which another dependent has previously qualified for an augmentation.

(b) An adjustment in a beneficiary's monthly benefit may be required because an overpayment or underpayment has been made to such beneficiary (see §§ 725.540 through 725.546).

(c) A suspension of a beneficiary's monthly benefits may be required when the Office has information indicating that reductions on account of excess earnings may reasonably be expected.

(d) Monthly benefit rates are payable in multiples of 10 cents. Any monthly benefit rate which, after the applicable computations, augmentations, and reductions is not a multiple of 10 cents, is increased to the next higher multiple of 10 cents. Since a fraction of a cent is not a multiple of 10 cents, a benefit rate which contains such a fraction in the third decimal is raised to the next higher multiple of 10 cents.

(e) Any individual entitled to a benefit, who is aware of any circumstances which could affect entitlement to benefits, eligibility for payment, or the amount of benefits, or result in the termination, suspension, or reduction of benefits, shall promptly report these circumstances to the Office. The Office may at any time require an individual receiving, or claiming entitlement to, benefits, either on his or her own behalf or on behalf of another, to submit a written statement giving pertinent information bearing upon the issue of whether or not an event has occurred which would cause such benefit to be terminated, or which would subject such benefit to reductions or suspension under the provisions of the Act. The failure of an individual to submit any such report or statement, properly executed, to the Office shall subject such benefit to reductions, suspension, or termination as the case may be.

§ 725.534 Reduction of State benefits.

No benefits under section 415 of part B of title IV of the Act shall be payable to the residents of a State which, after December 31, 1969, reduces the benefits payable to persons eligible to receive benefits under section 415 of the Act under State laws applicable to its general work force with regard to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance benefits which are funded in whole or in part out of employer contributions.

§ 725.535 Reductions; receipt of State or Federal benefit.

(a) As used in this section the term ''State or Federal benefit'' means a payment to an individual on account of total or partial disability or death due to pneumoconiosis only under State or Federal laws relating to workers' compensation. With respect to a claim for which benefits are payable for any month between July 1 and December 31, 1973, ''State benefit'' means a payment to a beneficiary made on account of disability or death due to pneumoconiosis under State laws relating to workers' compensation (including compensation for occupational disease), unemployment compensation, or disability insurance.

(b) Benefit payments to a beneficiary for any month are reduced (but not below zero) by an amount equal to any payments of State or Federal benefits received by such beneficiary for such month.

(c) Where a State or Federal benefit is paid periodically but not monthly, or in a lump sum as a commutation of or a substitution for periodic benefits, the reduction under this section is made at such time or times and in such amounts as the Office determines will approximate as nearly as practicable the reduction required under paragraph (b) of this section. In making such a determination, a weekly State or Federal benefit is multiplied by 4⅓ and a biweekly benefit is multiplied by 2⅙ to ascertain the monthly equivalent for reduction purposes.

(d) Amounts paid or incurred or to be incurred by the individual for medical, legal, or related expenses in connection with this claim for State or Federal benefits (defined in paragraph (a) of this section) are excluded in computing the reduction under paragraph (b) of this section, to the extent that they are consistent with State or Federal Law. Such medical, legal, or related expenses may be evidenced by the State or Federal benefit awards, compromise agreement, or court order in the State or Federal benefit proceedings, or by such other evidence as the Office may require. Such other evidence may consist of:

(1) A detailed statement by the individual's attorney, physician, or the employer's insurance carrier; or

(2) Bills, receipts, or canceled checks; or

(3) Other evidence indicating the amount of such expenses; or

(4) Any combination of the foregoing evidence from which the amount of such expenses may be determinable. Such expenses shall not be excluded unless established by evidence as required by the Office.

§ 725.536 Reductions; excess earnings.

In the case of a surviving parent, brother, or sister, whose claim was filed at any time, or of a miner whose claim was filed on or after January 1, 1982, benefit payments are reduced as appropriate by an amount equal to the deduction which would be made with respect to excess earnings under the provisions of sections 203(b), (f), (g), (h), (j), and (l) of the Social Security Act (42 U.S.C. 403(b), (f), (g), (h), (j), and (l)), as if such benefit payments were benefits payable under section 202 of the Social Security Act (42 U.S.C. 402) (see §§ 404.428 through 404.456 of this title).

§ 725.537 Reductions; retroactive effect of an additional claim for benefits.

Except as provided in § 725.212(b), beginning with the month in which a person other than a miner files a claim and becomes entitled to benefits, the benefits of other persons entitled to benefits with respect to the same miner, are adjusted downward, if necessary, so that no more than the permissible amount of benefits (the maximum amount for the number of beneficiaries involved) will be paid.

§ 725.538 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.

(a) Ordinarily, a written request that the benefits of a miner or surviving spouse be augmented on account of a qualified dependent is made as part of the claim for benefits. However, it may also be made thereafter.

(b) In the latter case, beginning with the month in which such a request is filed on account of a particular dependent and in which such dependent qualifies for augmentation purposes under this part, the augmented benefits attributable to other qualified dependents (with respect to the same miner or surviving spouse), if any, are adjusted downward, if necessary, so that the permissible amount of augmented benefits (the maximum amount for the number of dependents involved) will not be exceeded.

(c) Where, based on the entitlement to benefits of a miner or surviving spouse,

a dependent would have qualified for augmentation purposes for a prior month of such miner's or surviving spouse's entitlement had such request been filed in such prior month, such request is effective for such prior month. For any month before the month of filing such request, however, otherwise correct benefits previously certified by the Office may not be changed. Rather the amount of the augmented benefit attributable to the dependent filing such request in the later month is reduced for each month of the retroactive period to the extent that may be necessary. This means that for each month of the retroactive period, the amount payable to the dependent filing the later augmentation request is the difference, if any, between:

(1) The total amount of augmented benefits certified for payment for other dependents for that month, and

(2) The permissible amount of augmented benefits (the maximum amount for the number of dependents involved) payable for the month for all dependents, including the dependent filing later.

§ 725.539 More than one reduction event.

If a reduction for receipt of State or Federal benefits and a reduction on account of excess earnings are chargeable to the same month, the benefit for such month is first reduced (but not below zero) by the amount of the State or Federal benefits, and the remainder of the benefit for such month, if any, is then reduced (but not below zero) by the amount of excess earnings chargeable to such month.

Overpayments; Underpayments

§ 725.540 Overpayments.

(a) *General.* As used in this subpart, the term ''overpayment'' includes:

(1) Payment where no amount is payable under this part;

(2) Payment in excess of the amount payable under this part;

(3) A payment under this part which has not been reduced by the amounts required by the Act (see § 725.533);

(4) A payment under this part made to a resident of a State whose residents are not entitled to benefits (see §§ 725.402 and 725.403);

(5) Payment resulting from failure to terminate benefits to an individual no longer entitled thereto;

(6) Duplicate benefits paid to a claimant on account of concurrent eligibility under this part and parts 410 or 727 (see § 725.4(d)) of this title or as provided in § 725.309.

(b) *Overpaid beneficiary is living.* If the beneficiary to whom an overpayment was made is living at the time of a determination of such overpayment, is entitled to benefits at the time of the overpayment, or at any time thereafter becomes so entitled, no benefit for any month is payable to such individual, except as provided in paragraph (c) of this section, until an amount equal to the amount of the overpayment has been withheld or refunded.

(c) *Adjustment by withholding part of a monthly benefit.* Adjustment under paragraph (b) of this section may be effected by withholding a part of the monthly benefit payable to a beneficiary where it is determined that:

(1) Withholding the full amount each month would deprive the beneficiary of income required for ordinary and necessary living expenses;

(2) The overpayment was not caused by the beneficiary's intentionally false statement or representation, or willful concealment of, or deliberate failure to furnish, material information; and

(3) Recoupment can be effected in an amount of not less than $ 10 a month and at a rate which would not unreasonably extend the period of adjustment.

(d) *Overpaid beneficiary dies before adjustment.* If an overpaid beneficiary dies before adjustment is completed under the provisions of paragraph (b) of this section, recovery of the overpayment shall be effected through repayment by the estate of the deceased overpaid beneficiary, or by withholding of amounts due the estate of such deceased beneficiary, or both.

§ 725.541 Notice of waiver of adjustment or recovery of overpayment.

Whenever a determination is made that more than the correct amount of payment has been made, notice of the provisions of section 204(b) of the Social Security Act regarding waiver of adjustment or recovery shall be sent to the overpaid individual, to any other individual against whom adjustment or recovery of the overpayment is to be effected, and to any operator or carrier which may be liable to such overpaid individual.

§ 725.542 When waiver of adjustment or recovery may be applied.

There shall be no adjustment or recovery of an overpayment in any case where an incorrect payment has been made with respect to an individual:

(a) Who is without fault, and where

(b) Adjustment or recovery would either:

(1) Defeat the purpose of title IV of the Act, or

(2) Be against equity and good conscience.

§ 725.543 Standards for waiver of adjustment or recovery.

The standards for determining the applicability of the criteria listed in § 725.542 shall be the same as those applied by the Social Security Administration under §§ 404.506 through 404.512 of this title.

§ 725.544 Collection and compromise of claims for overpayment.

(a) *General effect of 31 U.S.C. 3711.* In accordance with 31 U.S.C. 3711 and applicable regulations, claims by the Office against an individual for recovery of an overpayment under this part not exceeding the sum of $ 100,000, exclusive of interest, may be compromised, or collection suspended or terminated, where such individual or his or her estate does not have the present or prospective ability to pay the full amount of the claim within a reasonable time (see paragraph (c) of this section), or the cost of collection is likely to exceed the amount of recovery (see paragraph (d) of this section), except as provided under paragraph (b) of this section.

(b) *When there will be no compromise, suspension, or termination of collection of a claim for overpayment.* (1) In any case where the overpaid individual is alive, a claim for overpayment will not be compromised, nor will there be suspension or termination of collection of the claim by the Office, if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such individual or on the part of any other party having any interest in the claim.

(2) In any case where the overpaid individual is deceased:

(i) A claim for overpayment in excess of $ 5,000 will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication of fraud, the filing of a false claim, or misrepresentation on the part of such deceased individual; and

(ii) A claim for overpayment, regardless of the amount, will not be compromised, nor will there be suspension or termination of collection of the claim by the Office if there is an indication that any person other than the deceased overpaid individual had a part in the fraudulent action which resulted in the overpayment.

(c) *Inability to pay claim for recovery of overpayment.* In determining whether the overpaid individual is unable to pay a claim for recovery of an overpayment under this part, the Office shall consider the individual's age, health, present and potential income (including inheritance prospects), assets (e.g., real property,

savings account), possible concealment or improper transfer of assets, and assets or income of such individual which may be available in enforced collection proceedings. The Office will also consider exemptions available to such individual under the pertinent State or Federal law in such proceedings. In the event the overpaid individual is deceased, the Office shall consider the available assets of the estate, taking into account any liens or superior claims against the estate.

(d) *Cost of collection or litigative probabilities.* Where the probable costs of recovering an overpayment under this part would not justify enforced collection proceedings for the full amount of the claim, or where there is doubt concerning the Office's ability to establish its claim as well as the time which it will take to effect such collection, a compromise or settlement for less than the full amount may be considered.

(e) *Amount of compromise.* The amount to be accepted in compromise of a claim for overpayment under this part shall bear a reasonable relationship to the amount which can be recovered by enforced collection proceedings, giving due consideration to the exemption available to the overpaid individual under State or Federal law and the time which collection will take.

(f) *Payment.* Payment of the amount the Office has agreed to accept as a compromise in full settlement of a claim for recovery of an overpayment under this part shall be made within the time and in the manner set by the Office. A claim for the overpayment shall not be considered compromised or settled until the full payment of the compromised amount has been made within the time and manner set by the Office. Failure of the overpaid individual or his or her estate to make such payment as provided shall result in reinstatement of the full amount of the overpayment less any amounts paid prior to such default.

§ 725.545 Underpayments.

