DEPARTMENT OF LABOR

Employment Standards Administration

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

RIN 1215–AA99

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

AGENCY: Employment Standards Administration, Labor.

ACTION: Final rule.

SUMMARY: On January 22, 1997, the Department issued a proposed rule to amend the regulations implementing the Black Lung Benefits Act. 62 FR 3338–3435 (Jan. 22, 1997). When the comment period closed on August 21, 1997, the Department had received written submissions from almost 200 interested persons, including coal miners, coal mine operators, insurers, physicians, and attorneys. The Department also held hearings in Charleston, West Virginia, and Washington, D.C. at which over 50 people testified. The Department carefully reviewed the testimony and the comments and, on October 8, 1999, issued a second notice of proposed rulemaking. 64 FR 54966–55072 (Oct. 8, 1999). In its second notice, the Department proposed changing several of the most important provisions in its initial proposal. The Department also explained its decision not to alter the original proposal with respect to other key regulations based on the comments received to date. Finally, the Department prepared an initial regulatory flexibility analysis. In order to ensure that small businesses that could be affected by the Department's proposal received appropriate notice of the Department's proposed changes, the Department mailed a copy of the second notice of proposed rulemaking to all coal mine operators contained in the databases maintained by the Mine Safety and Health Administration.

The Department initially allowed interested parties until December 7, 1999 to file comments to its second proposal, but extended that period until January 6, 2000. The Department received 37 written submissions before the close of the comment period, from groups representing both coal miners and coal mine operators. The Department also received comments from individual miners, various coal mining and insurance companies, as well as from claims processing organizations, attorneys, and various professional organizations. The Department has carefully reviewed all of the comments, and is issuing its final rule. The rule contains a final regulatory flexibility analysis as required by the Regulatory Flexibility Act.

EFFECTIVE DATE: January 19, 2001.

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

SUPPLEMENTARY INFORMATION: The Department's final rule reprints 20 CFR Parts 718 (except Tables B1 through B6 in Appendix B), 722, 725, and 726 in their entirety. The Department has not revised all of the regulations in these parts. A detailed list of the regulations to which the Department has made substantive revisions follows the Summary of Noteworthy Regulations below, accompanied by a list of regulations to which the Department has made technical revisions, a list of regulations that the Department has deleted, and a list of regulations that the Department has not changed in any manner.

Summary of Noteworthy Provisions

District Director Claims Processing

These final regulations implementing the Black Lung Benefits Act provide simplified administrative procedures for the adjudication of claims pending before the Office of Workers' Compensation Programs (OWCP). The new streamlined procedures are less formal and should be easier for claims participants to understand. They require the district director to issue fewer documents and therefore involve fewer procedural steps and deadlines. They also require fewer responses from the parties. These changes are in response to the many comments the Department has received asking that OWCP's procedures be simplified and made less formal and adversarial.

In its initial notice of proposed rulemaking, the Department announced its intent to amend these regulations with the goal of helping to improve services, streamline the adjudication process and simplify the regulations' language. The Department noted OWCP's many years of experience administering the program and the variety of ideas for change which had resulted from it. 62 FR 3338 (Jan. 22, 1997). In the second notice of proposed rulemaking, the Department emphasized its commitment to improve the quality of the information it provides the parties to a black lung claim. As part of this commitment, the Department noted its intent to substantially rewrite the documents used by district directors to notify parties of the ''initial findings'' on their claims. The Department stated its goal was to help make claim processing by district offices easier to understand and to give claimants a clear picture of the medical evidence developed in connection with their claims so that they were able to make more informed decisions as to how to proceed. The Department also noted that it had attempted to ''eliminat[e] the hierarchy of response times'' at the district director level. 64 FR 54992 (Oct. 8, 1999). After the receipt of many comments addressing its proposals, the Department has determined that a more comprehensive streamlining of district director procedures is warranted.

The Department has therefore eliminated the use of initial findings and the required responses to them, as well as the district director's initial adjudication as proposed in §§ 725.410–725.413. Similarly, the Department has altered the rules governing informal conferences, § 725.416. If a conference is held, no memorandum of conference will result, § 725.417(c). Instead, OWCP will issue only one decisional document at the conclusion of the district director's processing of a claim: in most cases a proposed decision and order, § 725.418. The proposed decision and order will give rise to the thirty-day period for requesting a hearing before the Office of Administrative Law Judges and, if no such hearing is requested, to the one-year period for filing a request for modification, § 725.419. The proposed decision and order will also contain the district director's final designation of the responsible operator liable for the payment of benefits, and the dismissal of all other potentially liable operators that had previously received notice of the claim.

The Department hopes that the absence of documents with titles such as ''initial findings'' and ''memorandum of conference'' will encourage a less adversarial and less formal development of the necessary evidence and will promote more timely evidentiary development. As previously proposed, the district director will engage in a preliminary gathering of the relevant evidence. He will develop medical evidence, including the complete pulmonary evaluation, §§ 725.405–725.406. He will identify and notify those coal mine operators among the claimant's former employers which he deems to be potentially liable operators, § 725.407, and gather evidence from them regarding their employment of the miner and their status as operators, § 725.408. At the conclusion of this evidence-gathering, however, rather than issue an initial finding (a document with the appearance of a preliminary adjudication of the claim), the district director will issue a schedule for the submission of additional evidence, § 725.410. This

document will contain a summary of the results of the complete pulmonary evaluation and the district director's preliminary analysis of that evidence. The analysis will include a discussion of any of the elements of entitlement that appear not to have been established and why. The schedule will also contain the district director's designation of a responsible operator liable for the payment of claimant's benefits. If the designated responsible operator is not the miner's last employer, the district director will include with the schedule the statements necessary to comply with § 725.495(d).

The schedule will allow the claimant and the designated responsible operator not less than 60 days to submit additional evidence, including evidence relevant to the claimant's entitlement to benefits and the employer's liability for them. The schedule will also allow at least an additional 30 days within which to respond to evidence the other party submits, § 725.410(b). These time periods may be extended for good cause shown, § 725.423. The district director will serve the schedule by certified mail on all parties and will include with it copies of all relevant evidence, § 725.410(c). The schedule will also inform the claimant and the designated responsible operator of their rights, including the right to submit additional evidence and the right to further adjudication of the claim, § 725.410(a)(4). Finally, the schedule will notify the claimant that he has the right to obtain representation and that, if the designated responsible operator fails to accept the claimant's entitlement within the specified time and the claimant establishes his entitlement to benefits payable by that operator, the responsible operator will be liable for a reasonable attorney's fee.

The new procedure requires a responsible operator to respond within 30 days as to the liability designation in the schedule, § 725.412(a)(1). Silence on the responsible operator's part will be deemed an acceptance of the district director's designation as to its liability. Silence on the operator's part with respect to claimant's entitlement, however, will be deemed a controversion. If the operator wishes to accept a claimant's entitlement to benefits, it must file a statement indicating this intent within 30 days of issuance of the district director's schedule, § 725.412(b). Thus, this schedule requires a less comprehensive operator response than the initial findings would have. The responsible operator must file a response only to contest its liability and/or to accept a claimant's entitlement to benefits. In addition, fewer parties are required to respond to the schedule since the claimant need not respond at all.

By contrast, if the district director concludes that there is no operator responsible for the payment of benefits and that the results of the complete pulmonary evaluation support a finding of eligibility, the district director shall issue a proposed decision and order awarding the claimant benefits, § 725.411. In such a case, no schedule for the submission of additional evidence is necessary, and no claimant response to the proposed decision and order is required.

At the conclusion of the time scheduled for the submission of additional evidence, § 725.415(b), the district director may either notify additional operators of their potential liability for benefits under § 725.407, issue another schedule for the submission of additional evidence identifying another potentially liable operator as the responsible operator liable for the payment of benefits, § 725.410, schedule a case for an informal conference, § 725.416, or issue a proposed decision and order, § 725.418. In the event the district director issues another schedule for the submission of additional evidence pursuant to § 725.410, the district director shall not permit the development or submission of any additional medical evidence until after he has determined the responsible operator liable for the payment of benefits. If the operator determined to be the responsible operator has not had the opportunity to submit medical evidence, the district director shall afford that operator the opportunity outlined in § 725.410. The designated responsible operator may elect to adopt any medical evidence previously submitted by another operator as its own, subject to the § 725.414 limitations.

The regulations also contain significant modifications to the informal conference procedure in order to reduce delay and to ensure that conferences are held only in appropriate cases. Thus, if an informal conference is scheduled, it must be held within 90 days of the conclusion of the evidentiary development period unless a party requests that it be postponed for good cause, § 725.416(a). A district director may schedule a conference only if all the parties to a claim are represented or deemed represented, although lay representation is sufficient, § 725.416(b). If all the pertinent requirements are met, however, and an informal conference is scheduled, the unexcused failure of a party to appear constitutes grounds for the imposition of sanctions, § 725.416(c). These sanctions may include denial of the claim by reason of abandonment, § 725.409(a)(4). In the event an ALJ ultimately reviews the denial by reason of abandonment and concludes that it was improper, he may proceed to address the merits of the claim, but only with the written agreement of the Director, § 725.409(c).

In most cases, however, at the conclusion of either the evidentiary development period or informal conference proceedings, the district director will issue a proposed decision and order setting forth his findings and conclusions with respect to the claim. In order to reduce the delay caused by informal conferences, the regulations require issuance of a proposed decision and order within 20 days after the conclusion of all informal conference proceedings, § 725.418(a). The proposed decision and order will contain the district director's final designation of the responsible operator liable for the payment of benefits, and will dismiss, as parties to the claim, all other potentially liable operators that received notification pursuant to § 725.407. Any party may request a hearing within 30 days of issuance of the decision and order, § 725.419(a). If no party responds to the proposed decision, it shall become final and effective upon the expiration of the 30-day period and no further proceedings with respect to the claim shall be possible, except for the filing of a request for modification, § 725.419(d).

The Department hopes that this simplified procedure will reduce, if not eliminate, hearing requests filed before the conclusion of a district director's claims processing. In the event a hearing request is filed before a district director has concluded his adjudication of the claim, however, OWCP will honor the request at the conclusion of processing in the absence of a party's affirmative statement that it no longer desires a hearing. Thus, if a claimant has previously requested a hearing and has been denied benefits in a proposed decision and order, the case will be forwarded to the Office of Administrative Law Judges for hearing in the absence of a statement that a hearing is no longer desired. Similarly, if an operator has previously requested a hearing, and the proposed decision and order awards the claimant benefits, OWCP will forward the claim for hearing absent a statement from the operator that it no longer desires a hearing, § 725.418(c).

Evidentiary Development

Documentary Evidence

With one substantive addition and several deletions, these final rules implement the Department's second proposal with respect to the development of both documentary medical evidence and evidence pertaining to operator liability. The designated responsible operator may submit documentary medical evidence either to the district director or to the administrative law judge (ALJ) up to 20 days before an ALJ hearing, or even thereafter, if good cause is shown. Documentary medical evidence may only be submitted up to the numerical limitations outlined in §§ 725.414(a), however, absent a showing of good cause, § 725.456(b). Thus, each side in a claim may submit two chest x-ray interpretations, the results of two pulmonary function tests, two arterial blood gas studies and two medical reports as its affirmative case. In addition, each party may submit one piece of evidence in rebuttal of each piece of evidence submitted by the opposing party. Finally, in a case in which rebuttal evidence has been submitted, the party that originally proferred the evidence which has been the subject of rebuttal may submit one additional statement to rehabilitate its evidence.