(a) *General.* As used in this subpart, the term ''underpayment'' includes a payment in an amount less than the amount of the benefit due for such month, and nonpayment where some amount of such benefits is payable.

(b) *Underpaid individual is living.* If an individual to whom an underpayment was made is living, the deficit represented by such underpayment shall be paid to such individual either in a single payment (if he or she is not entitled to a monthly benefit or if a single payment is requested by the claimant in writing) or by increasing one or more monthly benefit payments to which such individual becomes entitled.

(c) *Underpaid individual dies before adjustment of underpayment.* If an individual to whom an underpayment was made dies before receiving payment of the deficit or negotiating the check or checks representing payment of the deficit, such payment shall be distributed to the living person (or persons) in the highest order of priority as follows:

(1) The deceased individual's surviving spouse who was either:

(i) Living in the same household with the deceased individual at the time of such individual's death; or

(ii) In the case of a deceased miner, entitled for the month of death to black lung benefits as his or her surviving spouse or surviving divorced spouse.

(2) In the case of a deceased miner or spouse his or her child entitled to benefits as the surviving child of such miner or surviving spouse for the month in which such miner or spouse died (if more than one such child, in equal shares to each such child).

(3) In the case of a deceased miner, his parent entitled to benefits as the surviving parent of such miner for the month in which such miner died (if more than one such parent, in equal shares to each such parent).

(4) The surviving spouse of the deceased individual who does not qualify under paragraph (c)(1) of this section.

(5) The child or children of the deceased individual who do not qualify under paragraph (c)(2) of this section (if more than one such child, in equal shares to each such child).

(6) The parent or parents of the deceased individual who do not qualify under paragraph (c)(3) of this section (if more than one such parent, in equal shares to each such parent).

(7) The legal representative of the estate of the deceased individual as defined in paragraph (e) of this section.

(d) *Deceased beneficiary.* In the event that a person, who is otherwise qualified to receive payments as the result of a deficit caused by an underpayment under the provisions of paragraph (c) of this section, dies before receiving payment or before negotiating the check or checks representing such payment, his or her share of the underpayment shall be divided among the remaining living person(s) in the same order or priority. In the event that there is (are) no other such person(s), the underpayment shall be paid to the living person(s) in the next lower order of priority under paragraph (c) of this section.

(e) *Definition of legal representative.* The term ''legal representative,'' for the purpose of qualifying for receipt of an underpayment, generally means the executor or the administrator of the estate of the deceased beneficiary. However, it may also include an individual, institution or organization acting on behalf of an unadministered estate, provided the person can give the Office good acquittance (as defined in paragraph (f) of this section). The following persons may qualify as legal representative for purposes of this section, provided they can give the Office good acquittance:

(1) A person who qualifies under a State's ''small estate'' statute; or

(2) A person resident in a foreign country who under the laws and customs of that country, has the right to receive assets of the estate; or

(3) A public administrator; or

(4) A person who has the authority under applicable law to collect the assets of the estate of the deceased beneficiary.

(f) *Definition of ''good acquittance.''* A person is considered to give the Office *good acquittance* when payment to that person will release the Office from further liability for such payment.

§ 725.546 Relation to provisions for reductions or increases.

The amount of an overpayment or an underpayment is the difference between the amount to which the beneficiary was actually entitled and the amount paid. Overpayment and underpayment simultaneously outstanding against the same beneficiary shall first be adjusted against one another before adjustment pursuant to the other provisions of this subpart.

§ 725.547 Applicability of overpayment and underpayment provisions to operator or carrier.

(a) The provisions of this subpart relating to overpayments and underpayments shall be applicable to overpayments and underpayments made by responsible operators or their insurance carriers, as appropriate.

(b) No operator or carrier may recover, or make an adjustment of, an overpayment without prior application to, and approval by, the Office which shall exercise full supervisory authority over the recovery or adjustment of all overpayments.

§ 725.548 Procedures applicable to overpayments and underpayments.

(a) In any case involving either overpayments or underpayments, the Office may take any necessary action, and district directors may issue

appropriate orders to protect the rights of the parties.

(b) Disputes arising out of orders so issued shall be resolved by the procedures set out in subpart F of this part.

Subpart I—Enforcement of Liability; Reports

§ 725.601 Enforcement generally.

(a) The Act, together with certain incorporated provisions from the Longshoremen's and Harbor Workers' Compensation Act, contains a number of provisions which subject an operator or other employer, claimants and others to penalties for failure to comply with certain provisions of the Act, or failure to commence and continue prompt periodic payments to a beneficiary.

(b) It is the policy and intent of the Department to vigorously enforce the provisions of this part through the use of the remedies provided by the Act. Accordingly, if an operator refuses to pay benefits with respect to a claim for which the operator has been adjudicated liable, the Director shall invoke and execute the lien on the property of the operator as described in § 725.603. Enforcement of this lien shall be pursued in an appropriate U.S. district court. If the Director determines that the remedy provided by § 725.603 may not be sufficient to guarantee the continued compliance with the terms of an award or awards against the operator, the Director shall in addition seek an injunction in the U.S. district court to prohibit future noncompliance by the operator and such other relief as the court considers appropriate (see § 725.604). If an operator unlawfully suspends or terminates the payment of benefits to a claimant, the district director shall declare the award in default and proceed in accordance with § 725.605. In all cases payments in addition to compensation (see § 725.607) and interest (see § 725.608) shall be sought by the Director or awarded by the district director.

(c) In certain instances the remedies provided by the Act are concurrent; that is, more than one remedy might be appropriate in any given case. In such a case, the Director shall select the remedy or remedies appropriate for the enforcement action. In making this selection, the Director shall consider the best interests of the claimant as well as those of the fund.

§ 725.602 Reimbursement of the fund.

(a) In any case in which the fund has paid benefits, including medical benefits, on behalf of an operator or other employer which is determined liable therefore, or liable for a part thereof, such operator or other employer shall simultaneously with the first payment of benefits made to the beneficiary, reimburse the fund (with interest) for the full amount of all benefit payments made by the fund with respect to the claim.

(b) In any case where benefit payments have been made by the fund, the fund shall be subrogated to the rights of the beneficiary. The Secretary of Labor may, as appropriate, exercise such subrogation rights.

§ 725.603 Payments by the fund on behalf of an operator; liens.

(a) If an amount is paid out of the fund to an individual entitled to benefits under this part or part 727 of this subchapter (see § 725.4(d)) on behalf of an operator or other employer which is or was required to pay or secure the payment of all or a portion of such amount (see § 725.522), the operator or other employer shall be liable to the United States for repayment to the fund of the amount of benefits properly attributable to such operator or other employer.

(b) If an operator or other employer liable to the fund refuses to pay, after demand, the amount of such liability, there shall be a lien in favor of the United States upon all property and rights to property, whether real or personal, belonging to such operator or other employer. The lien arises on the date on which such liability is finally determined, and continues until it is satisfied or becomes unenforceable by reason of lapse of time. (c)(1) Except as otherwise provided under this section, the priority of the lien shall be determined in the same manner as under section 6323 of the Internal Revenue Code (26 U.S.C.).

(2) In the case of a bankruptcy or insolvency proceeding, the lien imposed under this section shall be treated in the same manner as a lien for taxes due and owing to the United States for purposes of the Bankruptcy Act or section 3466 of the Revised Statutes (31 U.S.C. 191).

(3) For purposes of applying section 6323(a) of the Internal Revenue Code (26 U.S.C.) to determine the priority between the lien imposed under this section and the Federal tax lien, each lien shall be treated as a judgment lien arising as of the time notice of such lien is filed.

(4) For purposes of the section, notice of the lien imposed hereunder shall be filed in the same manner as under section 6323(f) (disregarding paragraph (4) thereof) and (g) of the Internal Revenue Code (26 U.S.C.).

(5) In any case where there has been a refusal or neglect to pay the liability imposed under this section, the Secretary of Labor may bring a civil action in a district court of the United States to enforce the lien of the United States under this section with respect to such liability or to subject any property, of whatever nature, of the operator, or in which it has any right, title, or interest, to the payment of such liability.

(6) The liability imposed by this paragraph may be collected at a proceeding in court if the proceeding is commenced within 6 years after the date upon which the liability was finally determined, or prior to the expiration of any period for collection agreed upon in writing by the operator and the United States before the expiration of such 6-year period. This period of limitation shall be suspended for any period during which the assets of the operator are in the custody or control of any court of the United States, or of any State, or the District of Columbia, and for 6 months thereafter, and for any period during which the operator is outside the United States if such period of absence is for a continuous period of at least 6 months.

§ 725.604 Enforcement of final awards.

Notwithstanding the provisions of § 725.603, if an operator or other employer or its officers or agents fails to comply with an order awarding benefits that has become final, any beneficiary of such award or the district director may apply for the enforcement of the order to the Federal district court for the judicial district in which the injury occurred (or to the U.S. District Court for the District of Columbia if the injury occurred in the District). If the court determines that the order was made and served in accordance with law, and that such operator or other employer or its officers or agents have failed to comply therewith, the court shall enforce obedience to the order by writ of injunction or by other proper process, mandatory or otherwise, to enjoin upon such operator or other employer and its officers or agents compliance with the order.

§ 725.605 Defaults.

(a) Except as is otherwise provided in this part, no suspension, termination or other failure to pay benefits awarded to a claimant is permitted. If an employer found liable for the payment of such benefits fails to make such payments within 30 days after any date on which such benefits are due and payable, the person to whom such benefits are payable may, within one year after such default, make application to the district

director for a supplementary order declaring the amount of the default.

(b) If after investigation, notice and hearing as provided in subparts E and F of this part, a default is found, the district director or the administrative law judge, if a hearing is requested, shall issue a supplementary order declaring the amount of the default, if any. In cases where a lump-sum award has been made, if the payment in default is an installment, the district director or administrative law judge, may, in his or her discretion, declare the whole of the award as the amount in default. The applicant may file a certified copy of such supplementary order with the clerk of the Federal district court for the judicial district in which the operator has its principal place of business or maintains an office or for the judicial district in which the injury occurred. In case such principal place of business or office is in the District of Columbia, a copy of such supplementary order may be filed with the clerk of the U.S. District Court for the District of Columbia. Such supplementary order shall be final and the court shall, upon the filing of the copy, enter judgment for the amount declared in default by the supplementary order if such supplementary order is in accordance with law. Review of the judgment may be had as in civil suits for damages at common law. Final proceedings to execute the judgment may be had by writ of execution in the form used by the court in suits at common law in actions of assumpsit. No fee shall be required for filing the supplementary order nor for entry of judgment thereon, and the applicant shall not be liable for costs in a proceeding for review of the judgment unless the court shall otherwise direct. The court shall modify such judgment to conform to any later benefits order upon presentation of a certified copy thereof to the court.

(c) In cases where judgment cannot be satisfied by reason of the employer's insolvency or other circumstances precluding payment, the district director shall make payment from the fund, and in addition, provide any necessary medical, surgical, and other treatment required by subpart J of this part. A defaulting employer shall be liable to the fund for payment of the amounts paid by the fund under this section; and for the purpose of enforcing this liability, the fund shall be subrogated to all the rights of the person receiving such payments or benefits.

§ 725.606 Security for the payment of benefits.

(a) Following the issuance of an effective order by a district director (see § 725.418), administrative law judge (see § 725.479), Benefits Review Board, or court that requires the payment of benefits by an operator that has failed to secure the payment of benefits in accordance with section 423 of the Act and § 726.4 of this subchapter, or by a coal mine construction or transportation employer, the Director may request that the operator secure the payment of all benefits ultimately payable on the claim. Such operator or other employer shall thereafter immediately secure the payment of benefits in accordance with the provisions of this section, and provide proof of such security to the Director. Such security may take the form of an indemnity bond, a deposit of cash or negotiable securities in compliance with §§ 726.106(c) and 726.107 of this subchapter, or any other form acceptable to the Director.

(b) The amount of security initially required by this section shall be determined as follows:

(1) In a case involving an operator subject to section 423 of the Act and § 726.4 of this subchapter, the amount of the security shall not be less than $175,000, and may be a higher amount as determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration; or

(2) In a case involving a coal mine construction or transportation employer, the amount of the security shall be determined by the Director, taking into account the life expectancies of the claimant and any dependents using the most recent life expectancy tables published by the Social Security Administration.

(c) If the operator or other employer fails to provide proof of such security to the Director within 30 days of its receipt of the Director's request to secure the payment of benefits issued under paragraph (a) of this section, the appropriate adjudication officer shall issue an order requiring the operator or other employer to make a deposit of negotiable securities with a Federal Reserve Bank in the amount required by paragraph (b). Such securities shall comply with the requirements of sections 726.106(c) and 726.107 of this subchapter. In a case in which the effective order was issued by a district director, the district director shall be considered the appropriate adjudication officer. In any other case, the administrative law judge who issued the most recent decision in the case, or such other administrative law judge as the Chief Administrative Law Judge shall designate, shall be considered the appropriate adjudication officer, and shall issue an order under this paragraph on motion of the Director. The administrative law judge shall have jurisdiction to issue an order under this paragraph notwithstanding the pendency of an appeal of the award of benefits with the Benefits Review Board or court.

(d) An order issued under this section shall be considered effective when issued. Disputes regarding such orders shall be resolved in accordance with subpart F of this part.

(e) Notwithstanding any further review of the order in accordance with subpart F of this part, if an operator or other employer subject to an order issued under this section fails to comply with such order, the appropriate adjudication officer shall certify such non-compliance to the appropriate United States district court in accordance with § 725.351(c).

(f) Security posted in accordance with this section may be used to make payment of benefits that become due with respect to the claim in accordance with § 725.502. In the event that either the order awarding compensation or the order issued under this section is vacated or reversed, the operator or other employer may apply to the appropriate adjudication officer for an order authorizing the return of any amounts deposited with the United States Treasurer and not yet disbursed, and such application shall be granted. If at any time the Director determines that additional security is required beyond that initially required by paragraph (b) of this section, he may request the operator or other employer to increase the amount. Such request shall be treated as if it were issued under paragraph (a) of this section.

(g) If a coal mine construction or transportation employer fails to comply with an order issued under paragraph (c), and such employer is a corporation, the provisions of § 725.609 shall be applicable to the president, secretary, and treasurer of such employer.

§ 725.607 Payments in addition to compensation.

(a) If any benefits payable under the terms of an award by a district director (§ 725.419(d)), a decision and order filed and served by an administrative law judge (§ 725.478), or a decision filed by the Board or a U.S. court of appeals, are not paid by an operator or other employer ordered to make such payments within 10 days after such

payments become due, there shall be added to such unpaid benefits an amount equal to 20 percent thereof, which shall be paid to the claimant at the same time as, but in addition to, such benefits, unless review of the order making such award is sought as provided in section 21 of the LHWCA and an order staying payments has been issued.

(b) If, on account of an operator's or other employer's failure to pay benefits as provided in paragraph (a) of this section, benefit payments are made by the fund, the eligible claimant shall nevertheless be entitled to receive such additional compensation to which he or she may be eligible under paragraph (a) of this section, with respect to all amounts paid by the fund on behalf of such operator or other employer.

(c) The fund shall not be liable for payments in addition to compensation under any circumstances.

§ 725.608 Interest.

(a)(1) In any case in which an operator fails to pay benefits that are due (§ 725.502), the beneficiary shall also be entitled to simple annual interest, computed from the date on which the benefits were due. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary shall not be entitled to interest for any period following the date on which the beneficiary received payment of any benefits from the fund pursuant to § 725.522.

(2) In any case in which an operator is liable for the payment of retroactive benefits, the beneficiary shall also be entitled to simple annual interest on such benefits, computed from 30 days after the date of the first determination that such an award should be made. The first determination that such an award should be made may be a district director's initial determination of entitlement, an award made by an administrative law judge or a decision by the Board or a court, whichever is the first such determination of entitlement made upon the claim.

(3) In any case in which an operator is liable for the payment of additional compensation (§ 725.607), the beneficiary shall also be entitled to simple annual interest computed from the date upon which the beneficiary's right to additional compensation first arose.

(4) In any case in which an operator is liable for the payment of medical benefits, the beneficiary or medical provider to whom such benefits are owed shall also be entitled to simple annual interest, computed from the date upon which the services were rendered, or from 30 days after the date of the first determination that the miner is generally entitled to medical benefits, whichever is later. The first determination that the miner is generally entitled to medical benefits may be a district director's initial determination of entitlement, an award made by an administrative law judge or a decision by the Board or a court, whichever is the first such determination of general entitlement made upon the claim. The interest shall be computed through the date on which the operator paid the benefits, except that the beneficiary shall not be entitled to interest for any period following the date on which the beneficiary received payment of any benefits from the fund pursuant to § 725.522 or subpart I of this part.

(b) If an operator or other employer fails or refuses to pay any or all benefits due pursuant to an award of benefits or an initial determination of eligibility made by the district director and the fund undertakes such payments, such operator or other employer shall be liable to the fund for simple annual interest on all payments made by the fund for which such operator is determined liable, computed from the first date on which such benefits are paid by the fund, in addition to such operator's liability to the fund, as is otherwise provided in this part. Interest payments owed pursuant to this paragraph shall be paid directly to the fund.

(c) In any case in which an operator is liable for the payment of an attorney's fee pursuant to § 725.367, and the attorney's fee is payable because the award of benefits has become final, the attorney shall also be entitled to simple annual interest, computed from the date on which the attorney's fee was awarded. The interest shall be computed through the date on which the operator paid the attorney's fee.

(d) The rates of interest applicable to paragraphs (a), (b), and (c) of this section shall be computed as follows:

(1) For all amounts outstanding prior to January 1, 1982, the rate shall be 6% simple annual interest;

(2) For all amounts outstanding for any period during calendar year 1982, the rate shall be 15% simple annual interest; and

(3) For all amounts outstanding during any period after calendar year 1982, the rate shall be simple annual interest at the rate established by section 6621 of the Internal Revenue Code (26 U.S.C.) which is in effect for such period.

(e) The fund shall not be liable for the payment of interest under any circumstances, other than the payment of interest on advances from the United States Treasury as provided by section 9501(c) of the Internal Revenue Code (26 U.S.C.).

§ 725.609 Enforcement against other persons.

In any case in which an award of benefits creates obligations on the part of an operator or insurer that may be enforced under the provisions of this subpart, such obligations may also be enforced, in the discretion of the Secretary or district director, as follows:

(a) In a case in which the operator is a sole proprietorship or partnership, against any person who owned, or was a partner in, such operator during any period commencing on or after the date on which the miner was last employed by the operator;

(b) In a case in which the operator is a corporation that failed to secure its liability for benefits in accordance with section 423 of the Act and § 726.4 of this subchapter, and the operator has not secured its liability for the claim in accordance with § 725.606, against any person who served as the president, secretary, or treasurer of such corporation during any period commencing on or after the date on which the miner was last employed by the operator;

(c) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§ 725.494(e)), against any operator which became a successor operator with respect to the liable operator (§ 725.492) after the date on which the claim was filed, beginning with the most recent such successor operator;

(d) In a case in which the operator is no longer capable of assuming its liability for the payment of benefits (§ 725.494(e)), and such operator was a subsidiary of a parent company or a product of a joint venture, or was substantially owned or controlled by another business entity, against such parent entity, any member of such joint venture, or such controlling business entity; or

(e) Against any other person who has assumed or succeeded to the obligations of the operator or insurer by operation of any state or federal law, or by any other means.

§ 725.620 Failure to secure benefits; other penalties.

(a) If an operator fails to discharge its insurance obligations under the Act, the provisions of subpart D of part 726 of this subchapter shall apply.

(b) Any employer who knowingly transfers, sells, encumbers, assigns, or in

any manner disposes of, conceals, secrets, or destroys any property belonging to such employer, after one of its employees has been injured within the purview of the Act, and with intent to avoid the payment of benefits under the Act to such miner or his or her dependents, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than $1,000, or by imprisonment for not more than one year, or by both. In any case where such employer is a corporation, the president, secretary, and treasurer thereof shall be also severally liable for such penalty or imprisonment as well as jointly liable with such corporation for such fine.

(c) No agreement by a miner to pay any portion of a premium paid to a carrier by such miner's employer or to contribute to a benefit fund or department maintained by such employer for the purpose of providing benefits or medical services and supplies as required by this part shall be valid; and any employer who makes a deduction for such purpose from the pay of a miner entitled to benefits under the Act shall be guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not more than $1,000.

(d) No agreement by a miner to waive his or her right to benefits under the Act and the provisions of this part shall be valid.

(e) This section shall not affect any other liability of the employer under this part.

§ 725.621 Reports.

(a) Upon making the first payment of benefits and upon suspension, reduction, or increase of payments, the operator or other employer responsible for making payments shall immediately notify the district director of the action taken, in accordance with a form prescribed by the Office.

(b) Within 16 days after final payment of benefits has been made by an employer, such employer shall so notify the district director, in accordance with a form prescribed by the Office, stating that such final payment, has been made, the total amount of benefits paid, the name of the beneficiary, and such other information as the Office deems pertinent.

(c) The Director may from time to time prescribe such additional reports to be made by operators, other employers, or carriers as the Director may consider necessary for the efficient administration of the Act.

(d) Any employer who fails or refuses to file any report required of such employer under this section shall be subject to a civil penalty not to exceed $500 for each failure or refusal, which penalty shall be determined in accordance with the procedures set forth in subpart D of part 726 of this subchapter, as appropriate. The maximum penalty applicable to any violation of this paragraph that takes place after [effective date of the final rule] shall be $550.

(e) No request for information or response to such request shall be considered a report for purposes of this section or the Act, unless it is so designated by the Director or by this section.

Subpart J—Medical Benefits and Vocational Rehabilitation

§ 725.701 Availability of medical benefits.

(a) A miner who is determined to be eligible for benefits under this part or part 727 of this subchapter (see § 725.4(d)) is entitled to medical benefits as set forth in this subpart as of the date of his or her claim, but in no event before January 1, 1974. No medical benefits shall be provided to the survivor or dependent of a miner under this part.

(b) A responsible operator, other employer, or where there is neither, the fund, shall furnish a miner entitled to benefits under this part with such medical, surgical, and other attendance and treatment, nursing and hospital services, medicine and apparatus, and any other medical service or supply, for such periods as the nature of the miner's pneumoconiosis and disability requires.

(c) The medical benefits referred to in paragraphs (a) and (b) of this section shall include palliative measures useful only to prevent pain or discomfort associated with the miner's pneumoconiosis or attendant disability.

(d) The costs recoverable under this subpart shall include the reasonable cost of travel necessary for medical treatment (to be determined in accordance with prevailing United States government mileage rates) and the reasonable documented cost to the miner or medical provider incurred in communicating with the employer, carrier, or district director on matters connected with medical benefits.

(e) If a miner receives a medical service or supply, as described in this section, for any pulmonary disorder, there shall be a rebuttable presumption that the disorder is caused or aggravated by the miner's pneumoconiosis. The party liable for the payment of benefits may rebut the presumption by producing credible evidence that the medical service or supply provided was not for a covered pulmonary disorder as defined in § 718.201 of this subchapter, or was beyond that necessary to effectively treat a covered disorder, or was not for a pulmonary disorder at all.

(f) Evidence that the miner does not have pneumoconiosis or is not totally disabled by pneumoconiosis arising out of coal mine employment is insufficient to defeat a request for coverage of any medical service or supply under this subpart. In determining whether the treatment is compensable, the opinion of the miner's treating physician may be entitled to controlling weight pursuant to § 718.104(d). A finding that a medical service or supply is not covered under this subpart shall not otherwise affect the miner's entitlement to benefits.

§ 725.702 Claims for medical benefits only under section 11 of the Reform Act.