By contrast, documentary evidence as to operator liability must be submitted to the district director, absent a showing of exceptional circumstances, §§ 725.408(b)(2), 725.414(d), 725.456(b). There is no limit on the amount of such evidence that may be submitted, however.

At the urging of commenters representing both industry and claimants, the Department has made one addition to § 725.414(a). The Department has added a specific limitation on the amount of autopsy and biopsy evidence which may be submitted in a claim. Each side may submit one autopsy report and one report of each biopsy as part of an affirmative case. Each side may submit one autopsy report and one report of each biopsy in rebuttal of the opponent's case. Finally, where the original autopsy or biopsy evidence has been the subject of rebuttal, the party that submitted the original report may submit an additional statement from the physician who authored that report.

The Department has deleted language throughout § 725.414 referring to potentially liable operators since only the designated responsible operator and/or the Trust Fund will have the authority to develop documentary medical evidence in a claim. The Department has also deleted one provision of proposed § 725.414, § 725.414(e), as well as the comparable provision proposed as § 725.456(c). These subsections would have provided that any evidence obtained by a party while a claim was pending before a district director but withheld from the district director or any other party shall not be admitted into the record in any later proceedings in the absence of extraordinary circumstances unless its admission is requested by another party. Commenters opposed these provisions, and the Department has agreed to delete them. The Department believes they are no longer necessary, given the significant alteration in the district director's methods for gathering evidence under the new regulations, *see* preamble to § 725.456. In addition, these rules would have posed a danger to parties who are unrepresented before the district director and might have run afoul of the rules unintentionally.

Complete Pulmonary Evaluation

With one exception, these final rules implement the Department's second proposal with respect to the administration of the complete pulmonary evaluation required by 30 U.S.C. 923(b). The Department will allow each claimant to select the physician or facility to perform his evaluation from a list of authorized providers maintained by the Department. The list in each case will include all authorized physicians and facilities in the state of the miner's residence and contiguous states, § 725.406(b). The Department will also make available to the claimant's treating physician, at the claimant's request, the results of the objective testing administered as part of the complete pulmonary evaluation and will inform the claimant that any opinion submitted by his treating physician will count as one of the two medical reports that the miner may submit, § 725.406(d).

The Department has not included in the final regulation at § 725.406, however, the provision proposed as subsection (e) which would have allowed the district director to require the claimant to be reexamined after the completion of the complete pulmonary evaluation if the district director believed that unresolved medical questions remained. Commenters from both industry and claimants' groups opposed this provision, and the Department has concluded it is no longer necessary. The complete pulmonary evaluation will now be performed by a highly qualified physician who may be asked by the district director to clarify and/or supplement an initial report if unresolved medical questions remain. In addition, the components of the complete pulmonary evaluation are to be in substantial compliance with the applicable quality standards and the district director retains authority elsewhere in § 725.406 to schedule the miner for further examination or testing to ensure compliance with these standards.

In the second notice of proposed rulemaking, the Department also announced its intent to perform the best possible respiratory and pulmonary evaluation of miners applying for benefits. The Department promised a thorough examination, performed in compliance with the quality standards, in order to provide each claimant with a realistic appraisal of his condition and the district director with a sound evidentiary basis for a preliminary evaluation of the claim. The Department also announced its intent to develop more rigorous standards for physicians who perform complete pulmonary evaluations. The Department invited the interested public to comment on the possible standards that might be used to select physicians and facilities, 64 FR 54988–54989 (Oct. 8, 1999).

The comments the Department received are discussed in detail in the preamble to § 725.406. It is the Department's intent, however, to include in its Black Lung Program Manual the requirements for a physician's or medical facility's inclusion on the list. The Manual is available to the public in every district office of OWCP. Thus, the requirements for participation in OWCP's program and the manner in which the Department has used those requirements to select physicians for inclusion on the approved list will be public information. The Department does not intend to screen the contents of physicians' prior reports and testimony before including them on the list. The Department intends only to ascertain that the required professional credentials are present.

Witnesses

These final rules adopt the provisions governing witness testimony proposed in the Department's second notice of proposed rulemaking. No person shall be permitted to testify as a witness at a hearing, pursuant to deposition or by interrogatory unless that person meets the requirements of § 725.414(c). Thus, in the case of a witness offering testimony relevant to the liability of a potentially liable operator or the identification of a responsible operator,

the witness must have been identified while the claim was pending before the district director in the absence of extraordinary circumstances, § 725.457(c)(1). In the case of a physician offering testimony relevant to the physical condition of the miner, the physician must have prepared a medical report submitted into evidence. Alternatively, the party offering the physician's testimony must have submitted fewer than two medical reports into evidence in which case the physician's testimony shall be considered a medical report for the purpose of the evidentiary limitations in § 725.414(c). A party may offer the testimony of more than two physicians only upon a finding of good cause, § 725.457(c)(2).

Treating Physicians' Opinions

The Department has adopted a rule governing the weighing of treating physicians' opinions similar to the one proposed in its second notice of proposed rulemaking, § 718.104(d). The rule is discussed in detail in the preamble to § 718.104. The language of § 718.104(d) has been altered to provide that, in appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight. *See* § 718.104(d)(5). The rule's purpose is to recognize that a physician's professional relationship with the miner may enhance his insight into the miner's pulmonary condition. A treating physician may develop a more in-depth knowledge and understanding of the miner's respiratory and pulmonary condition than a physician who examines the miner only once or who reviews others' examination reports. Section 718.104(d) is not an outcome-determinative evidentiary rule, however. It does not preclude consideration of other relevant evidence of record. Rather, it provides criteria for evaluating the quality of the doctor-patient relationship. The criteria at § 718.104(d)(1)–(4) are indicia of the potential insight the physician may have gained from on-going treatment of the miner. The rule is designed to force a careful and thorough assessment of the treatment relationship. If the adjudicator concludes the treating physician has a special understanding of the miner's pulmonary health, that opinion may receive ''controlling weight'' over contrary opinions. That determination may be made, however, only after the adjudicator considers the credibility of the physician's opinion in light of its documentation and reasoning and the relative merits of the other relevant medical evidence of record.

Definition of Pneumoconiosis and Establishing Total Disability Due to Pneumoconiosis

The Department has adopted the proposed definition of pneumoconiosis without alteration. In the preamble to § 718.201, the Department explains that the term ''legal pneumoconiosis'' does not create a new medical diagnosis, but rather reflects the statute's definition of the disease as ''a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.'' 30 U.S.C. 902(b). The preamble also explains in detail the Department's decision to include chronic obstructive pulmonary disease in the definition of pneumoconiosis to the extent it is shown to have arisen from coal mine employment. The Department attempts to clarify that not all obstructive lung disease is pneumoconiosis. It remains the claimant's burden of persuasion to demonstrate that his obstructive lung disease arose out of his coal mine employment and therefore falls within the statutory definition of pneumoconiosis. The Department has concluded, however, that the prevailing view of the medical community and the substantial weight of the medical and scientific literature supports the conclusion that exposure to coal mine dust may cause chronic obstructive pulmonary disease. Each miner must therefore be given the opportunity to prove that his obstructive lung disease arose out of his coal mine employment and constitutes ''legal'' pneumoconiosis.

The Department has also adopted the proposed regulation defining total disability and disability due to pneumoconiosis with one alteration, § 718.204. To clarify its original intent concerning the extent to which pneumoconiosis must contribute to a miner's total disability, the Department has amended the language of §§ 718.204(c)(1)(i) and 718.204(c)(1)(ii) by adding the words ''material'' and ''materially.'' Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine dust. Evidence that pneumoconiosis made only a negligible, inconsequential or insignificant contribution to the miner's disability is insufficient to establish total disability due to pneumoconiosis. This change is discussed in detail in the preamble at § 718.204. The Department has also adopted one important proposed change with respect to the clinical evidence which may be used to establish total disability, *see* preamble to § 718.103. The Department has concluded that the claims adjudication process would benefit by making mandatory the use of the flow-volume loop in pulmonary function testing (spirometry testing). The Department has previously noted that the test, conducted in this manner, provides a ''more reliable method of ensuring valid, verifiable results * * *.'' 64 FR 54975 (Oct. 8, 1999). In the second notice of proposed rulemaking, the Department announced its intent to conduct a survey of physicians, clinics and facilities which perform pulmonary function testing to evaluate the prevalence of spirometers capable of producing a flow-volume loop. The Department has now evaluated the results of its survey and has concluded that the prevalence of the necessary equipment and the willingness of those physicians who do not currently have it to buy it, warrant the mandatory usage of such equipment.

Subsequent Claims

These final rules adopt the regulation governing subsequent claims that was proposed in the Department's second notice of proposed rulemaking. A subsequent claim is an application for benefits filed more than one year after the denial of a previous claim. It may be adjudicated on its merits only if the claimant demonstrates that an applicable condition of entitlement has changed in the interim. In the second proposal, the Department justified the rule by noting that ''allowing the filing of a subsequent claim for benefits which alleges a worsening of the miner's condition, * * * merely recognizes the progressive nature of pneumoconiosis.'' 64 FR 54968 (Oct. 8, 1999). In the preamble to § 725.309, the Department responds in detail to those commenters who oppose the regulation. They argue, in part, that the Department's recognition of pneumoconiosis as a latent and progressive disease is scientifically unsound. The Department has summarized the scientific and medical evidence supporting its view that pneumoconiosis is both latent and progressive and has responded to the criticism leveled at that evidence. It is the Department's conclusion that the record contains abundant evidence to justify the regulation governing subsequent claims.

Attorneys' Fees

With minor changes, these final rules promulgate the regulation governing the payment of a claimant's attorney's fee as it was proposed in the Department's second notice of proposed rulemaking, § 725.367. The Department wishes to encourage attorneys to represent claimants early in the administrative process, given the important decisions which may be made by a claimant while a claim is pending before the district director. For example, the rules now limit the quantity of medical evidence that a claimant may submit in support of his entitlement. A claimant may request that the Department send the objective test results from his complete pulmonary evaluation to his treating physician. Any treating physician's opinion which is submitted to the district director, however, may become one of the claimant's two medical reports. The Department's rule governing attorney's fees, therefore, seeks to encourage early attorney involvement by providing a different starting point for employer and Fund attorney fee liability. Although the creation of an adversarial relationship and the ultimately successful prosecution of a claim are still necessary to trigger employer or Fund liability, once that liability is triggered, a reasonable fee will be awarded for all necessary work performed, even if it was performed before the creation of the adversarial relationship.

The text of the regulation has been altered in minor ways. The language describing the fee to which an attorney is entitled has been amended to conform with § 725.366. Section 725.367 therefore provides for the payment of a ''reasonable fee[] for necessary services performed. * * *'' In addition, the regulation has been amended to conform with the revised district director claims procedure. Thus, § 725.367(a)(1) now provides that if the responsible operator designated by the district director pursuant to § 725.410(a)(3) fails to accept the claimant's entitlement to benefits within the 30 day period provided by § 725.412(b) and is ultimately determined to be liable for benefits, the operator shall also be liable for a reasonable attorney's fee. Similarly, if there is no operator that may be held liable for the payment of benefits, the district director issues a schedule for the submission of additional evidence under § 725.410, and the claimant successfully prosecutes his application for benefits, the Fund will be liable for a reasonable attorney's fee, § 725.367(a)(2). Finally, if the district director issues more than one schedule for the submission of additional evidence in order to designate a different operator as the responsible operator, and that operator is ultimately determined to be liable for the payment of benefits, that operator will be liable for the payment of claimant's attorney's fee if it fails to accept the claimant's entitlement within 30 days of the date upon which it is notified of its designation as responsible operator.

True Doubt

The Department has not adopted a ''true doubt'' rule in these regulations. 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. The Department believes that evaluation of conflicting medical evidence requires careful consideration of a wide variety of disparate factors affecting the credibility of that evidence. The presence of these factors makes it unlikely that a factfinder will be able to conclude that conflicting evidence is truly in equipoise. *See* preamble to § 718.3.

Criteria for Determining a Responsible Operator

The Department has made two changes to the regulation governing the identification of a responsible operator, § 725.495. That regulation now provides that if the miner's most recent employer was a self-insured operator which no longer possesses sufficient assets to secure the payment of benefits when the miner files his claim, the Department will not name a previous employer as responsible operator. Rather, the claim will be the responsibility of the Black Lung Disability Trust Fund. The Department has made this change in response to a comment that stated that it is unfair to name a prior employer as liable for a claim when the financial inability of the later employer to pay the claim is the fault of the Department. Because the Department has the authority to accept or reject applications for self-insurance and to set minimum standards for qualifying as a self-insurer, the Department agrees with the commenter. Thus, to the extent the security deposited by a self-insured coal mine operator pursuant to § 726.104 proves insufficient to pay individual claims, liability will not be placed on previous employers, but rather on the Trust Fund. The Department has also altered the language of § 725.495(d) to reflect the changes made in the regulations governing district director claims processing, §§ 725.410–725.413. The district director will no longer issue an initial finding naming a responsible operator but rather will finally designate in a proposed decision and order one operator as the responsible operator liable for a claim, § 725.418(d).

Insurance Endorsement

In the second notice of proposed rulemaking, the Department opened § 726.203 for comment, noting that representatives of the insurance industry had told the Department that a different version of the insurance endorsement than the one contained in § 726.203(a) had been in use since 1984 with the Department's consent. The Department invited the submission of any document the insurance industry might possess from the Department authorizing use of the different endorsement. 64 FR 54969–70, 55005–06 (Oct. 8, 1999). The Department has carefully considered the comments submitted in response to the second notice of proposed rulemaking and declines to amend § 726.203. The revised black lung endorsement offered by the commenters would materially alter the obligations and coverage provided by the insurance industry, thereby increasing the potential exposure of coal mine operators and the Black Lung Disability Trust Fund, *see* preamble to § 726.203.

Explanation of Changes

Complete List of Substantive Revisions

The Department has made substantive revisions to 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, 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, § 726.3, § 726.8, § 726.101, § 726.104, § 726.105, § 726.106, § 726.109, § 726.110, § 726.111, § 726.114, § 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, and § 726.320. Detailed explanations of the reasons for the Department's revisions may be found in the discussion of individual regulations below.

Complete List of Technical Revisions

The Department has made only technical changes to the following regulations: § 718.1, § 718.2, § 718.4, 718.303, Appendix A to Part 718, § 725.3, § 725.102, § 725.201, § 725.206, § 725.207, § 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, § 725.455, § 725.462, § 725.463, § 725.466, § 725.480, § 725.496, § 725.497, § 725.501, § 725.504, § 725.505, § 725.506, § 725.507, § 725.510, § 725.513, § 725.514, § 725.521, § 725.531, § 725.532, § 725.536, § 725.540, § 725.601, § 725.603, § 725.604, § 725.605, § 725.607, § 725.702, § 725.703, § 725.704, § 725.705, § 725.707, § 725.708, § 725.711, § 726.1, § 726.4, § 726.103, § 726.203, § 726.207, § 726.208, § 726.209, § 726.210, § 726.211, § 726.212, and § 726.213. In its first notice of proposed rulemaking, the Department revised § 725.3 to create a new subpart E in part 725, and to recognize the relabeling of the remaining subparts. The Department inadvertently omitted the regulation from the list of technical revisions, however. Accordingly, § 725.3 now appears in the complete list of technical revisions. The Department also inadvertently omitted §§ 725.206 and 725.540 from the list of technical revisions. The Department added a reference to § 725.4(d) to each regulation, *see* 62 FR 3340–41 (Jan. 22, 1997). The Department also inadvertently omitted § 725.207 from the list of technical revisions. The Department replaced commas in subsections (b) and (c) with the word ''and.'' The Department also inadvertently omitted § 725.497 from the list of technical revisions. The Department replaced references to the ''Trust Fund'' with references to the ''fund,'' the term defined in § 725.101(a)(8), and capitalized the word ''section'' in subsections (a) and (b). Finally, the Department inadvertently omitted § 725.601 from the list of technical revisions. The Department replaced references to ''deputy commissioner'' with references to ''district director,'' *see* 62 FR 3340 (Jan. 22, 1997), and replaced a reference to the ''Trust Fund'' with a reference to the ''fund.'' The Department explained the other technical changes that it was making to the regulations in its first and second notices of proposed rulemaking. *See* 62 FR 3340–41 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). With the exception of § 726.203, none of the regulations listed above were open for comment. The Department's decision not to revise § 726.203, other than the technical revisions discussed in the Department's first notice of proposed rulemaking, is explained in the preamble to § 726.203.

Complete List of Deleted Regulations

The following regulations have been deleted: § 718.307, § 718.401, § 718.402, § 718.403, § 718.404, § 725.453A, § 725.459A, § 725.503A, § 725.701A, and part 727 (entire). The Department explained its decision to incorporate the text of sections 725.453A, 725.459A, 725.503A, and 725.701A into other regulations in its first notice of proposed rulemaking. *See* list of Technical revisions, 62 FR 3341 (Jan. 22, 1997). Detailed explanations of the Department's decision to delete the remaining regulations in this list may be found in the discussion of individual regulations below.

Complete List of Unchanged Regulations

The following regulations have not been revised: § 718.203, § 718.206, § 718.302, § 718.304, § 718.305, § 718.306, § 725.205, § 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, § 725.511, § 725.512, § 725.520, § 725.534, § 725.535, § 725.538, § 725.539, § 725.541, § 725.542, § 725.545, § 725.546, § 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. The Department did not accept comments on these regulations, and is re-promulgating the regulations for the convenience of readers.

For purposes of this preamble, ''he'', ''his'', and ''him'' shall include ''she'', ''hers'', and ''her''.

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

Subpart A—General

20 CFR 718.3

(a)(i) In the initial notice of proposed rulemaking, the Department invited public comment on the continued use of the ''true doubt'' rule, and specifically on the language contained in § 718.3(c), which had been cited to the Supreme Court in support of the rule. 62 FR 3341 (Jan. 22, 1997). The ''true doubt'' rule is an evidentiary principle which requires the adjudicator to find in favor of the claimant on a factual issue if the evidence for and against the claimant is evenly balanced. The Supreme Court invalidated the ''true doubt'' rule in *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994). The Court held § 718.3(c) failed to define the rule effectively, and that the rule, as applied by the Benefits Review Board, violated the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.*, by relieving the claimant of the burden of proving his or her claim by a preponderance of the evidence (the ''burden of persuasion''). The Department therefore proposed deleting § 718.3(c) and moving the existing 20 CFR 718.403 (1999) (''Burden of proof'') to proposed § 725.103. (ii) In the second notice of proposed rulemaking, the Department addressed the comments responding to the proposed deletion of paragraph (c). 64 FR 54974 (Oct. 8, 1999). Some comments urged the Department to promulgate a version of the ''true doubt'' rule which would comply with *Greenwich Collieries.* Other comments suggested retaining paragraph (c) as a statement of general principle and a reminder to adjudicators of the purpose of the Black Lung Benefits Act (BLBA). The Department rejected both suggestions. The Department concluded a ''true doubt'' evidentiary rule would not improve claims adjudication. Rather, the factfinder must conduct an in-depth analysis of the medical evidence in each case, and resolve credibility issues. The Department also noted that evidence is rarely in equipoise because a factfinder must consider such a wide variety of factors in weighing it: Physicians' qualifications, clinical documentation,

reasoning, relationship to other medical evidence, etc. With respect to paragraph (c) as a statement of principle, the Department considered the provision unnecessary because it would be unenforceable, and because the principles appear in the legislative history of the BLBA which may be cited by a party in litigation. Moreover, the Department noted it had addressed the difficulties confronted by claimants in proving their claims in other regulations, *e.g.,* by requiring substantial compliance rather than strict compliance with the quality standards for medical evidence. (iii) The Department has received four additional comments concerning the ''true doubt'' rule.

(b) Two comments observe that the Department has the regulatory authority to promulgate a ''true doubt'' rule which will comply with *Greenwich Collieries,* and three comments urge the need for such a rule to implement Congressional intent that all reasonable doubt be resolved in the claimant's favor. The Department recognizes that it has the statutory authority to depart from the requirements of the APA and allocate burdens of production and persuasion among the parties. The Department, however, does not believe codification of the ''true doubt'' rule is necessary to afford claimants the protections Congress intended in directing resolution of reasonable doubts in their favor. Rather than a statement of general principle, the Department has provided assistance to claimants in other ways. As noted in the second notice of proposed rulemaking, the Department eased the level of compliance with the quality standards for clinical tests and medical reports from strict adherence to ''substantial compliance.'' 64 FR 54974 (Oct. 8, 1999). The reduced standard allows the adjudicator more leeway to determine in each particular case whether any defects in compliance undermine the credibility of the test or report. Another example is the ''treating physician'' rule in § 718.104(d). The regulation enhances the weight an adjudicator may give to a miner's treating physician's opinion provided the opinion meets certain standards. In addition, § 725.406(d) provides each claimant with the opportunity to have his or her treating physician receive objective test results (such as a chest x-ray reading and pulmonary function study results), in substantial compliance with the regulations' quality standards. This provision ensures that the claimant's treating physician's opinion may be based on complying evidence. Finally, the Department has adopted burden-shifting presumptions such as the default onset date for the commencement of benefits, § 725.503(b), (d), and the presumption of coverage for pulmonary-related medical benefits, § 725.701(e), which assist claimants on medical treatment issues. These provisions significantly reduce the need for a ''true doubt'' rule.

(c) Three comments contend a ''true doubt'' rule is necessary because the limitations on the quantity of medical evidence imposed by the regulations will result in increased instances in which the evidence for and against entitlement is in equipoise despite scrupulous consideration of all relevant factors affecting credibility. The Department disagrees. The adjudicator must examine several variables in weighing the credibility of each item of medical evidence, especially physicians' opinions. Age of the opinion, reasoning, underlying clinical data, the physician's level of expertise, reliability of employment, social and medical histories, etc., are all factors to be considered in each report. As for clinical studies, the quality standards establish criteria to measure the reliability of the clinical results, and physicians' reviews of the results provide additional information on the studies' validity. When all available information is assembled, the Department believes few medical records for and against entitlement will be in equipoise. Furthermore, the limitations on evidence should prompt each party to bolster the credibility of its medical evidence and challenge the credibility of its opponent's case.