(a) Section 11 of the Reform Act directs the Secretary of Health, Education and Welfare to notify each miner receiving benefits under part B of title IV of the Act that he or she may file a claim for medical treatment benefits described in this subpart. Section 725.308(b) provides that a claim for medical treatment benefits shall be filed on or before December 31, 1980, unless the period is enlarged for good cause shown. This section sets forth the rules governing the processing, adjudication, and payment of claims filed under section 11.

(b) (1) A claim filed pursuant to the notice described in paragraph (a) of this section shall be considered a claim for medical benefits only, and shall be filed, processed, and adjudicated in accordance with the provisions of this part, except as provided in this section. While a claim for medical benefits must be treated as any other claim filed under part C of title IV of the Act, the Department shall accept the Social Security Administration's finding of entitlement as its initial determination.

(2) In the case of a part B beneficiary whose coal mine employment terminated before January 1, 1970, the Secretary shall make an immediate award of medical benefits. Where the part B beneficiary's coal mine employment terminated on or after January 1, 1970, the Secretary shall immediately authorize the payment of medical benefits and thereafter inform the responsible operator, if any, of the operator's right to contest the claimant's entitlement for medical benefits.

(c) A miner on whose behalf a claim is filed under this section (see § 725.301) must have been alive on March 1, 1978, in order for the claim to be considered.

(d) The criteria contained in subpart C of part 727 of this subchapter (see

§ 725.4(d)) are applicable to claims for medical benefits filed under this section.

(e) No determination made with respect to a claim filed under this section shall affect any determination previously made by the Social Security Administration. The Social Security Administration may, however, reopen a previously approved claim if the conditions set forth in § 410.672(c) of this chapter are present. These conditions are generally limited to fraud or concealment.

(f) If medical benefits are awarded under this section, such benefits shall be payable by a responsible coal mine operator (see subpart G of this part), if the miner's last employment occurred on or after January 1, 1970, and in all other cases by the fund. An operator which may be required to provide medical treatment benefits to a miner under this section shall have the right to participate in the adjudication of the claim as is otherwise provided in this part.

(g) Any miner whose coal mine employment terminated after January 1, 1970, may be required to submit to a medical examination requested by an identified operator. The unreasonable refusal to submit to such an examination shall have the same consequences as are provided under § 725.414.

(h) If a miner is determined eligible for medical benefits in accordance with this section, such benefits shall be provided from the date of filing, except that such benefits may also include payments for any unreimbursed medical treatment costs incurred personally by such miner during the period from January 1, 1974, to the date of filing which are attributable to medical care required as a result of the miner's total disability due to pneumoconiosis. No reimbursement for health insurance premiums, taxes attributable to any public health insurance coverage, or other deduction or payments made for the purpose of securing third party liability for medical care costs is authorized by this section. If a miner seeks reimbursement for medical care costs personally incurred before the filing of a claim under this section, the district director shall require documented proof of the nature of the medical service provided, the identity of the medical provider, the cost of the service, and the fact that the cost was paid by the miner, before reimbursement for such cost may be awarded.

§ 725.703 Physician defined.

The term ''physician'' includes only doctors of medicine (MD) and osteopathic practitioners within the scope of their practices as defined by State law. No treatment or medical services performed by any other practitioner of the healing arts is authorized by this part, unless such treatment or service is authorized and supervised both by a physician as defined in this section and the district director.

§ 725.704 Notification of right to medical benefits; authorization of treatment.

(a) Upon notification to a miner of such miner's entitlement to benefits, the Office shall provide the miner with a list of authorized treating physicians and medical facilities in the area of the miner's residence. The miner may select a physician from this list or may select another physician with approval of the Office. Where emergency services are necessary and appropriate, authorization by the Office shall not be required.

(b) The Office may, on its own initiative, or at the request of a responsible operator, order a change of physicians or facilities, but only where it has been determined that the change is desirable or necessary in the best interest of the miner. The miner may change physicians or facilities subject to the approval of the Office.

(c) If adequate treatment cannot be obtained in the area of the claimant's residence, the Office may authorize the use of physicians or medical facilities outside such area as well as reimbursement for travel expenses and overnight accommodations.

§ 725.705 Arrangements for medical care.

(a) *Operator liability.* If an operator has been determined liable for the payment of benefits to a miner, the Office shall notify such operator or insurer of the names, addresses, and telephone numbers of the authorized providers of medical benefits chosen by an entitled miner, and shall require the operator or insurer to:

(1) Notify the miner and the providers chosen that such operator will be responsible for the cost of medical services provided to the miner on account of the miner's total disability due to pneumoconiosis;

(2) Designate a person or persons with decisionmaking authority with whom the Office, the miner and authorized providers may communicate on matters involving medical benefits provided under this subpart and notify the Office, miner and providers of such designation;

(3) Make arrangements for the direct reimbursement of providers for their services.

(b) *Fund liability.* If there is no operator found liable for the payment of benefits, the Office shall make necessary arrangements to provide medical care to the miner, notify the miner and medical care facility selected of the liability of the fund, designate a person or persons with whom the miner or provider may communicate on matters relating to medical care, and make arrangements for the direct reimbursement of the medical provider.

§ 725.706 Authorization to provide medical services.

(a) Except as provided in paragraph (b) of this section, medical services from an authorized provider which are payable under § 725.701 shall not require prior approval of the Office or the responsible operator.

(b) Except where emergency treatment is required, prior approval of the Office or the responsible operator shall be obtained before any hospitalization or surgery, or before ordering an apparatus for treatment where the purchase price exceeds $300. A request for approval of non-emergency hospitalization or surgery shall be acted upon expeditiously, and approval or disapproval will be given by telephone if a written response cannot be given within 7 days following the request. No employee of the Department of Labor, other than a district director or the Chief, Branch of Medical Analysis and Services, DCMWC, is authorized to approve a request for hospitalization or surgery by telephone.

(c) Payment for medical services, treatment, or an apparatus shall be made at no more than the rate prevailing in the community in which the providing physician, medical facility or supplier is located.

§ 725.707 Reports of physicians and supervision of medical care.

(a) Within 30 days following the first medical or surgical treatment provided under § 725.701, the treating physician or facility shall furnish to the Office and the responsible operator, if any, a report of such treatment.

(b) In order to permit continuing supervision of the medical care provided to the miner with respect to the necessity, character and sufficiency of any medical care furnished or to be furnished, the treating physician, facility, employer or carrier shall provide such reports in addition to those required by paragraph (a) of this section as the Office may from time to time require. Within the discretion of

the district director, payment may be refused to any medical provider who fails to submit any report required by this section.

§ 725.708 Disputes concerning medical benefits.

(a) Whenever a dispute develops concerning medical services under this part, the district director shall attempt to informally resolve such dispute. In this regard the district director may, on his or her own initiative or at the request of the responsible operator order the claimant to submit to an examination by a physician selected by the district director.

(b) If no informal resolution is accomplished, the district director shall refer the case to the Office of Administrative Law Judges for hearing in accordance with this part. Any such hearing shall be scheduled at the earliest possible time and shall take precedence over all other requests for hearing except for prior requests for hearing arising under this section and as provided by § 727.405 of this subchapter (see § 725.4(d)). During the pendency of such adjudication, the Director may order the payment of medical benefits prior to final adjudication under the same conditions applicable to benefits awarded under § 725.522.

(c) In the development or adjudication of a dispute over medical benefits, the adjudication officer is authorized to take whatever action may be necessary to protect the health of a totally disabled miner.

(d) Any interested medical provider may, if appropriate, be made a party to a dispute over medical benefits.

§ 725.710 Objective of vocational rehabilitation.

The objective of vocational rehabilitation is the return of a miner who is totally disabled for work in or around a coal mine and who is unable to utilize those skills which were employed in the miner's coal mine employment to gainful employment commensurate with such miner's physical impairment. This objective may be achieved through a program of re-evaluation and redirection of the miner's abilities, or retraining in another occupation, and selective job placement assistance.

§ 725.711 Requests for referral to vocational rehabilitation assistance.

Each miner who has been determined entitled to receive benefits under part C of title IV of the Act shall be informed by the OWCP of the availability and advisability of vocational rehabilitation services. If such miner chooses to avail himself or herself of vocational rehabilitation, his or her request shall be processed and referred by OWCP vocational rehabilitation advisors pursuant to the provisions of §§ 702.501 through 702.508 of this chapter as is appropriate.

5. Part 726 is proposed to be revised as follows:

PART 726—BLACK LUNG BENEFITS; REQUIREMENTS FOR COAL MINE OPERATOR'S INSURANCE

Subpart A—General

Subpart B—Authorization of Self-Insurers

Subpart C—Insurance Contracts

Reports by Carrier

Subpart D—Civil Money Penalties

Authority: 5 U.S.C. 301, Reorganization Plan No. 6 of 1950, 15 FR 3174, 30 U.S.C. 901 et seq., 902(f), 925, 932, 933, 934, 936, 945; 33 U.S.C. 901 et seq., Secretary's Order 7–87, 52 FR 48466, Employment Standards Order No. 90–02.

Subpart A—General

§ 726.1 Statutory insurance requirements for coal mine operators.

Section 423 of title IV of the Federal Coal Mine Health and Safety Act as amended (hereinafter the Act) requires each coal mine operator who is operating or has operated a coal mine in a State which is not included in the list published by the Secretary (see part 722 of this subchapter) to secure the payment of benefits for which he may be found liable under section 422 of the Act and the provisions of this subchapter by either:

(a) Qualifying as a self-insurer, or

(b) By subscribing to and maintaining in force a commercial insurance contract (including a policy or contract procured from a State agency).

§ 726.2 Purpose and scope of this part.

(a) This part provides rules directing and controlling the circumstances under which a coal mine operator shall fulfill his insurance obligations under the Act.

(b) This subpart A sets forth the scope and purpose of this part and generally describes the statutory framework within which this part is operative.

(c) Subpart B of this part sets forth the criteria a coal mine operator must meet in order to qualify as a self-insurer.

(d) Subpart C of this part sets forth the rules and regulations of the Secretary governing contracts of insurance entered into by coal operators and commercial insurance sources for the payment of black lung benefits under part C of the Act.

(e) Subpart D of this part sets forth the rules governing the imposition of civil money penalties on coal mine operators that fail to secure their liability under the Act.

§ 726.3 Relationship of this part to other parts in this subchapter.

(a) This part 726 implements and effectuates responsibilities for the payment of black lung benefits placed upon coal operators by sections 415 and 422 of the Act and the regulations of the Secretary in this subchapter, particularly those set forth in part 725 of this subchapter. All definitions, usages, procedures, and other rules affecting the responsibilities of coal operators prescribed in part 725 of this subchapter are applicable, as appropriate, to this part 726.

(b) If the provisions of this part appear to conflict with any provision of any other part in this subchapter, the apparently conflicting provisions should be read harmoniously to the fullest extent possible. If a harmonious interpretation is not possible, the provisions of this part should be applied to govern the responsibilities and obligations of coal mine operators to secure the payment of black lung benefits as prescribed by the Act. The provisions of this part do not apply to matters falling outside the scope of this part.

§ 726.4 Who must obtain insurance coverage.

(a) Section 423 of part C of title IV of the Act requires each operator of a coal mine or former operator in any State which does meet the requirements prescribed by the Secretary pursuant to section 411 of part C of title IV of the Act to self-insure or obtain a policy or contract of insurance to guarantee the payment of benefits for which such operator may be adjudicated liable under section 422 of the Act. In enacting sections 422 and 423 of the Act Congress has unambiguously expressed its intent that coal mine operators bear the cost of providing the benefits established by part C of title IV of the Act. Section 3 of the Act defines an ''operator'' as any owner, lessee, or other person who operates, controls, or supervises a coal mine.