(d) One comment states the ''true doubt'' rule is especially needed for weighing chest x-rays because that type of evidence involves very few variables (film quality, readers' expertise) which can affect the credibility of the evidence. The Department believes no need exists to adopt a specialized ''true doubt'' rule for use in weighing only x-rays. Such a rule would place undue importance on one type of evidence, and would overemphasize the role of x-rays in determining whether the miner has pneumoconiosis. Chest x-rays are used to determine whether the miner has ''clinical'' pneumoconiosis, *i.e.,* ''the lung disease caused by fibrotic reaction of the lung tissue to inhaled dust, which is generally visible on chest x-rays as opacities.'' *Hobbs* v. *Clinchfield Coal Co.,* 917 F.2d 790, 791 n. 1 (4th Cir. 1990) (citation omitted). The BLBA explicitly prohibits the denial of a claim based solely on negative x-rays. 30 U.S.C. 923(b). The reason for this prohibition is Congress' reservations about the reliability of negative x-rays as trustworthy evidence that the miner does not have pneumoconiosis. *Usery* v. *Turner Elkhorn Mining Co.,* 428 U.S. 1, 31–34 (1976). Consequently, Congress has limited the use of negative x-rays in evaluating a miner's entitlement to benefits. Even if the x-ray readings in a particular claim appear to be truly balanced and therefore insufficient to meet the preponderance standard, however, the claimant may nevertheless establish the existence of clinical pneumoconiosis. For example, a factfinder might find one x-ray reading more credible than another based on a radiologist's explanation, contained in a supplemental report or deposition testimony, of the reasons for his x-ray diagnosis. Such reasons may include consideration of the miner's complete occupational history, including the length of his or her coal mine employment, and the absence of other injurious exposures, *see* 45 FR 13687, Discussion and changes, § 718.202 (Feb. 29, 1980). In addition, a claimant may prove the existence of ''legal'' pneumoconiosis. This broader category of compensable disease comprises ''all lung diseases which * * * [are] significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'' *Hobbs,* 917 F.2d 4 791 n. 1; *see also Barber* v. *Director, OWCP,* 43 F.3d 899, 901 (4th Cir. 1995). In weighing medical evidence relevant to ''legal'' pneumoconiosis, the adjudicator may consider a variety of factors which affect the weight of the medical evidence, *e.g.*, the physicians' expertise, the reasoning and documentation in the medical reports, the comparative consistency or inconsistency of the opinions with other medical evidence such as hospital reports, etc. A claimant has ample opportunity to establish that (s)he has a lung disease caused by coal mine employment in addition to the narrow type of disease discoverable by x-rays. The Department therefore rejects the position that a ''true doubt'' rule should be available for the purpose of resolving conflicts in x-ray evidence.

(e) One comment suggests a ''true doubt'' rule would be useful in resolving conflicts between qualifying and nonqualifying pulmonary function and blood gas studies. The commenter acknowledges that more factors exist to determine the credibility of these types of clinical evidence than exist when chest x-ray evidence is in conflict, but nevertheless recommends making the rule applicable in the event the evidence is in equipoise. Both pulmonary function (§ 718.103) and

blood gas studies (§ 718.105) must comply with far more detailed quality standards than x-rays. Although only ''substantial compliance'' is required under the regulations, the more detailed standards necessarily provide more points of comparison between studies and more bases for preferring one study to another. A party may challenge another party's study by submitting expert opinion evidence demonstrating the study is unreliable or invalid. Given the numerous means of challenging or bolstering a study, the Department does not believe a ''true doubt'' rule would play a significant role in weighing pulmonary function studies and blood gas studies. No change in the regulation is appropriate.

(f) No other comments have been received concerning this section, and no changes have been made in it.

Subpart B

20 CFR 718.101

(a) In the initial notice of proposed rulemaking, the Department added subsection (b) to emphasize that the part 718 quality standards apply to all evidence developed by any party in connection with a claim filed after March 31, 1980, and to claims governed by part 727 if the evidence was developed after that date. 62 FR 3341 (Jan. 22, 1997). Paragraph (b) also established a single standard of compliance for all clinical tests and medical reports, in place of the varying standards contained in the former individual regulations. The Department revised paragraph (b) in the second notice of proposed rulemaking to clarify that the quality standards will apply only prospectively to evidence developed in connection with a claim, after promulgation of these regulations. The Department noted it wished to avoid invalidating evidence already submitted in pending claims based on the parties' settled expectations. 64 FR 54974–75 (Oct. 8, 1999). The Department also responded to numerous comments received after the initial notice of proposed rulemaking. It rejected comments opposing the general applicability of the quality standards to medical evidence and advocating consideration of noncomplying evidence, citing the need for technically accurate and reliable evidence for the adjudication of entitlement issues. For the same reason, the Department rejected comments disputing its authority to impose quality standards on medical evidence as inconsistent with the Black Lung Benefits Act's (BLBA) requirement that ''all relevant evidence'' be considered. *See* 30 U.S.C. 923(b). The Department concluded quality standards are consistent with the mandated consideration of all relevant evidence because noncomplying evidence is inherently unreliable, and therefore not relevant to the adjudication of a claim. The Department rejected the suggestion that the criteria enumerated in the quality standards should provide the only grounds for invalidating medical evidence; rather, parties may develop any evidence which addresses the validity of the evidence. The Department explained there was no need to add an exemption from the quality standards for hospitalization and treatment records because § 718.101 is clear that it applies quality standards only to evidence developed ''in connection with a claim'' for black lung benefits. Finally, the Department rejected as unnecessary a requirement that the Department notify a party if its evidence is noncomplying and allow it to rehabilitate the evidence because the responsibility for submitting complying evidence rests with the party submitting it. The district director is already responsible for ensuring the complete pulmonary examination required by 30 U.S.C. 923(b) complies with all applicable quality standards. In addition, if an opposing party challenges evidence as noncomplying, the party originally submitting it may rehabilitate the evidence by submitting an additional report from the author of the original report.

(b) Two comments reiterate the general argument that 30 U.S.C. 923(b) and the Administrative Procedure Act (APA), 5 U.S.C. 556(d), require consideration of ''all relevant evidence,'' and the Department therefore cannot exclude from the adjudicator's consideration noncomplying medical evidence. The Department previously addressed, and rejected, this argument in the second notice of proposed rulemaking. 64 FR 54974 (Oct. 8, 1999). The Department stated that noncomplying evidence is not ''relevant evidence'' because it is inherently unreliable, and cannot form the basis for awarding or denying a claim. Upon further consideration, the Department concludes this statement, while accurate in the majority of cases, should be qualified. Evidence which does not substantially comply with the applicable standard generally is not very reliable. Noncomplying evidence should only form the basis for awarding or denying a claim in limited circumstances. All three of the following requirements must be met: no evidence exists which does comply with the applicable standards; the defect(s) cannot be cured by a supplementary opinion or other evidence; and the death of the miner precludes developing evidence which would be in substantial compliance. In order for such evidence to support an award or denial, the adjudicator must find the evidence sufficiently reliable to establish the fact(s) for which it is offered despite its failure to meet the threshold ''substantial compliance'' standard. The Department therefore rejects the commenters' general position that noncomplying evidence cannot be excluded under 30 U.S.C. 923(b), although the Department recognizes a limited exception to the standards' gatekeeping function for some claims involving deceased miners.

(c) Two comments cite specific examples of circumstances in which allegedly probative physicians' opinions could be disregarded on compliance grounds. (i) In one example, the commenter cites as potentially noncomplying a medical opinion diagnosing ''legal'' pneumoconiosis based on valid pulmonary function and arterial blood gas testing, but omitting any chest x-ray testing. The Department has previously considered the position that a medical report should not automatically be found noncomplying based on the absence of an x-ray. 64 FR 54977 (Oct. 8, 1999). In rejecting the comment that the quality standard applicable to reports of physical examination (§ 718.104) should not make a chest x-ray a standard requirement, the Department noted that an x-ray is an integral part of any examination for pneumoconiosis. The Department further noted, however, that medical evidence must only be in ''substantial compliance'' with the applicable quality standards; the party proffering the evidence may demonstrate that the evidence is reliable despite its failure to comply with every criterion in the standard. The Department reiterates that position. Whether any particular piece of evidence is in ''substantial compliance'' with the standards, and therefore reliable, is a matter for the adjudicator to determine taking into consideration all relevant circumstances. One important factor is the element(s) of entitlement for which the evidence is offered. In the example cited above, the lack of an x-ray is not necessarily fatal. The report may contain: valid and pertinent other tests and information upon which the physician can make a diagnosis; accurate medical, smoking and employment histories; results of a physical examination confirming the

presence of pulmonary symptoms or impairment; and pulmonary function study and/or blood gas studies demonstrating impairment. Based on this documentation, the physician may provide a documented and reasoned diagnosis of ''legal pneumoconiosis'' which the adjudicator considers reliable, *i.e.,* in ''substantial compliance'' with the quality standards. *See* 45 FR 13687 (Feb. 29, 1980), § 718.202, Discussion and changes (h). (ii) In another example, the commenter posits a ''positive'' medical opinion based on an invalid pulmonary function test, valid arterial blood gas testing, physical examination and other data. The lack of a valid pulmonary function study is not necessarily a reason to reject the entire report. The hypothetical assumes a valid blood gas test, physical examination, etc. As in the first example, this testing and information may support a documented and reasoned diagnosis depending on the purpose for which the report is offered. If the physical examination and clinical tests other than the pulmonary function study substantiate the presence of a pulmonary/respiratory impairment, the factfinder may deem the physician's diagnosis a reliable assessment of the miner's extent of impairment. If the employment, smoking and other personal information is accurate, the adjudicator may accept the physician's conclusions about the cause of the miner's pulmonary or respiratory impairment. If, however, the physician clearly relied on the invalid pulmonary function study (or other inaccurate data or information), the adjudicator may find the opinion unreliable in one or more respects. (iii) The Department emphasizes that the ''substantial compliance'' standard is a rule of reason. In each case in which an issue of noncompliance is raised, the factfinder must identify any failure to comply strictly with the applicable quality standard. The factfinder must then determine whether the test or report is reliable despite its failure to comply with every criterion in the standard. This finding is necessarily dependent to an extent on the element(s) of entitlement for which the test or report may be relevant. The significance of the particular defect must therefore be ascertained by considering whether it is critical to the physician's conclusions. In the first example, the lack of an x-ray may be excused if the physician has offered a documented and reasoned diagnosis of ''legal'' pneumoconiosis. In the second example, the invalid pulmonary function study may or may not affect an otherwise documented and reasoned evaluation of the miner's respiratory/pulmonary condition. No categorical response, however, can be given to the hypotheticals since the reliability, and therefore the probative value, of the reports can only be evaluated in the context of an actual claim. No change in the regulation is warranted.

(d) One comment urges the Department to include a provision specifically exempting those medical tests and reports generated outside the black lung benefits claim context from the quality standards. Specifically, the commenter requests that the text of the regulation make clear that chest x-rays, pulmonary function tests and blood gas studies administered in the hospital or as part of the miner's routine care be exempted from quality standards applicability. The Department previously addressed this concern in the second notice of proposed rulemaking. 64 FR 54975 (Oct. 8, 1999). The Department noted that § 718.101 limits the applicability of the quality standards to evidence ''developed * * * in connection with a claim for benefits'' governed by 20 CFR parts 718, 725 or 727. Despite the inapplicability of the quality standards to certain categories of evidence, the adjudicator still must be persuaded that the evidence is reliable in order for it to form the basis for a finding of fact on an entitlement issue. Additional exclusionary language in the regulation is therefore unnecessary.

(e) One comment contends all medical evidence involving a deceased miner should be considered without regard to the quality standards because the miner is no longer available for further testing. The Department disagrees. The regulations provide that a deceased miner's noncomplying chest x-rays, pulmonary function studies and medical reports may form the basis of an award or denial of benefits under certain circumstances provided no complying study or report is available. *See* §§ 718.102(e) (x-rays), 718.103(c) (pulmonary function studies), 718.104(c) (medical reports). The Department has added a similar provision to § 718.105 (arterial blood gas studies). With respect to each category of evidence, the availability of tests or reports in substantial compliance with the applicable quality standards makes reliance on the noncomplying tests or reports unnecessary; the record already contains reliable evidence addressing the deceased miner's pulmonary condition, and reliable evidence is the fundamental purpose of the quality standards. Furthermore, excusing noncompliance for all evidence involving a deceased miner ignores the fact that existing evidence may be brought into substantial compliance despite the unavailability of the miner. The party offering the evidence may obtain a supplementary opinion from the physician who conducted the noncomplying test or authored the report, and cure the defect(s). Finally, the party may submit the noncomplying evidence in any event, ecognizing that it may be considered but cannot establish any fact for which complying evidence is in the record.

(f) One comment suggests that applying the quality standards only prospectively will sanction the acceptance of inferior evidence if the evidence was developed before the effective date of these regulations. The commenter also contends the Department's rationale for prospective application implies the former quality standards will not apply to evidence developed before the effective date of these regulations, especially for unrepresented claimants. The Department disagrees. In the initial notice of proposed rulemaking, proposed § 718.101(b) required all evidence developed in conjunction with a black lung benefits claim to comply with the applicable quality standards. 62 FR 3374 (Jan. 22, 1997). The Department stated that the purpose of § 718.101(b) was to make clear the Department's disagreement with Benefits Review Board precedent holding the former 20 CFR part 718 quality standards applied only to evidence developed by the Director. 62 FR 3341 (January 22, 1997). One comment, in response to the first proposal, noted that, as written, § 718.101(b) would invalidate evidence in claims pending before the Department which was valid under prevailing Board precedent at the time the evidence was generated. The Department responded to this concern in the second notice of proposed rulemaking by revising § 718.101 to apply the quality standards only to evidence developed after the effective date of the regulations. 64 FR 55010 (Oct. 8, 1999). In explaining the revision, the Department acknowledged the ''substantial hardship'' which might occur, especially for unrepresented claimants, if medical evidence which complied with the law when submitted into evidence became invalid after the regulations become effective. This explanation, however, is not a concession as to the correctness of the Board's decisions. Since 1980, the Department has consistently taken the position that the 20 CFR part 718 quality standards apply to all evidence

developed by any party in black lung benefits claim litigation. Although the Board has rejected the Department's position, *Gorzalka* v. *Big Horn Coal Co.,* 16 Black Lung Rep. 1–48, 1–51 (1990) (and cases collected), the only court of appeals to consider the issue has agreed with the Department. *Director, OWCP* v. *Mangifest,* 826 F.2d 1318 (3d Cir. 1987). The Department adheres to this view with respect to any evidence developed in conjunction with a claim by any party before the effective date of the proposed regulations.

(g) Two comments approve of the prospective application of the quality standards. One comment approves of the ''substantial compliance'' standard.

(h) No other comments have been received concerning this section, and no changes have been made in it.

20 CFR 718.102

(a) In the initial notice of proposed rulemaking, the Department proposed three minor changes to § 718.102: eliminating the reference to the compliance standard in light of the substantial compliance language of general applicability in § 718.101(b); adding language presuming compliance with the technical criteria for chest x-rays in Appendix A; and correcting a typographical error in subsection (e) which cited to a nonexistent regulation. 62 FR 3342 (Jan. 22, 1997). The Department did not propose any additional changes in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999). In the final rule, the Department has changed subsection (e) to clarify the probative value of noncomplying x-rays in the case of a deceased miner. Specifically, this provision states that an x-ray, which is not in substantial compliance with the quality standard, may still establish the presence or absence of pneumoconiosis if the x-ray is of sufficient quality for a board-eligible radiologist, board-certified radiologist, or ''B'' reader to interpret the film. The Department has also added a sentence to subsection (b) to inform interested parties where they may obtain a copy of the ILO classification.

(b) One comment argues that § 718.102(b) should state that an x-ray cannot establish the absence of pneumoconiosis unless it complies with the quality standards and is classified according to a recognized scheme. The commenter further argues that § 718.102(b) and (e), in conjunction with § 718.101(b), are insufficient to impose this requirement. Section 718.102(b) identifies the classification systems which are acceptable for black lung claims. Subsection (e) states that no x-ray may demonstrate either the presence or absence of pneumoconiosis unless it complies with reporting requirements, *i.e.,* paragraph (b). Section 718.101(b) reinforces this requirement by stating that ''any evidence'' which is not in substantial compliance with the applicable quality standard cannot ''establish the fact for which it is proffered.'' For purposes of the quality standards, ''substantial compliance'' may mean less than strict compliance with each and every requirement of the applicable quality standard if the evidence is nevertheless deemed reliable by the factfinder. The adjudicator must determine whether the x-ray reading is, or is not, in substantial compliance if one or more items of required information have been omitted, including classification of x-ray findings according to any of the reporting schemes in § 718.102(b). In some circumstances, the adjudicator may determine that the x-ray interpretation provides sufficient information to make a factual finding on the presence or absence of pneumoconiosis. For example, the physician may describe the film findings in terms of ''no pneumoconiosis,'' rather than classifying the film as ''0/-, 0/0 or 0/1.'' Such a reading may be considered sufficiently detailed to be in ''substantial compliance'' notwithstanding the lack of classification. Conversely, the physician's description or reporting of x-ray film findings may indicate (s)he read the film for reasons unrelated to diagnosing the existence of pneumoconiosis, *e.g.,* lung cancer or cardiac surgery. The adjudicator may consider that evidence not in substantial compliance because it does not reliably address the presence or absence of pneumoconiosis. Accordingly, the Department disagrees with the commenter's position that any unclassified x-ray is not in ''substantial compliance'' with § 718.102.

(c) Four comments suggest adding the phrase ''in and of itself'' to the subsection (e) prohibition on using unclassified x-rays to demonstrate the presence or absence of pneumoconiosis. The comments contend that the change would make clear that x-ray evidence of some disease process, in conjunction with other evidence, could be used to prove the miner has a lung disease caused by coal dust exposure, *i.e.,* ''legal'' pneumoconiosis. The recommended change is unnecessary. An unclassified x-ray which yields positive indications of lung disease cannot establish the presence of pneumoconiosis under § 718.202(a)(1), which is intended as a means of proving only the existence of clinical pneumoconiosis. An x-ray report, however, may also be part of a medical report which must be considered under § 718.202(a)(4). Even an unclassified x-ray may therefore provide some clinical basis for a diagnosis of a respiratory disease arising out of coal mine employment under that section. Consequently, provision is already made for consideration of the results of an unclassified x-ray in the context of a medical report. In this context, it may be used to support a diagnosis of legal pneumoconiosis.

(d) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.103

(a)(i) The Department proposed amending § 718.103 in the initial notice of proposed rulemaking to take into account proposed § 718.101(b), which would establish a single standard of ''substantial compliance'' for all of the quality standards. 62 FR 3342 (Jan. 22, 1997). The Department also proposed changes to § 718.103(c) to harmonize it with § 718.102(e) (X-rays). Both provisions operate in the same manner and for the same purposes: to presume compliance with technical requirements in the applicable appendices to part 718; to permit rebuttal of the presumed compliance with relevant evidence; and to permit exceptions to the quality standards for a deceased miner if the claim presents limited evidence. (ii) In response to comments received concerning the initial notice of proposed rulemaking, the Department recommended several additional changes to § 718.103 in the second notice of proposed rulemaking. 64 FR 54975–76 (Oct. 8, 1999). One physician testified at the Washington, D.C., hearing that a flow-volume loop provided a more acceptable basis for obtaining verifiable test results than the proposed prohibition on an initial inspiration from room air. The Department agreed, and proposed changing both § 718.103 and Appendix B to require flow-volume loops for every pulmonary function test obtained after the effective date of the final regulation. The Department invited additional comment on this proposal. The Department also announced its intention to survey clinics and facilities which specialize in the treatment of pulmonary conditions to ascertain the extent to which they already used spirometers capable of producing flow-volume loops. The same physician observed that 20 CFR 718.103(a) (1999) required that pulmonary function

testing produce either a Forced Vital Capacity (FVC) or a Maximum Voluntary Ventilation (MVV) result, yet also required a one-second Forced Expiratory Volume (FEV1) which must be derived from the FVC. The Department agreed the regulation was inconsistent, and proposed a revision to § 718.103(a) making the FVC a required result along with the FEV1 and the MVV optional. The Department also proposed increasing the allowable difference between the two largest MVV values from 5 percent to 10 percent in § 718.103(b) to harmonize the regulation with Appendix B. The former and initially proposed § 718.103(b) required submission of three tracings of the MVV maneuver unless the two largest MVV results were within 5 percent of each other, in which case only two tracings were necessary. By contrast, Appendix B has consistently stated that the variation between the two largest MVV shall not exceed 10 percent. The Department chose the more liberal variation. The Department agreed that the validity of the MVV and FEVl/FVC values must be assessed independently, and that the MVV maneuver is optional for compliance purposes. The Department, however, rejected the suggestion to remove certain technical requirements from the quality standards to avoid invalidating a pulmonary function test for less than strict compliance; the Department responded that the ''substantial compliance'' standard would allow a party to establish the credibility of the study, notwithstanding the absence of one or more of the § 718.103 requirements. Finally, the Department proposed revisions to §§ 718.104(a)(6) and 718.204(b)(2)(iv) to recognize that a medical report cannot be rejected for lack of a pulmonary function study if the performance of the test was medically contraindicated. (iii) For the final rule, the Department has changed the word ''submitted'' in § 718.103(b) to ''developed'' to conform the regulation to similar usage in § 718.101(b). The Department also changed the opening phrase of the first sentence in § 718.103(c) to clarify that paragraph (c) is an exception to the remainder of § 718.103. Finally, the Department amended the final sentence in subsection (c) to make clear that a noncomplying pulmonary function test involving a deceased miner may be used to establish the presence or absence of a respiratory or pulmonary impairment under limited circumstances. If no complying test is in the record and, in the adjudicator's opinion, the noncomplying test yielded technically valid results and the miner provided good cooperation, the party submitting the noncomplying test may rely on it.