(b) Section 422(i) of the Act clearly recognizes that any individual or business entity who is or was a coal mine operator may be found liable for the payment of pneumoconiosis benefits after December 31, 1973. Within this framework it is clear that the Secretary has wide latitude for determining which operator shall be liable for the payment of part C benefits. Comprehensive standards have been promulgated in subpart G of part 725 of this subchapter for the purpose of guiding the Secretary in making such determination. It must be noted that pursuant to these standards any parent or subsidiary corporation, any individual or corporate partner, or partnership, any lessee or lessor of a coal mine, any joint venture or participant in a joint venture, any transferee or transferor of a corporation or other business entity, any former, current, or future operator or any other form of business entity which has had or will have a substantial and reasonably direct interest in the operation of a coal mine may be determined liable for the payment of pneumoconiosis benefits after December 31, 1973. The failure of any such business entity to self-insure or obtain a policy or contract of insurance shall in no way relieve such business entity of its obligation to pay pneumoconiosis benefits in respect of any case in which such business entity's responsibility for such payments has been properly adjudicated. Any business entity described in this section shall take appropriate steps to insure that any liability imposed by part C of the Act on such business entity shall be dischargeable.

§ 726.5 Effective date of insurance coverage.

Pursuant to section 422(c) of part C of title IV of the Act, no coal mine operator shall be responsible for the payment of any benefits whatsoever for any period prior to January 1, 1974. However, coal mine operators shall be liable as of January 1, 1974, for the payment of benefits in respect of claims which were filed under section 415 of part B of title IV of the Act after July 1, 1973. Section 415(a)(3) requires the Secretary to notify any operator who may be liable for the payment of benefits under part C of title IV beginning on January 1, 1974, of the pendency of a section 415 claim. Section 415(a)(5) declares that any operator who has been notified of the pendency of a section 415 claim shall be bound by the determination of the Secretary as to such operator's liability and as to the claimant's entitlement to benefits as if the claim were filed under part C of title IV of the Act and section 422 thereof had been applicable to such operator. Therefore, even though no benefit payments shall be required of an operator prior to January 1, 1974, the liability for these payments may be finally adjudicated at any time after July 1, 1973. Neither the failure of an operator to exercise his right to participate in the adjudication of such a claim nor the failure of an operator to obtain insurance coverage in respect of claims filed after June 30, 1973, but before January 1, 1974, shall excuse such operator from his liability for the payment of benefits to such claimants under part C of title IV of the Act.

§ 726.6 The Office of Workers' Compensation Programs.

The Office of Workers' Compensation Programs (hereinafter the Office or OWCP) is that subdivision of the Employment Standards Administration of the U.S. Department of Labor which has been empowered by the Secretary of Labor to carry out his functions under section 415 and part C of title IV of the Act. As noted throughout this part 726 the Office shall perform a number of functions with respect to the regulation of both the self-insurance and commercial insurance programs. All correspondence with or submissions to the Office should be addressed as follows: Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor, Washington, D.C. 20210.

§ 726.7 Forms, submission of information.

Any information required by this part 726 to be submitted to the Office of Workmen's Compensation Programs or any other office or official of the Department of Labor, shall be submitted on such forms or in such manner as the Secretary deems appropriate and has authorized from time to time for such purposes.

§ 726.8 Definitions.

In addition to the definitions provided in part 725 of this subchapter, the following definitions apply to this part:

(a) *Director* means the Director, Office of Workers' Compensation Programs, and includes any official of the Office of Workers' Compensation Programs authorized by the Director to perform any of the functions of the Director under this part and part 725 of this subchapter.

(b) *Person* includes any individual, partnership, corporation, association, business trust, legal representative, or organized group of persons.

(c) *Secretary* means the Secretary of Labor or such other official as the Secretary shall designate to carry out any responsibility under this part.

(d) The terms *employ* and *employment* shall be construed as broadly as possible, and shall include any relationship under which an operator retains the right to direct, control, or supervise the work performed by a miner, or any other relationship under which an operator derives a benefit from the work performed by a miner. Any individuals who participate with one or more persons in the mining of coal, such as owners, proprietors, partners, and joint venturers, whether they are compensated by wages, salaries, piece rates, shares, profits, or by any other means, shall be deemed employees. It is the specific intention of this paragraph to disregard any financial arrangement or business entity devised by the actual owners or operators of a coal mine or coal mine-related enterprise to avoid the payment of benefits to miners who, based upon the economic reality of their relationship to this enterprise, are, in fact, employees of the enterprise.

Subpart B—Authorization of Self-Insurers

§ 726.101 Who may be authorized to self-insure.

(a) Pursuant to section 423 of part C of title IV of the Act, authorization to self-insure against liability incurred by coal mine operators on account of the total disability or death of miners due to pneumoconiosis may be granted or denied in the discretion of the Secretary. The provisions of this subpart describe the minimum requirements established by the Secretary for determining whether any particular coal mine operator shall be authorized as a self-insurer.

(b) The minimum requirements which must be met by any operator seeking authorization to self-insure are as follows:

(1) Such operator must, at the time of application, have been in the business of mining coal for at least the 3 consecutive years prior to such application; and,

(2) Such operator must demonstrate the administrative capacity to fully service such claims as may be filed against him; and,

(3) Such operator's average current assets over the preceding 3 years (in computing average current assets such operator shall not include the amount of any negotiable securities which he may be required to deposit to secure his obligations under the Act) must exceed current liabilities by the sum of—

(i) The estimated aggregate amount of black lung benefits (including medical benefits) which such operator may expect to be required to pay during the ensuing year; and,

(ii) The annual premium cost for any indemnity bond purchased; and

(4) Such operator must obtain security, in a form approved by the Office (see § 726.104) and in an amount to be determined by the Office (see § 726.105); and

(5) No operator with fewer than 5 full-time employee-miners shall be permitted to self-insure.

(c) No operator who is unable to meet the requirements of this section should apply for authorization to self-insure and no application for self-insurance shall be approved by the Office until such time as the amount prescribed by the Office has been secured as prescribed in this subpart.

§ 726.102 Application for authority to become a self-insurer; how filed; information to be submitted.

(a) *How filed.* Application for authority to become a self-insurer shall be addressed to the Office and be made on a form provided by the Office. Such application shall be signed by the applicant over his typewritten name and if the applicant is not an individual, by the principal officer of the applicant duly authorized to make such application over his typewritten name and official designation and shall be sworn to by him. If the applicant is a corporation, the corporate seal shall be affixed. The application shall be filed with the Office in Washington, DC.

(b) *Information to be submitted.* Each application for authority to self-insure shall contain:

(1) A statement of the employer's payroll report for each of the preceding 3 years;

(2) A statement of the average number of employees engaged in employment within the purview of the Act for each of the preceding 3 years;

(3) A list of the mine or mines to be covered by any particular self-insurance agreement. Each such mine or mines listed shall be described by name and reference shall be made to the Federal Identification Number assigned such mine by the Bureau of Mines, U.S. Department of the Interior;

(4) A certified itemized statement of the gross and net assets and liabilities of the operator for each of the 3 preceding years in such manner as prescribed by the Office;

(5) A statement demonstrating the applicant's administrative capacity to provide or procure adequate servicing for a claim including both medical and dollar claims; and

(6) In addition to the aforementioned, the Office may in its discretion, require the applicant to submit such further information or such evidence as the Office may deem necessary to have in order to enable it to give adequate consideration to such application.

(c) *Who may file.* An application for authorization to self-insure may be filed by any parent or subsidiary corporation, partner or partnership, party to a joint venture or joint venture, individual, or other business entity which may be determined liable for the payment of black lung benefits under part C of title IV of the Act, regardless of whether such applicant is directly engaged in the business of mining coal. However, in each case for which authorization to self-insure is granted, the agreement and undertaking filed pursuant to § 726.110 and the security deposit shall be respectively filed by and deposited in the name of the applicant only.

§ 726.103 Application for authority to self-insure; effect of regulations contained in this part.

As appropriate, each of the regulations, interpretations and requirements contained in this part 726 including those described in subpart C of this part shall be binding upon each applicant under this subpart, and the applicant's consent to be bound by all requirements of the said regulations shall be deemed to be included in and a part of the application, as fully as though written therein.

§ 726.104 Action by the Office upon application of operator.

(a) Upon receipt of a completed application for authorization to self-insure, the Office shall, after examination of the information contained in the application deny the applicant's request for authorization to self-insure or, determine the amount of security which must be given by the applicant to guarantee the payment of benefits and the discharge of all other obligations which may be required of such applicant under the Act.

(b) The applicant shall thereafter be notified that he may give security in the amount fixed by the Office (see § 726.105):

(1) In the form of an indemnity bond with sureties satisfactory to the Office;

(2) By a deposit of negotiable securities with a Federal Reserve Bank in compliance with §§ 726.106(c) and 726.107;

(3) In the form of a letter of credit issued by a financial institution satisfactory to the Office (except that a letter of credit shall not be sufficient by itself to satisfy a self-insurer's obligations under this part); or

(4) By funding a trust pursuant to section 501(c)(21) of the Internal Revenue Code (26 U.S.C.).

(c) Any applicant who cannot meet the security deposit requirements imposed by the Office should proceed to obtain a commercial policy or contract of insurance. Any applicant for authorization to self-insure whose application has been rejected or who believes that the security deposit requirements imposed by the Office are excessive may, in writing, request that the Office review its determination. A request for review should contain such information as may be necessary to support the request that the amount of security required be reduced.

(d) Upon receipt of any such request the Office shall review its previous determination in light of any new or additional information submitted and inform the applicant whether or not a reduction in the amount of security initially required is warranted.

§ 726.105 Fixing the amount of security.

The amount of security to be fixed and required by the Office shall be such as the Office shall deem to be necessary and sufficient to secure the performance by the applicant of all obligations imposed upon him as an operator by the Act. In determining the amount of security required, the factors that the Office will consider include, but are not limited to, the operator's net worth, the existence of a guarantee by a parent corporation, and the operator's existing liability for benefits. Other factors such as the Office may deem relevant to any particular case shall be considered. The amount of security which shall be required may be increased or decreased when experience or changed conditions so warrant.

§ 726.106 Type of security.

(a) The Office shall determine the type or types of security which an applicant shall or may procure. (See § 726.104(b).)

(b) In the event the indemnity bond option is selected such indemnity bond shall be in such form and contain such provisions as the Office may prescribe: *Provided,* That only corporations may act as sureties on such indemnity bonds. In each case in which the surety on any such bond is a surety company, such company must be one approved by the U.S. Treasury Department under the laws of the United States and the applicable rules and regulations governing bonding companies (see Department of Treasury's Circular–570).

(c) An applicant for authorization to self-insure authorized to deposit negotiable securities to secure his obligations under the Act in the amount fixed by the Office shall deposit any negotiable securities acceptable as security for the deposit of public moneys of the United States under regulations issued by the Secretary of the Treasury. (See 31 CFR part 225.) The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States.

§ 726.107 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; authority to sell such securities; interest thereon.

Deposits of securities provided for by the regulations in this part shall be made with any Federal Reserve bank or any branch of a Federal Reserve bank designated by the Office, or the Treasurer of the United States, and shall be held subject to the order of the Office with power in the Office, in its discretion in the event of default by the said self-insurer, to collect the interest as it may become due, to sell the securities or any of them as may be required to discharge the obligations of the self-insurer under the Act and to apply the proceeds to the payment of any benefits or medical expenses for which the self-insurer may be liable. The Office may, however, whenever it deems it unnecessary to resort to such securities for the payment of benefits, authorize the self-insurer to collect interest on the securities deposited by him.

§ 726.108 Withdrawal of negotiable securities.

No withdrawal of negotiable securities deposited by a self-insurer, shall be made except upon authorization by the Office. A self-insurer discontinuing business, or discontinuing operations within the purview of the Act, or providing security for the payment of benefits by commercial insurance under the provisions of the Act may apply to the Office for the withdrawal of securities deposited under the regulations in this part. With such application shall be filed a sworn statement setting forth:

(a) A list of all outstanding cases in which benefits are being paid, with the names of the miners and other beneficiaries, giving a statement of the amounts of benefits paid and the periods for which such benefits have been paid; and

(b) A similar list of all pending cases in which no benefits have as yet been paid. In such cases withdrawals may be authorized by the Office of such securities as in the opinion of the Office may not be necessary to provide adequate security for the payment of outstanding and potential liabilities of such self-insurer under the Act.