(b) The Department announced its intention in the second notice of proposed rulemaking to conduct a survey of the physicians, clinics and facilities which perform pulmonary function testing (spirometry testing) to evaluate the prevalence of spirometers capable of producing a flow-volume loop. The Department considered the survey necessary in light of its conclusion that the flow-volume loop may provide a ''more reliable method of ensuring valid, verifiable results in pulmonary function testing.'' 64 FR 54975 (Oct. 8, 1999). The Department also cited the relatively inexpensive cost (approximately $2000) for a spirometer capable of producing the flow-volume loop. The Department sent out the survey, dated March 7, 2000, to approximately 1800 pulmonary clinics, facilities and physicians board-certified in internal medicine with a subspecialty in pulmonary disease (Rulemaking Record Ex. 107), and received 225 responses (Rulemaking Record Ex. 109). Of those responses, only nine indicated they did not perform pulmonary function testing on equipment producing a flow-volume loop. Of those nine, five indicated they would consider obtaining the necessary equipment. An additional 19 surveys did not respond to the questions concerning spirometric testing. The remaining respondents, 197 in all, unanimously used the flow-volume loop. Based on these survey results, the Department concludes the benefit to the claims adjudication process in obtaining reliable pulmonary function data warrants revising § 718.103(a) and Appendix B to make the flow-volume loop a mandatory requirement for any pulmonary function test conducted after the effective date of these regulations in connection with a claim for benefits under the Black Lung Benefits Act (BLBA).

(c) One comment opposes the flow-volume loop requirement because spirometric equipment which records this data may not be universally available. The Department disagrees. In the second notice of proposed rulemaking, the Department proposed using the flow-volume loop because it provides a reliable and relatively inexpensive means of producing valid, verifiable pulmonary function test results. 64 FR 54975 (Oct. 8, 1999). The Department's survey of physicians, clinics and facilities which perform pulmonary function testing confirmed the widespread use of spirometers capable of producing flow-volume loops. Although some clinics and individual physicians may not utilize such machines, the Department has concluded that the overall benefit to the claims adjudication process warrants required use of this technology. In any event, the claimant should always have access to one set of testing which complies with the quality standards, including the flow-volume loop requirement, as a result of the pulmonary examination authorized by 30 U.S.C. 923(b). This provision of the BLBA requires the Black Lung Disability Trust Fund to afford each miner-claimant the opportunity to substantiate his or her claim by means of a complete pulmonary examination at no expense to the claimant. *See* also § 725.406(a). Under § 725.406(c), the district director is responsible for ensuring that the examination authorized by 30 U.S.C. 923(b) is in ''substantial compliance'' with the requirements of part 718, including the quality standards. Section 725.406(d) requires the Department to make available to the claimant's physician, on the claimant's request, the clinical test results obtained in conjunction with the pulmonary examination. Thus, contrary to the commenter's concern, the claimant's physician should routinely be able to consider substantially complying clinical testing of the miner in formulating an opinion, despite the lack of capable technology in his or her own practice.

(d) One comment approves of the § 718.103 revisions generally, and particularly approves of the language making clear that the Maximum Voluntary Ventilation maneuver is optional. One comment supports the use of flow-volume loops and changes to § 718.103(a) which eliminate internal inconsistencies and clarify that the Maximum Voluntary Ventilation maneuver is optional. One comment approves of requiring pulmonary function test results using flow-volume loops and the increase from 5 percent to 10 percent in the maximum variation between the two largest MVV values.

(e) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.104

(a)(i) The Department proposed several changes to § 718.104 in the initial notice of proposed rulemaking. 62 FR 3342–43, 3375 (Jan. 22, 1997). One change required that each medical opinion developed in connection with a claim be based on specified tests and information, including a chest x-ray and pulmonary function study which comply with the applicable quality standards. Another change proposed

guidelines for the adjudicator to determine whether to afford special weight to an opinion from the miner's treating physician. The Department considered codification of the treating physician's special status appropriate, given its longstanding judicial recognition in the caselaw. In order to ensure a critical analysis of the physician-patient relationship, the guidelines described four basic factors the adjudicator must consider: whether the physician provided pulmonary or non-pulmonary treatment; how long the physician treated the miner; how often the physician treated the miner; and what types of tests and examinations the physician conducted. Finally, the Department emphasized that the adjudicator must consider not only the quality of the physician's relationship with the miner, but also the reasoning and documentation in the opinion itself, and in the context of the remainder of the record, before crediting that opinion. (ii) In the second notice of proposed rulemaking, the Department responded to the extensive comments which the proposed regulation had elicited. 64 FR 54976–77 (Oct. 8, 1999). The Department revised the regulation to excuse mandatory pulmonary function testing if it was medically contraindicated and the physician conducted other types of medically accepted diagnostic tests; to make explicit that a treating physician's opinion could be used to establish all elements of a miner's entitlement; and to accept the physician's statement as to subsection (d)'s treating relationship criteria, absent contrary evidence from another party. The Department rejected comments which advocated the automatic acceptance of a treating physician's opinion if it satisfied the criteria of subsections (d)(1) through (5) and was documented and reasoned, regardless of the remaining medical evidence. The Department also rejected one comment which contended the regulation already mandated the automatic acceptance of a treating physician's opinion in violation of 30 U.S.C. 923(b) (requiring consideration of all relevant evidence). In response, the Department emphasized that § 718.104(d) only required the adjudicator to consider the possible enhanced value of a treating physician's opinion, and did not require a mechanistic acceptance of that opinion. The Department responded in similar fashion to several comments which contended that all medical opinions, including a treating physician's opinion, should be evaluated only on the strength of their documentation and reasoning and each physician's professional qualifications. With respect to a comment recommending placement of the treating physician rule in a separate regulation, the Department concluded no change was warranted; subsection (d)'s position in the quality standards governing reports of physician examinations underscored that a treating physician's opinion was required to satisfy the same quality standards as any other physician examination report developed in connection with a claim for benefits. The Department acknowledged some commenters' concern that unrepresented claimants would likely submit noncomplying reports from their treating physicians. The Department, however, rejected the suggestion that treating physicians' opinions should be exempted from the evidentiary limitations for that reason. Instead, the Department noted its own obligation to inform claimants in an understandable manner about the evidentiary limitations, and to provide any claimant's treating physician with the results of the § 725.406 objective testing upon the claimant's request. The Department denied one comment's suggestion that language in the initial notice of proposed rulemaking (*see* 62 FR 3339 (Jan. 22, 1997)) made an adjudicator's failure to consider a physician's training and specialization reversible error. In the Department's view, a physician's qualifications were an issue only when raised by a party. The Department also rejected the suggestion that a chest x-ray, administered and read in accordance with § 718.102, not be mandatory documentation for a complying report of physical examination. The Department cited the importance of such a diagnostic test and the flexibility of the ''substantial compliance'' standard in excusing noncompliance depending on the particular circumstances of the case. In response to two comments, the Department declined to remove a limitation on the use of noncomplying medical opinions. The regulation therefore allowed consideration of reports of physical examination not in substantial compliance with § 718.104 only if the miner was deceased, the physician was unavailable to cure the defects in the report, and there was no complying report in the record. In explanation, the Department emphasized that entitlement decisions must be based on the best available evidence. Finally, the Department invited additional public comment on alternative means of determining when a treating physician's opinion should receive ''controlling weight,'' including whether the Department should adopt the Social Security Administration's rule. (iii) For purposes of the final rule, the Department has altered subsection (c) to conform this provision to the general ''substantial compliance'' standard in § 718.101(b). As amended, § 718.104(c) makes clear that a noncomplying report of physical examination may nevertheless provide evidence for a factual finding in certain limited circumstances involving a deceased miner and the lack of any complying report of physical examination in the record. The report must have been prepared by a physician who is ''unavailable,'' *e.g.,* deceased, whose whereabouts are unknown, etc. The report must also be found to possess sufficient indicia of reliability that the adjudicator may reasonably rely on it for factual findings.

(b) Several comments oppose granting special weight to the opinion of a miner's treating physician, contending the rule either intrudes on the adjudicator's role in evaluating evidence or compels the acceptance of an opinion from the treating physician regardless of contrary opinions from physicians with greater expertise in pulmonary medicine. The Department responded to a similar criticism in the second notice of proposed rulemaking. 64 FR 54976 (Oct. 8, 1999). In rejecting a commenter's view that § 718.104(d) effectively precluded consideration of all relevant evidence in favor of the opinion of the miner's treating physician, the Department emphasized the real purpose of the rule: to recognize that a physician's professional relationship with the miner may enhance his or her insight into the miner's pulmonary condition. The Department does not believe that, as proposed, section 718.104(d) contained an outcome-determinative evidentiary rule. *See* 64 FR 54977 (Oct. 8, 1999). The Department has revised the language of section 718.104(d), however, in light of several commenters' continued confusion as to the role of § 718.104(d) in weighing reports of physical examinations. The Department hopes to clarify its original intent with this revision. Like the previously proposed version, subsection (d) acknowledges the special weight which the opinion of a miner's treating physician may receive from the adjudicator. Section 718.104(d)(1)–(4) provide criteria for evaluating the quality of that doctor-patient relationship as indicia of the potential insight the physician may have gained from on-going treatment of the miner.

Instead of compelling the automatic acceptance of the treating physician's opinion, section 718.104(d) is designed to force a careful and thorough assessment of the treatment relationship. The adjudicator may conclude that no additional weight is due the physician's opinion because one or more of the criteria establish facts which make such weight inappropriate. For example, the physician may have provided only a short-term course of treatment, or have actually examined the miner only infrequently. The adjudicator should consider giving additional weight to the treating physician's opinion only when review of the regulatory criteria establishes the physician's thorough understanding of the miner's pulmonary condition. Subsection (d)(5) describes the next step in the adjudicator's inquiry: the adjudicator must consider whether the treating physician's opinion is supported by sufficient documentation and reasoning, and must weigh it with all other reasoned and documented medical opinions in the record. In addition, the fact finder must consider all other relevant evidence of record. The regulation provides that only after the adjudicator finishes this weighing may he, in appropriate cases, base his decision to give ''controlling weight'' to the opinion of the miner's treating physician on that physician's superior understanding of the miner's pulmonary condition. The Department recognizes that each case will present different issues regarding both the extent to which the treating physician meets the four criteria in subsection (d)(1)–(4), the documentation and reasoning of that physician's opinion, and the relative merits of the other relevant medical evidence of record. As a result, the regulation does not attempt to dictate the outcome of any particular case. The Department therefore rejects the position that § 718.104(d) intrudes on the fact-finding responsibilities of the adjudicator.