§ 726.109 Increase or reduction in the amount of security.

Whenever in the opinion of the Office the amount of security given by the self-insurer is insufficient to afford adequate security for the payment of benefits and medical expenses under the Act, the self-insurer shall, upon demand by the Office, file such additional security as the Office may require. At any time upon application of a self-insurer, or on the initiative of the Office, when in its opinion the facts warrant, the amount of security may be reduced. A self-insurer seeking such reduction shall furnish such information as the Office may request relative to his current affairs, the nature and hazard of the work of his employees, the amount of the payroll of his employees engaged in coal mine employment within the purview of the Act, his financial condition, and such other evidence as may be deemed material, including a record of payment of benefits made by him.

§ 726.110 Filing of agreement and undertaking.

(a) In addition to the requirement that adequate security be procured as set forth in this subpart, the applicant for the authorization to self-insure shall as a condition precedent to receiving authorization to act as a self-insurer, execute and file with the Office an agreement and undertaking in a form prescribed and provided by the Office in which the applicant shall agree:

(1) To pay when due, as required by the provisions of said Act, all benefits payable on account of total disability or death of any of its employee-miners within the purview of the Act;

(2) In such cases to furnish medical, surgical, hospital, and other attendance, treatment, and care as required by the provisions of the Act;

(3) To provide security in a form approved by the Office (see § 726.104) and in an amount established by the Office (see § 726.105), accordingly as elected in the application;

(4) To authorize the Office to sell any negotiable securities so deposited or any part thereof and from the proceeds thereof to pay such benefits, medical, and other expenses and any accrued

penalties imposed by law as it may find to be due and payable.

(b) At such time when an applicant has provided the requisite security, such applicant shall send a completed agreement and undertaking together with satisfactory proof that his obligations and liabilities under the Act have been secured to the Office in Washington, D.C.

§ 726.111 Notice of authorization to self-insure.

Upon receipt of a completed agreement and undertaking and satisfactory proof that adequate security has been provided an applicant for authorization to self-insure shall be notified by the Office in writing, that he is authorized to self-insure to meet the obligations imposed upon such applicant by section 415 and part C of title IV of the Act.

§ 726.112 Reports required of self-insurer; examination of accounts of self-insurer.

(a) Each operator who has been authorized to self-insure under this part shall submit to the Office reports containing such information as the Office may from time to time require or prescribe.

(b) Whenever it deems it to be necessary, the Office may inspect or examine the books of account, records, and other papers of a self-insurer for the purpose of verifying any financial statement submitted to the Office by the self-insurer or verifying any information furnished to the Office in any report required by this section, or any other section of the regulations in this part, and such self-insurer shall permit the Office or its duly authorized representative to make such an inspection or examination as the Office shall require. In lieu of this requirement the Office may in its discretion accept an adequate report of a certified public accountant.

(c) Failure to submit or make available any report or information requested by the Office from an authorized self-insurer pursuant to this section may, in appropriate circumstances result in a revocation of the authorization to self-insure.

§ 726.113 Disclosure of confidential information.

Any financial information or records, or other information relating to the business of an authorized self-insurer or applicant for the authorization of self-insurance obtained by the Office shall be exempt from public disclosure to the extent provided in 5 U.S.C. 552(b) and the applicable regulations of the Department of Labor promulgated thereunder. (See 29 CFR part 70.)

§ 726.114 Period of authorization as self-insurer; reauthorization.

(a) No initial authorization as a self-insurer shall be granted for a period in excess of 18 months. A self-insurer who has made an adequate deposit of negotiable securities in compliance with §§ 726.106(c) and 726.107 will be reauthorized for the ensuing fiscal year without additional security if the Office finds that his experience as a self-insurer warrants such action. If it is determined that such self-insurer's experience indicates a need for the deposit of additional security, no reauthorization shall be issued for the ensuing fiscal year until such time as the Office receives satisfactory proof that the requisite amount of additional securities have been deposited. A self-insurer who currently has on file an indemnity bond, will receive from the Office each year a bond form for execution in contemplation of reauthorization, and the submission of such bond duly executed in the amount indicated by the Office will be deemed and treated as such self-insurer's application for reauthorization for the ensuing Federal fiscal year.

(b) In each case for which there is an approved change in the amount of security provided, a new agreement and undertaking shall be executed.

(c) Each operator authorized to self-insure under this part shall apply for reauthorization for any period during which it engages in the operation of a coal mine and for additional periods after it ceases operating a coal mine. Upon application by the operator, accompanied by proof that the security posted by the operator is sufficient to secure all benefits potentially payable to miners formerly employed by the operator, the Office shall issue a certification that the operator is exempt from the requirements of this part based on its prior operation of a coal mine. The provisions of subpart D of this part shall be applicable to any operator that fails to apply for reauthorization in accordance with the provisions of this section.

§ 726.115 Revocation of authorization to self-insure.

The Office may for good cause shown suspend or revoke the authorization of any self-insurer. Failure by a self-insurer to comply with any provision or requirement of law or of the regulations in this part, or with any lawful order or communication of the Office, or the failure or insolvency of the surety on his indemnity bond, or impairment of financial responsibility of such self-insurer, may be deemed good cause for such suspension or revocation.

Subpart C—Insurance Contracts

§ 726.201 Insurance contracts—generally.

Each operator of a coal mine who has not obtained authorization as a self-insurer shall purchase a policy or enter into a contract with a commercial insurance carrier or State agency. Pursuant to authority contained in sections 422(a) and 423 (b) and (c) of part C of title IV of the Act, this subpart describes a number of provisions which are required to be incorporated in a policy or contract of insurance obtained by a coal mine operator for the purpose of meeting the responsibility imposed upon such operator by the Act in respect of the total disability or death of miners due to pneumoconiosis.

§ 726.202 Who may underwrite an operator's liability.

Each coal mine operator who is not authorized to self-insure shall insure and keep insured the payment of benefits as required by the Act with any stock company or mutual company or association, or with any other person, or fund, including any State fund while such company, association, person, or fund is authorized under the law of any State to insure workmen's compensation.

§ 726.203 Federal Coal Mine Health and Safety Act endorsement.

(a) The following form of endorsement shall be attached and applicable to the standard workmen's compensation and employer's liability policy prepared by the National Council on Compensation Insurance affording coverage under the Federal Coal Mine Health and Safety Act of 1969, as amended:

It is agreed that: (1) With respect to operations in a State designated in item 3 of the declarations, the unqualified term ''workmen's compensation law'' includes part C of title IV of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. section 931–936, and any laws amendatory thereto, or supplementary thereto, which may be or become effective while this policy is in force, and definition (a) of Insuring Agreement III is amended accordingly; (2) with respect to such insurance as is afforded by this endorsement, (a) the States, if any, named below, shall be deemed to be designated in item 3 of the declaration; (b) Insuring Agreement IV(2) is amended to read ''by disease caused or aggravated by exposure of which the last day of the last exposure, in the employment of the insured, to conditions causing the disease occurs during the policy period, or occurred prior to (effective date) and claim based on such disease is first filed against the insured during the policy period.''

(b) The term ''effective date'' as used in the endorsement provisions

contained in paragraph (a) of this section shall be construed to mean the effective date of the first policy or contract of insurance procured by an operator for purposes of meeting the obligations imposed on such operator by section 423 of part C of title IV of the Act.

(c) The Act contains a number of provisions and imposes a number of requirements on operators which differ in varying degrees from traditional workmen's compensation concepts. To avoid unnecessary administrative delays and expense which might be occasioned by the drafting of an entirely new standard workmen's compensation policy specially tailored to the Act, the Office has determined that the existing standard workmen's compensation policy subject to the endorsement provisions contained in paragraph (a) of this section shall be acceptable for purposes of writing commercial insurance coverage under the Act. However, to avoid undue disputes over the meaning of certain policy provisions and in accordance with the authority contained in section 423(b)(3) of the Act, the Office has determined that the following requirements shall be applicable to all commercial insurance policies obtained by an operator for the purpose of insuring any liability incurred pursuant to the Act:

(1) *Operator liability.* (i) Section 415 and part C of title IV of the Act provide coverage for total disability or death due to pneumoconiosis to all claimants who meet the eligibility requirements imposed by the Act. Section 422 of the Act and the regulations duly promulgated thereunder (part 725 of this subchapter) set forth the conditions under which a coal mine operator may be adjudicated liable for the payment of benefits to an eligible claimant for any period subsequent to December 31, 1973.

(ii) Section 422(c) of the Act prescribes that except as provided in 422(i) (see paragraph (c)(2) of this section) an operator may be adjudicated liable for the payment of benefits in any case if the total disability or death due to pneumoconiosis upon which the claim is predicated arose at least in part out of employment in a mine in any period during which it was operated by such operator. The Act does not require that such employment which contributed to or caused the total disability or death due to pneumoconiosis occur subsequent to any particular date in time. The Secretary in establishing a formula for determining the operator liable for the payment of benefits (see subpart D of part 725 of this subchapter) in respect of any particular claim, must therefore, within the framework and intent of title IV of the Act find in appropriate cases that an operator is liable for the payment of benefits for some period after December 31, 1973, even though the employment upon which an operator's liability is based occurred prior to July 1, 1973, or prior to the effective date of the Act or the effective date of any amendments thereto, or prior to the effective date of any policy or contract of insurance obtained by such operator. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(2) *Successor liability.* Section 422(i) of part C of title IV of the Act requires that a coal mine operator who after December 30, 1969, acquired his mine or substantially all of the assets thereof from a person who was an operator of such mine on or after December 30, 1969, shall be liable for and shall secure the payment of benefits which would have been payable by the prior operator with respect to miners previously employed in such mine if the acquisition had not occurred and the prior operator had continued to operate such mine. In the case of an operator who is determined liable for the payment of benefits under section 422(i) of the Act and part 725 of this subchapter, such liability shall accrue to such operator regardless of the fact that the miner on whose total disability or death the claim is predicated was never employed by such operator in any capacity. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate this requirement in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(3) *Medical eligibility.* Pursuant to section 422(h) of part C of title IV of the Act and the regulations described therein (see subpart D of part 410 of this title) benefits shall be paid to eligible claimants on account of total disability or death due to pneumoconiosis and in cases where the miner on whose death a claim is predicated was totally disabled by pneumoconiosis at the time of his death regardless of the cause of such death. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these requirements in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(4) *Payment of benefits, rates.* Section 422(c) of the Act by incorporating section 412(a) of the Act requires the payment of benefits at a rate equal to 50 per centum of the minimum monthly payment to which a Federal employee in grade GS–2, who is totally disabled is entitled at the time of payment under Chapter 81 of title 5, United States Code. These benefits are augmented on account of eligible dependents as appropriate (see section 412(a) of part B of title IV of the Act). Since the dollar amount of benefits payable to any beneficiary is required to be computed at the time of payment such amounts may be expected to increase from time to time as changes in the GS–2 grade are enacted into law. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act, the requirement that the payment of benefits to eligible beneficiaries shall be made in such dollar amounts as are prescribed by section 412(a) of the Act computed at the time of payment.

(5) *Compromise and waiver of benefits.* Section 422(a) of part C of title IV of the Act by incorporating sections 15(b) and 16 of the Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 915(b) and 916) prohibits the compromise and/or waiver of claims for benefits filed or benefits payable under section 415 and part C of title IV of the Act. The endorsement provisions contained in paragraph (a) of this section shall be construed to incorporate these prohibitions in any policy or contract of insurance obtained by an operator to meet the obligations imposed on such operator by section 423 of the Act.