(c) One comment opposes requiring each physician's opinion to include an x-ray or pulmonary function study conducted according to the applicable quality standards. The commenter suggests these tests are not always necessary for a relevant and credible opinion, and cites three examples: (i) A physician diagnoses an obstructive lung impairment based on valid pulmonary function testing, examination, etc., but does not obtain an x-ray. With respect to the mandatory x-ray requirement, the Department has previously addressed this argument in the second notice of proposed rulemaking, 64 FR 54977 (Oct. 8, 1999), and reiterates its position in responding to comments under § 718.101 of this rule. X-rays are an integral part of any informed and complete pulmonary evaluation of a miner; a general requirement for inclusion of this test is therefore appropriate. The Department also notes, however, that the quality standards require only ''substantial compliance'' with the various criteria, not technical compliance with every criterion in every quality standard in every case. A factfinder may conclude the omission of an x-ray does not undermine the overall credibility of the opinion, but this determination must be made on a case-by-case basis. The same commenter poses this example in the context of § 718.101. The Department's response to that hypothetical makes certain critical assumptions in concluding the physician's opinion may be found in ''substantial compliance'' with the quality standards: the valid pulmonary function study demonstrates the presence of a pulmonary/respiratory impairment; the physician's examination of the miner identifies signs or symptoms of a pulmonary condition; and the physician has an accurate understanding of the miner's employment, smoking and personal histories. If the clinical tests and other information provide a documented basis for a reasoned and reliable opinion, the factfinder may find the diagnosis of ''legal pneumoconiosis'' in ''substantial compliance'' with § 718.104 despite the absence of the x-ray. (ii) A physician finds complicated pneumoconiosis on an x-ray, but does not conduct a pulmonary function test. One means of diagnosing complicated pneumoconiosis is by x-ray. 30 U.S.C. 921(c)(3)(A). The x-ray evidence is relevant to §§ 718.202(a)(3) and 718.304(a); accordingly, § 718.102 provides the applicable quality standards, and not § 718.104. The lack of a pulmonary function study does not affect the probative value of the x-ray reading(s) as evidence of complicated pneumoconiosis under 30 U.S.C. 921(c)(3)(A), because a pulmonary function study is not relevant to that means of invoking the irrebuttable presumption. Although all relevant evidence must be weighed in determining whether the miner has complicated pneumoconiosis, *Melnick* v. *Consolidation Coal Co.,* 16 Black Lung Rep. 1–31, 1–33 (1991), the evidence must pertain to the means of diagnosing or refuting the existence of complicated pneumoconiosis as provided by 30 U.S.C. 921(c)(3)(B) and (C). *Cf. Double B Mining* v. *Blankenship,* 177 F.3d 240, 243 (4th Cir. 1999) (holding factfinder must determine whether evidence relevant to each method of invoking irrebuttable presumption is ''equivalent,'' and establishes same underlying condition). The physician's report may provide additional valuable insight into his or her reasons for interpreting the x-ray as positive for complicated pneumoconiosis rather than some other condition detectable by x-ray; to that extent, the report may be relevant to weighing the credibility of the x-ray evidence. As a report of physical examination, however, the hypothetical report does not satisfy the ''substantial compliance'' standard. (iii) In his report of physical examination, a physician relies in part on a noncomplying pulmonary function test, but another complying test yields comparable results. Again, ''substantial compliance'' is a test of evidentiary reliability based on all relevant circumstances of the particular case. The factfinder must evaluate those circumstances and determine whether the specific omission undermines the credibility of the evidence. In the hypothetical, the factfinder must consider not only the defects in the physician's pulmonary function study, but also the remaining documentation in the report (other clinical studies, the miner's employment, smoking and personal information, *etc.*). If the report otherwise complies with § 718.104, the invalid pulmonary function study may be mitigated by the presence of a complying study which confirms the physician's interpretation of the invalid study.

(d) One comment supports the revision of § 718.104(a)(6) in the second notice of proposed rulemaking, which exempts a miner from mandatory pulmonary function testing if the test is medically contraindicated, and allows a physician preparing a report of physical examination to substitute other medically acceptable clinical and laboratory diagnostic techniques in support of his conclusions. 64 FR 54976, 55011 (Oct. 8, 1999).

(e) One comment recommends the Department delete the conditions in § 718.104(c) that, in the case of a deceased miner, limit the consideration of a report from a physician who is not available if the report is not in substantial compliance with the quality standards. This provision permits the adjudicator to base a finding on such evidence only if the record does not contain any physician's report which is in substantial compliance. No change in the regulation is necessary. Although ''substantial compliance'' is a flexible

concept, it is also necessary to ensure that claims are adjudicated using the most reliable evidence available. Consequently, the Department has incorporated limitations throughout the quality standards on the use of noncomplying evidence in claims involving deceased miners in which there is no complying evidence of record. The fact that a miner is deceased is not necessarily a bar to rehabilitating noncomplying evidence. With respect to reports of physical examination, the physician who is available to review and further comment on his or her own report may cure the defect and bring the report into substantial compliance. If, however, the physician is unavailable, § 718.104(c) permits noncomplying evidence to be considered if there is no complying evidence of record. The Department believes noncomplying evidence should be used to establish facts about a deceased miner's condition only when no practical alternative is available. As long as complying evidence or the means of achieving compliance exist, noncomplying evidence should not be the basis for determining the validity of a claim.

(f) One comment objects to the retroactive application of the changes made to § 718.104. None of these changes, however, apply retroactively. Section 718.101(b) provides that the ''standards for the administration of clinical tests and examinations'' will govern all evidence developed in connection with benefits claims after the effective date of the final rule. Section 718.104 contains the quality standards for any ''[r]eport of physical examinations,'' including reports prepared by a miner's treating physician. Physicians' medical reports are expressly included in the terms of § 718.101(b). Consequently, the changes to § 718.104 apply only to evidence developed after the effective date of the final rule. With respect to treating physicians' opinions developed and submitted before the effective date of the final rule, the judicial precedent summarized in the Department's initial notice of proposed rulemaking continues to apply. *See* 62 FR 3342 (Jan. 22, 1997). These decisions recognize that special weight may be afforded the opinion of a miner's treating physician based on the physician's opportunity to observe the miner over a period of time.

(g) Two comments state the ''treating physician'' rule has no scientific basis because a treating physician is in no better position than any other physician to assess a miner's pulmonary status. The commenters note that a primary care physician will often, as a matter of medical practice, refer an individual to a physician with particular training for specialized care; the primary care provider may therefore have little, if any, qualified understanding of the patient's health problems. The commenters also state that the essential basis for a reasoned diagnosis is valid objective testing and sound interpretation of the data rather than patient complaints and physical examinations. Finally, the commenters conclude that frequency of contact alone does not provide any advantage for a physician in developing a comprehensive understanding of the patient's condition. The commenters' concerns do not provide a basis for abandoning the rule. First, the miner's ''treating physician'' is not necessarily the physician with whom the miner has a long-standing generalized relationship if another physician actually provides specialized treatment for respiratory or pulmonary problems. If the miner's primary care provider refers the miner to a pulmonary specialist for treatment, then that specialist may be considered the miner's ''treating physician'' for purposes of his or her pulmonary condition. If, however, the specialist provides an opinion to the primary care physician which forms the basis for the miner's treatment by the latter, the primary care physician's opinion is strengthened by reliance on the specialist's expertise. Second, the Department agrees that valid clinical testing and a reasoned medical report are necessary prerequisites for a credible medical opinion. A treating physician's opinion is subject to the Department's quality standards, which require the report to be based on specific clinical tests, findings and other data and information. See § 718.104(a)(l)-(6). A treating physician's report must be reasoned as well as documented (§ 718.104(d)(5)). In this regard, a treating physician's opinion is no different than any other physician's opinion developed in connection with a claim for benefits. The Department does not intend to displace the long-standing judicial precedent that sanctions the rejection of a treating physician's report if it fails the basic requirements for credible evidence. *See, e.g., Sterling Smokeless Coal Co.* v. *Akers,* 131 F.3d 43 8, 441 (4th Cir. 1997); *Lango* v. *Director, OWCP,* 104 F.3d 573, 577 (3d Cir. 1997); *Peabody Coal Co.* v. *Helms,* 901 F.2d 571, 573–74 (7th Cir. 1990); *see generally Halsey* v. *Richardson,* 441 F.2d 1230, 1236 (6th Cir. 1971) (rejecting ''a mechanical rule insulating a treating doctor's opinion from attack, no matter how respectable and persuasive may be opposing opinions by doctors who examined a claimant on only one occasion''). As for the commenters' statement that the frequency of patient contact provides no advantage to a physician, this view is too simplistic. Frequency of treatment is only one of the regulatory criteria (§ 718.104(d)(3)) the adjudicator must consider in assessing the treating physician relationship. The number of visits must be viewed in the context of the other criteria (nature of relationship, duration of relationship, type and extent of treatment). The totality of the information demanded by the criteria establishes the overall quality of the doctor-patient relationship, which guides the adjudicator in determining whether to accord the treating physician's opinion controlling weight. The comments do not state a basis for changing or eliminating the ''treating physician'' rule.

(h) Two comments contend the ''treating physician'' rule creates an ''evidentiary preference'' which violates section 7 of the Administrative Procedure Act (APA), 5 U.S.C. 556. Although the Social Security Administration (SSA) has also promulgated a regulation, 20 CFR 404.1527(d) (1999), addressing the weight to be given a treating physician's opinion, the commenters argue there is no adverse party in SSA claims, and the APA does not apply to SSA claims adjudication. By implication, the commenters suggest the Department cannot adopt a ''treating physician'' rule comparable to the SSA model, or any rule which affords special weight to a treating physician's opinion. The Department disagrees. As an initial matter, whether the APA does or does not apply to SSA claims adjudications is irrelevant to evaluating the validity of § 718.104(d). The Supreme Court has expressly refused to resolve the issue because ''the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.'' *Richardson* v. *Perales,* 402 U.S. 389, 409 (1971). In any event, the commenters misapprehend both the nature of § 718.104(d) and the critical differences between that regulation and the SSA version. The commenters describe the ''treating physician'' rule as an ''evidentiary preference.'' The Department interprets this phrase to characterize the rule as a burden-shifting presumption which imposes on the party opposing the claim the burden to overcome the ''preference'' for the treating physician's opinion. The Department, however, has repeatedly emphasized in the second

notice of proposed rulemaking and its responses to comments in this rule that § 718.104(d) does not create a presumption in favor of the treating physician's opinion. *See* 64 FR 54976–77 (Oct. 8, 1999). The regulation provides a set of criteria to guide the adjudicator's evaluation of the treating physician's professional relationship with the miner, and ensure a critical and thorough factual determination whether that opinion should ultimately be given ''controlling weight.'' Aside from assessing the strength or weakness of the treating physician's report, the adjudicator must also weigh that report against all other relevant evidence in the record. Consequently, § 718.104(d) is not a strict, outcome-determinative rule like more traditional evidentiary presumptions. These characteristics also distinguish § 718.104(d) from SSA's version in 20 CFR 404.1527(d). Both regulations state that ''controlling weight'' may be given to a treating physician's report. Section 404.1527(d), however, provides that ''[g]enerally, we give more weight to opinions from your treating sources, * * *.'' 20 CFR 404.1527(d)(2) (1999). This language demonstrates an affirmative preference for reports from treating physicians; § 718.104(d) is more qualified in permitting ''controlling weight'' only if the regulatory criteria warrant it. Another significant difference between the regulations is the role the criteria play in determining the weight given the medical evidence. Section 404.1527(d) makes the criteria relevant only after the adjudicator refuses to give the treating physician ''controlling weight:'' ''Unless we give a treating source's opinion controlling weight * * * we consider all of the following factors in deciding the weight we give to any medical opinion.'' The regulation lists several criteria which are similar to those listed in § 718.104(d)(l)-(4). Section 718.104(d) makes the same criteria the basis for determining in the first place whether to give the treating physician controlling weight. To the extent 20 CFR 404.1527(d) operates like an evidentiary presumption, it does not affect the validity of § 718.104(d) because § 718.104(d) clearly is not a presumption in favor of the treating physician's opinions. Accordingly, the Department rejects the commenters' position that the rule violates the APA.