(6) *Additional requirements.* In addition to the requirements described in paragraph (c)(1) through (5) of this section, the endorsement provisions contained in paragraph (a) of this section shall, to the fullest extent possible, be construed to bring any policy or contract of insurance entered into by an operator for the purpose of insuring such operator's liability under part C of title IV of the Act into conformity with the legal requirements placed upon such operator by section 415 and part C of title IV of the Act and parts 720 and 725 of this subchapter.

(d) Nothing in this section shall relieve any operator or carrier of the duty to comply with any State workmen's compensation law, except

insofar as such State law is in conflict with the provisions of this section.

§ 726.204 Statutory policy provisions.

Pursuant to section 423(b) of part C of title IV of the Act each policy or contract of insurance obtained to comply with the requirements of section 423(a) of the Act must contain or shall be construed to contain—

(a) A provision to pay benefits required under section 422 of the Act, notwithstanding the provisions of the State workmen's compensation law which may provide for lesser payments; and,

(b) A provision that insolvency or bankruptcy of the operator or discharge therein (or both) shall not relieve the carrier from liability for such payments.

§ 726.205 Other forms of endorsement and policies.

Forms of endorsement or policies other than that described in § 726.203 may be entered into by operators to insure their liability under the Act. However, any form of endorsement or policy which materially alters or attempts to materially alter an operator's liability for the payment of any benefits under the Act shall be deemed insufficient to discharge such operator's duties and responsibilities as prescribed in part C of title IV of the Act. In any event, the failure of an operator to obtain an adequate policy or contract of insurance shall not affect such operator's liability for the payment of any benefits for which he is determined liable.

§ 726.206 Terms of policies.

A policy or contract of insurance shall be issued for the term of 1 year from the date that it becomes effective, but if such insurance be not needed except for a particular contract or operation, the term of the policy may be limited to the period of such contract or operation.

§ 726.207 Discharge by the carrier of obligations and duties of operator.

Every obligation and duty in respect of payment of benefits, the providing of medical and other treatment and care, the payment or furnishing of any other benefit required by the Act and in respect of the carrying out of the administrative procedure required or imposed by the Act or the regulations in this part or part 725 of this subchapter upon an operator shall be discharged and carried out by the carrier as appropriate. Notice to or knowledge of an operator of the occurrence of total disability or death due to pneumoconiosis shall be notice to or knowledge of such carrier. Jurisdiction of the operator by a district director, administrative law judge, the Office, or appropriate appellate authority under the Act shall be jurisdiction of such carrier. Any requirement under any benefits order, finding, or decision shall be binding upon such carrier in the same manner and to the same extent as upon the operator.

Reports by Carrier

§ 726.208 Report by carrier of issuance of policy or endorsement.

Each carrier shall report to the Office each policy and endorsement issued, canceled, or renewed by it to an operator. The report shall be made in such manner and on such form as the Office may require.

§ 726.209 Report; by whom sent.

The report of issuance, cancellation, or renewal of a policy and endorsement provided for in § 726.208 shall be sent by the home office of the carrier, except that any carrier may authorize its agency or agencies to make such reports to the Office.

§ 726.210 Agreement to be bound by report.

Every carrier seeking to write insurance under the provisions of the Act shall be deemed to have agreed that the acceptance by the Office of a report of the issuance or renewal of a policy of insurance, as provided for by § 726.208 shall bind the carrier to full liability for the obligations under the Act of the operator named in said report. It shall be no defense to this agreement that the carrier failed or delayed to issue, cancel, or renew the policy to the operator covered by this report.

§ 726.211 Name of one employer only shall be given in each report.

A separate report of the issuance or renewal of a policy and endorsement, provided for by § 726.208, shall be made for each operator covered by a policy. If a policy is issued or renewed insuring more than one operator, a separate report for each operator so covered shall be sent to the Office with the name of only one operator on each such report.

§ 726.212 Notice of cancellation.

Cancellation of a contract or policy of insurance issued under authority of the Act shall not become effective otherwise than as provided by 33 U.S.C. 936(b); and notice of a proposed cancellation shall be given to the Office and to the operator in accordance with the provisions of 33 U.S.C. 912(c), 30 days before such cancellation is intended to be effective (see section 422(a) of part C of title IV of the Act).

§ 726.213 Reports by carriers concerning the payment of benefits.

Pursuant to 33 U.S.C. 914(c) as incorporated by section 422(a) of part C of title IV of the Act and § 726.207 each carrier issuing a policy or contract of insurance under the Act shall upon making the first payment of benefits and upon the suspension of any payment in any case, immediately notify the Office in accordance with a form prescribed by the Office that payment of benefit has begun or has been suspended as the case may be. In addition, each such carrier shall at the request of the Office submit to the Office such additional information concerning policies or contracts of insurance issued to guarantee the payment of benefits under the Act and any benefits paid thereunder, as the Office may from time to time require to carry out its responsibilities under the Act.

Subpart D—Civil Money Penalties

§ 726.300 Purpose and scope.

Any operator which is required to secure the payment of benefits under section 423 of the Act and § 726.4 and which fails to secure such benefits shall be subject to a civil penalty of not more than $1,000 for each day during which such failure occurs. If the operator is a corporation, the president, secretary, and treasurer of the operator shall also be severally liable for the penalty based on the operator's failure to secure the payment of benefits. This subpart defines those terms necessary for administration of the civil money penalty provisions, describes the criteria for determining the amount of penalty to be assessed, and sets forth applicable procedures for the assessment and contest of penalties.

§ 726.301 Definitions.

In addition to the definitions provided in part 725 of this subchapter and § 726.8, the following definitions apply to this subpart:

(a) Division Director means the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, Employment Standards Administration, or such other official authorized by the Division Director to perform any of the functions of the Division Director under this subpart.

(b) President, secretary, or treasurer means the officers of a corporation as designated pursuant to the laws and regulations of the state in which the corporation is incorporated or, if that state does not require the designation of such officers, to the employees of a company who are performing the work

usually performed by such officers in the state in which the corporation's principal place of business is located.

(c) Principal means any person who has an ownership interest in an operator that is not a corporation, and shall include, but is not limited to, partners, sole proprietors, and any other person who exercises control over the operation of a coal mine.

§ 726.302 Determination of penalty.

(a) The following method shall be used for determining the amount of any penalty assessed under this subpart.

(b) The penalty shall be determined by multiplying the daily base penalty amount or amounts, determined in accordance with the formula set forth in this section, by the number of days in the period during which the operator is subject to the security requirements of section 423 of the Act and § 726.4, and fails to secure its obligations under the Act. The period during which an operator is subject to liability for a penalty for failure to secure its obligations shall be deemed to commence on the first day on which the operator met the definition of the term ''operator'' as set forth in § 725.101 of this subchapter. The period shall be deemed to continue even where the operator has ceased coal mining and any related activity, unless the operator secured its liability for all previous periods through a policy or policies of insurance obtained in accordance with subpart C of this part or has obtained a certification of exemption in accordance with the provisions of § 726.114.

(c)(1) A daily base penalty amount shall be determined for all periods up to and including the 10th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, during which the operator failed to secure its obligations under section 423 of the Act and § 726.4.

(2)(i) The daily base penalty amount shall be determined based on the number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on each day of the period defined by this section, and shall be computed as follows:

Employees	Penalty (per day)
Less than 25	$100
25 to 50	200
51 to 100	300
More than 100	400

(ii) For any period after the operator has ceased coal mining and any related activity, the daily penalty amount shall be computed based on the largest number of persons employed in coal mine employment by the operator, or engaged in coal mine employment on behalf of the operator, on any day while the operator was engaged in coal mining or any related activity. For purposes of this section, it shall be presumed, in the absence of evidence to the contrary, that any person employed by an operator is employed in coal mine employment.

(3) In any case in which the operator had prior notice of the applicability of the Black Lung Benefits Act to its operations, the daily base penalty amounts set forth in paragraph (b) of this section shall be doubled. Prior notice may be inferred where the operator, or an entity in which the operator or any of its principals had an ownership interest, or an entity in which the operator's president, secretary, or treasurer were employed:

(i) Previously complied with section 423 of the Act and § 726.4;

(ii) Was notified of its obligation to comply with section 423 of the Act and § 726.4; or

(iii) Was notified of its potential liability for a claim filed under the Black Lung Benefits Act pursuant to § 725.407 of this subchapter.

(4) Commencing with the 11th day after the operator's receipt of the notification sent by the Director pursuant to § 726.303, the daily base penalty amounts set forth in paragraph (b) shall be increased by $100.

(5) In any case in which the operator, or any of its principals, or an entity in which the operator's president, secretary, or treasurer were employed, has been the subject of a previous penalty assessment under this part, the daily base penalty amounts shall be increased by $300, up to a maximum daily base penalty amount of $1,000. The maximum daily base penalty amount applicable to any violation of § 726.4 that takes place after [effective date of the final rule] shall be $1,100.

(d) The penalty shall be subject to reduction for any period during which the operator had a reasonable belief that it was not required to comply with section 423 of the Act and § 726.4 or a reasonable belief that it had obtained insurance coverage to comply with section 423 of the Act and § 726.4. A notice of contest filed in accordance with § 726.307 shall not be sufficient to establish a reasonable belief that the operator was not required to comply with the Act and regulations.

§ 726.303 Notification; investigation.

(a) If the Director determines that an operator has violated the provisions of section 423 of the Act and § 726.4, he or she shall notify the operator of its violation and request that the operator immediately secure the payment of benefits. Such notice shall be sent by certified mail.

(b) The Director shall also direct the operator to supply information relevant to the assessment of a penalty. Such information, which shall be supplied within 30 days of the Director's request, may include:

(1) The date on which the operator commenced its operation of a coal mine;

(2) The number of persons employed by the operator since it began operating a coal mine and the dates of their employment; and

(3) The identity and last known address:

(i) In the case of a corporation, of all persons who served as president, secretary, and treasurer of the operator since it began operating a coal mine; or

(ii) In the case of an operator which is not incorporated, of all persons who were principals of the operator since it began operating a coal mine;

(c) In conducting any investigation of an operator under this subpart, the Division Director shall have all of the powers of a district director, as set forth at § 725.351(a) of this subchapter. For purposes of § 725.351(c), the Division Director shall be considered to sit in the District of Columbia.

§ 726.304 Notice of initial assessment.

(a) After an operator receives notification under § 726.303 and fails to secure its obligations for the period defined in § 726.302(b), and following the completion of any investigation, the Director may issue a notice of initial penalty assessment in accordance with the criteria set forth in § 726.302.

(b)(1) A copy of such notice shall be sent by certified mail to the operator. If the operator is a corporation, a copy shall also be sent by certified mail to each of the persons who served as president, secretary, or treasurer of the operator during any period in which the operator was in violation of section 423 of the Act and § 726.4.

(2) Where service by certified mail is not accepted by any person, the notice shall be deemed received by that person on the date of attempted delivery. Where service is not accepted, the Director may exercise discretion to serve the notice by regular mail.

§ 726.305 Contents of notice.

The notice required by § 726.304 shall:

(a) Identify the operator against whom the penalty is assessed as well as the name of any other person severally liable for such penalty;

(b) Set forth the determination of the Director as to the amount of the penalty and the reason or reasons therefor;

(c) Set forth the right of each person identified in paragraph (a) of this section to contest the notice and request a hearing before the Office of Administrative Law Judges;

(d) Set forth the method for each person identified in paragraph (a) to contest the notice and request a hearing before the Office of Administrative Law Judges; and

(e) Inform any affected person that in the absence of a timely contest and request for hearing received within 30 days of the date of receipt of the notice, the Director's assessment will become final and unappealable as to that person.

§ 726.306 Finality of administrative assessment.

Except as provided in § 726.307(c), if any person identified as potentially liable for the assessment does not, within 30 days after receipt of notice, contest the assessment, the Director's assessment shall be deemed final as to that person, and collection and recovery of the penalty may be instituted pursuant to § 726.320.

§ 726.307 Form of notice of contest and request for hearing.

(a) Any person desiring to contest the Director's notice of initial assessment shall request an administrative hearing pursuant to this part. The notice of contest shall be made in writing to the Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, Employment Standards Administration, United States Department of Labor. The notice of contest must be received no later than 30 days after the date of receipt of the notice issued under § 726.304. No additional time shall be added where service of the notice is made by mail.

(b) The notice of contest shall:

(1) Be dated;

(2) Be typewritten or legibly written;

(3) State the specific issues to be contested. In particular, the person must indicate his agreement or disagreement with:

(i) The Director's determination that the person against whom the penalty is assessed is an operator subject to the requirements of section 423 of the Act and § 726.4, or is the president, secretary, or treasurer of an operator, if the operator is a corporation.

(ii) The Director's determination that the operator violated section 423 of the Act and § 726.4 for the time period in question; and

(iii) The Director's determination of the amount of penalty owed;

(4) Be signed by the person making the request or an authorized representative of such person; and

(5) Include the address at which such person or authorized representative desires to receive further communications relating thereto.

(c) A notice of contest filed by the operator shall be deemed a notice of contest on behalf of all other persons to the Director's determinations that the operator is subject to section 423 of the Act and § 726.4 and that the operator violated those provisions for the time period in question, and to the Director's determination of the amount of penalty owed. An operator may not contest the Director's determination that a person against whom the penalty is assessed is the president, secretary, or treasurer of the operator.

(d) Failure to specifically identify an issue as contested pursuant to paragraph (b)(3) of this section shall be deemed a waiver of the right to contest that issue.

§ 726.308 Service and computation of time.

(a) Service of documents under this part shall be made by delivery to the person, an officer of a corporation, or attorney of record, or by mailing the document to the last known address of the person, officer, or attorney. If service is made by mail, it shall be considered complete upon mailing. Unless otherwise provided in this subpart, service need not be made by certified mail. If service is made by delivery, it shall be considered complete upon actual receipt by the person, officer, or attorney; upon leaving it at the person's, officer's or attorney's office with a clerk or person in charge; upon leaving it at a conspicuous place in the office if no one is in charge; or by leaving it at the person's or attorney's residence.

(b) If a complaint has been filed pursuant to § 726.309, two copies of all documents filed in any administrative proceeding under this subpart shall be served on the attorneys for the Department of Labor. One copy shall be served on the Associate Solicitor, Black Lung Benefits Division, Room N–2605, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, DC 20210, and one copy on the attorney representing the Department in the proceeding.

(c) The time allowed a party to file any response under this subpart shall be computed beginning with the day following the action requiring a response, and shall include the last day of the period, unless it is a Saturday, Sunday, or federally-observed holiday, in which case the time period shall include the next business day.

§ 726.309 Referral to the Office of Administrative Law Judges.

(a) Upon receipt of a timely notice of contest filed in accordance with § 726.307, the Director, by the Associate Solicitor for Black Lung Benefits or the Regional Solicitor for the Region in which the violation occurred, may file a complaint with the Office of Administrative Law Judges. The Director may, in the complaint, reduce the total penalty amount requested. A copy of the notice of initial assessment issued by the Director and all notices of contest filed in accordance with § 726.307 shall be attached. A notice of contest shall be given the effect of an answer to the complaint for purposes of the administrative proceeding, subject to any amendment that may be permitted under this subpart and 29 CFR part 18.

(b) A copy of the complaint and attachments thereto shall be served by counsel for the Director on the person who filed the notice of contest.

(c) The Director, by counsel, may withdraw a complaint filed under this section at any time prior to the date upon which the decision of the Department becomes final by filing a motion with the Office of Administrative Law Judges or the Secretary, as appropriate. If the Director makes such a motion prior to the date on which an administrative law judge renders a decision in accordance § 726.313, the dismissal shall be without prejudice to further assessment against the operator for the period in question.

§ 726.310 Appointment of Administrative Law Judge and notification of hearing date.

Upon receipt from the Director of a complaint filed pursuant to § 726.309, the Chief Administrative Law Judge shall appoint an Administrative Law Judge to hear the case. The Administrative Law Judge shall notify all interested parties of the time and place of the hearing.

§ 726.311 Evidence.

(a) Except as specifically provided in this subpart, and to the extent they do not conflict with the provisions of this subpart, the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges established by the Secretary at 29 CFR part 18 shall apply to administrative proceedings under this subpart.

(b) Notwithstanding 29 CFR 18.1101(b)(2), subpart B of the Rules of Practice and Procedure for Administrative Hearings Before the Office of Administrative Law Judges shall apply to administrative

proceedings under this part, except that documents contained in Department of Labor files and offered on behalf of the Director shall be admissible in proceedings under this subpart without regard to their compliance with the Rules of Practice and Procedure.

§ 726.312 Burdens of proof.

(a) The Director shall bear the burden of proving the existence of a violation, and the time period for which the violation occurred. To prove a violation, the Director must establish:

(1) That the person against whom the penalty is assessed is an operator, or is the president, secretary, or treasurer of an operator, if such operator is a corporation.

(2) That the operator violated section 423 of the Act and § 726.4. The filing of a complaint shall be considered *prima facie* evidence that the Director has searched the records maintained by OWCP and has determined that the operator was not authorized to self-insure its liability under the Act for the time period in question, and that no insurance carrier reported coverage of the operator for the time period in question.

(b) The Director need not produce further evidence in support of his burden of proof with respect to the issues set forth in paragraph (a) if no party contested them pursuant to § 726.307(b)(3).

(c) The Director shall bear the burden of proving the size of the operator as required by § 726.302, except that if the Director has requested the operator to supply information with respect to its size under § 726.303 and the operator has not fully complied with that request, it shall be presumed that the operator has more than 100 employees engaged in coal mine employment. The person or persons liable for the assessment shall thereafter bear the burden of proving the actual number of employees engaged in coal mine employment.

(d) The Director shall bear the burden of proving the operator's receipt of the notification required by § 726.303, the operator's prior notice of the applicability of the Black Lung Benefits Act to its operations, and the existence of any previous assessment against the operator, the operator's principals, or the operator's officers.

(e) The person or persons liable for an assessment shall bear the burden of proving the applicability of the mitigating factors listed in § 726.302(d).

§ 726.313 Decision and order of Administrative Law Judge.

(a) The Administrative Law Judge shall render a decision on the issues referred by the Director.

(b) The decision of the Administrative Law Judge shall be limited to determining, where such issues are properly before him or her:

(1) Whether the operator has violated section 423 of the Act and § 726.4;

(2) Whether other persons identified by the Director as potentially severally liable for the penalty were the president, treasurer, or secretary of the corporation during the time period in question; and

(3) The appropriateness of the penalty assessed by the Director in light of the factors set forth in § 726.302. The Administrative Law Judge shall not render determinations on the legality of a regulatory provision or the constitutionality of a statutory provision.

(c) The decision of the Administrative Law Judge shall include a statement of findings and conclusions, with reasons and bases therefor, upon each material issue presented on the record. The decision shall also include an appropriate order which may affirm, reverse, or modify, in whole or in part, the determination of the Director.

(d) The Administrative Law Judge shall serve copies of the decision on each of the parties by certified mail.

(e) The decision of the Administrative Law Judge shall be deemed to have been issued on the date that it is rendered, and shall constitute the final order of the Secretary unless there is a request for reconsideration by the Administrative Law Judge pursuant to paragraph (f) of this section or a petition for review filed pursuant to § 726.314.

(f) Any party may request that the Administrative Law Judge reconsider his or her decision by filing a motion within 30 days of the date upon which the decision of the Administrative Law Judge is issued. A timely motion for reconsideration will suspend the running of the time for any party to file a petition for review pursuant to § 726.314.

(g) Following issuance of the decision and order, the Chief Administrative Law Judge shall promptly forward the complete hearing record to the Director.

§ 726.314 Review by the Secretary.

(a) The Director or any party aggrieved by a decision of the Administrative Law Judge may petition the Secretary for review of the decision by filing a petition within 30 days of the date on which the decision was issued. Any other party may file a cross-petition for review within 15 days of its receipt of a petition for review or within 30 days of the date on which the decision was issued, whichever is later. Copies of any petition or cross-petition shall be served on all parties and on the Chief Administrative Law Judge.

(b) A petition filed by one party shall not affect the finality of the decision with respect to other parties.

(c) If any party files a timely motion for reconsideration, any petition for review, whether filed prior to or subsequent to the filing of the timely motion for reconsideration, shall be dismissed without prejudice as premature. The 30-day time limit for filing a petition for review by any party shall commence upon issuance of a decision on reconsideration.

§ 726.315 Contents.

Any petition or cross-petition for review shall:

(a) Be dated;

(b) Be typewritten or legibly written;

(c) State the specific reason or reasons why the party petitioning for review believes the Administrative Law Judge's decision is in error;

(d) Be signed by the party filing the petition or an authorized representative of such party; and

(e) Attach copies of the Administrative Law Judge's decision and any other documents admitted into the record by the Administrative Law Judge which would assist the Secretary in determining whether review is warranted.

§ 726.316 Filing and service.

(a) *Filing.* All documents submitted to the Secretary shall be filed with the Secretary of Labor, U.S. Department of Labor, 200 Constitution Ave., NW, Washington, DC 20210.

(b) *Number of copies.* An original and four copies of all documents shall be filed.

(c) *Computation of time for delivery by mail.* Documents are not deemed filed with the Secretary until actually received by the Secretary either on or before the due date. No additional time shall be added where service of a document requiring action within a prescribed time was made by mail.

(d) *Manner and proof of service.* A copy of each document filed with the Secretary shall be served upon all other parties involved in the proceeding. Service under this section shall be by personal delivery or by mail. Service by mail is deemed effected at the time of mailing to the last known address.

§ 726.317 Discretionary review.

(a) Following receipt of a timely petition for review, the Secretary shall

determine whether the decision warrants review, and shall send a notice of such determination to the parties and the Chief Administrative Law Judge. If the Secretary declines to review the decision, the Administrative Law Judge's decision shall be considered the final decision of the agency. The Secretary's determination to review a decision by an Administrative Law Judge under this subpart is solely within the discretion of the Secretary.

(b) The Secretary's notice shall specify:

(1) The issue or issues to be reviewed; and

(2) The schedule for submitting arguments, in the form of briefs or such other pleadings as the Secretary deems appropriate.

(c) Upon receipt of the Secretary's notice, the Director shall forward the record to the Secretary.

§ 726.318 Final decision of the Secretary.

The Secretary's review shall be based upon the hearing record. The findings of fact in the decision under review shall be conclusive if supported by substantial evidence in the record as a whole. The Secretary's review of conclusions of law shall be *de novo.* Upon review of the decision, the Secretary may affirm, reverse, modify, or vacate the decision, and may remand the case to the Office of Administrative Law Judges for further proceedings. The Secretary's final decision shall be served upon all parties and the Chief Administrative Law Judge, in person or by mail to the last known address.

§ 726.319 Retention of official record.

The official record of every completed administrative hearing held pursuant to this part shall be maintained and filed under the custody and control of the Director.

§ 726.320 Collection and recovery of penalty.

(a) When the determination of the amount of any civil money penalty provided for in this part becomes final, in accordance with the administrative assessment thereof, or pursuant to the decision and order of an Administrative Law Judge in an administrative proceeding as provided in, or following the decision of the Secretary, the amount of the penalty as thus determined is immediately due and payable to the U.S. Department of Labor on behalf of the Black Lung Disability Trust Fund. The person against whom such penalty has been assessed or imposed shall promptly remit the amount thereof, as finally determined, to the Secretary by certified check or by money order, made payable to the order of U.S. Department of Labor, Black Lung Program. Such remittance shall be delivered or mailed to the Director.

(b) If such remittance is not received within 30 days after it becomes due and payable, it may be recovered in a civil action brought by the Secretary in any court of competent jurisdiction, in which litigation the Secretary shall be represented by the Solicitor of Labor.

PART 727—[REMOVED]

6. Under the authority of sections 932 and 936 of the Black Lung Benefits Act, part 727 is proposed to be removed.

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