(i) Three comments oppose the requirement in § 718.104(d)(5) that the adjudicator must weigh a treating physician's opinion against the contrary relevant evidence in the record. One comment states that affording a treating physician's opinion ''controlling weight'' is meaningless unless the adjudicator may accept the opinion despite a reasoned and documented contrary opinion by a pulmonary specialist submitted by another party; otherwise, according to the commenter, a treating physician's opinion will prevail only when it echoes similar opinions from other physicians. Another comment interprets subsection (d) as a burden-shifting device which affords the treating physician's opinion presumptive controlling weight unless the opposing party overcomes that opinion by a preponderance of the evidence. The Department has previously responded to comments contending that a treating physician's opinion should receive conclusive weight once the adjudicator reviews the opinion in light of the criteria enumerated in subsection (d)(1)–(4). 64 FR 54976 (Oct. 8, 1999). The Department rejected this position because it artificially limits the adjudicator's consideration of the evidence, and may promote a mechanistic and uncritical acceptance of the treating physician's opinion at the expense of more credible contrary evidence. No basis for departing from this position is established by the new comments. The Department emphasizes that the ''treating physician'' rule guides the adjudicator in determining whether the physician's doctor-patient relationship warrants special consideration of the doctor's conclusions. The rule does not require the adjudicator to defer to those conclusions regardless of the other evidence in the record. The adjudicator must have the latitude to determine which, among the conflicting opinions, presents the most comprehensive and credible assessment of the miner's pulmonary health. For the same reasons, the Department does not consider subsection (d) to be an evidentiary presumption which shifts the burden of production or persuasion to the party opposing entitlement upon the submission of an opinion from a miner's treating physician. Accordingly, the Department declines to eliminate the requirement in subsection (d)(5) that a treating physician's opinion must be considered in light of all relevant evidence in the record.

(j) One comment objects to comparing a treating physician's qualifications to those of any other physician in the record. The commenter suggests comparative qualifications may provide a basis for refusing controlling weight to the treating physician's opinion if another physician has superior credentials. The Department responded to a similar comment in the second notice of proposed rulemaking, and noted that professional credentials are only one factor the adjudicator may consider in weighing medical opinions. 64 FR 54977 (Oct. 8, 1999). No basis exists, however, for insulating the treating physician from a consideration of his or her qualifications, or prohibiting giving additional weight to the opinion of a physician with specialized training in a relevant area of medicine. Although expertise is only one of several potentially relevant factors to consider, it is nonetheless a significant consideration. *See, e.g., Milburn Colliery Co.* v. *Hicks,* 138 F.3d 524, 536 (4th Cir. 1998). Furthermore, the commenter's concern over comparative qualifications overlooks an important consideration underlying the ''treating physician'' rule. In black lung benefits claims, the principal issue ordinarily is the miner's pulmonary condition. The treating physician may develop a more in-depth knowledge and understanding of that issue than a physician with greater academic credentials and minimal, or nonexistent, contact with the miner. The purpose of the § 718.104(d) criteria is to enable the adjudicator to determine whether the treating physician has such informed knowledge that his or her opinion merits special weight.

(k) One comment suggests a consultative physician's opinion should receive the same weight accorded a treating physician if the consultant relies on the treating physician's report, the results of clinical tests, medical records, etc., and the consulting report satisfies the § 718.104(d) criteria. The Department rejects this suggestion. If any physician (other than the treating physician) could receive enhanced weight by incorporating consideration of the treating physician's opinion into his or her consulting opinion, the consultative physician(s) for each party would stand on equal footing based on access to the treating physician's report. No reason would therefore exist for the rule. In any event, a consultative physician's reliance on the treating physician's report does not necessarily confer the same benefit the treating physician may derive from the nature, duration, frequency and extent of treatment during the physician-patient relationship with the miner.

(l) Two comments oppose making the quality standards applicable to the report of physical examination prepared by a miner's treating physician. The commenters suggest removing subsection (d) from § 718.104 and making it a separate regulation. The Department rejected the identical

argument in the second notice of proposed rulemaking. 64 FR 54976–77 (Oct. 8, 1999). The Department intends the quality standards to apply to any physician's report developed in connection with a claim for benefits, including any report prepared by a treating physician. Although a treating physician may have a superior perspective on the miner's health in certain circumstances, status alone does not guarantee the validity of the physician's opinion.

(m) Two comments recommend allowing a miner or a miner's family members to attest to the nature of the miner's relationship with his or her treating physician. The Department disagrees. Although persons other than the physician may have some direct knowledge of the miner's treatment, only the physician can provide a complete picture of the doctor-patient relationship, as well as documentary evidence of the specific clinical tests conducted. In addition, if representations as to the criteria in (d)(1) through (4) are challenged, it is the physician's records, including treatment notes, etc., which will enable the adjudicator to evaluate the quality of the relationship. Evidence from persons other than the physician may supplement the physician's characterization of the miner's treatment, but the physician (or the physician's records) remains the best primary source for depicting the miner's treatment.

(n) In the second notice of proposed rulemaking, the Department invited comment on alternatives to the revised ''treating physician'' rule, including whether to adopt a version of the rule comparable to the Social Security Administration's (SSA) regulation, 20 CFR 404.1527(d) (1999). 64 FR 54976 (Oct. 8, 1999). (i) Two comments oppose in general terms using the SSA regulation to evaluate the treating physician's opinion. (ii) One comment recommends incorporating language from the SSA regulation that more weight should ''generally'' be given a miner's treating physician. *See* 20 CFR 404.1527(d)(2) (1999). The commenter opposes any other use of the SSA regulation. The additional language is inappropriate. *See* paragraph (h), above. Section 718.104(d) outlines the circumstances in which a treating physician may be afforded ''controlling weight'' on entitlement issues. Although the regulation recognizes the special value which may attach to a treating physician's report in certain circumstances, the Department does not intend to deflect attention from the necessity for critical examination of the physician's reasoning and documentation. The Department has previously explained the intended limits of section 718.104(d) as an evidentiary rule which guides consideration of a treating physician's opinion but does not impose a strict outcome. 64 FR 54977 (Oct. 8, 1999). The recommended additional language does not further this purpose. Accordingly, the recommendation is rejected. (iii) No comment recommended adopting the SSA regulation in place of the regulation as proposed by the Department.

(o) Several comments approve generally of the ''treating physician'' rule.

(p) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.105

(a)(i) In the initial notice of proposed rulemaking, the Department proposed amending § 718.105 to address arterial blood gas studies which are administered during a miner's terminal hospitalization, *i.e.,* ''deathbed'' studies. 62 FR 3342–43 (Jan. 22, 1997). Specifically, the Department expressed concern that such studies may produce qualifying values for reasons unrelated to chronic pulmonary disease. The Department therefore suggested a new requirement that a claimant must submit a physician's report linking the blood gas study results to a chronic pulmonary condition caused by exposure to coal mine dust in order to rely on the qualifying results as evidence of total disability. 62 FR 3375 (Jan. 22, 1997). (ii) In response to comments received, the Department deleted the requirement that, in the case of blood gas studies administered during a hospitalization that ends in the miner's death, the chronic pulmonary condition must be shown to be related to the miner's exposure to coal mine dust; the Department agreed the causation requirement was inappropriate because § 718.105 addresses the existence of a chronic pulmonary impairment, and not its source. 64 FR 54977–78 (Oct. 8, 1999). The Department also agreed to a minor change in technical nomenclature by changing ''p'' to ''P'' to denote partial pressure. Finally, the Department rejected those comments which opposed requiring the claimant to establish a link between a miner's ''deathbed'' blood gas study and a chronic pulmonary condition. The Department concluded the proposed requirement was necessary because the miner's qualifying test results during a terminal hospitalization may be related to an acute non-pulmonary condition rather than a chronic pulmonary impairment. 64 FR 54977 (Oct. 8, 1999).

(b) One comment recommends the Department afford consideration to noncomplying blood gas studies in the case of a deceased miner since such consideration is given elsewhere in the regulations for x-rays (§ 718.102(e)) and pulmonary function studies (§ 718.103(c)). The regulations also outline specific circumstances under which a report of physical examination of a miner now deceased may be considered by an adjudication officer notwithstanding its failure to substantially comply with § 718.104(a) and (b). *See* § 718.104(c), above. The Department agrees, and has revised § 718.105 accordingly by adding subsection (e). This provision is comparable to § 718.103(c), and permits the adjudicator to consider a deceased miner's blood gas studies not in substantial compliance with subsections (a), (b) and (c) if they are the only available tests and, in the adjudicator's opinion, are technically valid. Subsection (e) also requires any such test to meet the requirements of subsection (d) if the test was obtained during a miner's hospitalization ending in death and yielded qualifying values. The claimant must submit a physician's opinion establishing that the qualifying values reflect a chronic pulmonary impairment and not some acute condition unrelated to a chronic pulmonary impairment.

(c) Two comments oppose requiring the claimant to prove a miner's chronic respiratory or pulmonary impairment caused his qualifying ''deathbed'' blood gas results. The commenters argue that the party opposing entitlement should bear the burden of proving a non-respiratory or non-pulmonary condition caused the qualifying results since that party has equal access to the miner's hospital records and physicians. The Department disagrees. The claimant bears the general burden of persuasion to establish entitlement to benefits by a preponderance of the evidence, except to the extent a presumption eases that burden. *See generally Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994). One facet of the claimant's burden is the responsibility to ensure that the clinical tests such as blood gas studies substantially comply with the quality standard. The quality standard provides some assurance to the adjudicator that the clinical test is valid, accurate and reliable evidence of the factual proposition for which it is proffered. The Department considers a physician's opinion necessary to establish a nexus between ''deathbed''

blood gas studies and a chronic pulmonary disease; raw clinical test results under these circumstances are not sufficiently instructive for a lay adjudicator to make such a determination. The fact that the party opposing entitlement may have equal access to relevant information about the circumstances and interpretation of the blood gas testing is not determinative in allocating the burden of persuasion. The Department does not perceive any basis for shifting the overall burden of proof from the claimant to the opposing party in the case of qualifying ''deathbed'' blood gas studies. The comments do not address the Department's explanation in the second notice of proposed rulemaking, 64 FR 54977–78 (Oct. 8, 1999), for imposing this requirement, beyond noting continued opposition. The Department therefore rejects the comments' position.

(d) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.106

(a) The Department proposed minor changes to § 718.106 in the initial notice of proposed rulemaking to account for the adoption of a general standard of substantial compliance with the quality standards (§ 718.101), and to adopt consistent terminology for evidence which is not in substantial compliance with the applicable standard. 62 FR 3343 (Jan. 22, 1997). The Department responded to several comments in the second notice of proposed rulemaking. 64 FR 54978 (Oct. 8, 1999). At the urging of several commenters, the Department restored subsection (c) to § 718.106, explaining that the omission of that provision from the initial proposed version of the regulation was inadvertent. Other comments expressed concern that the requirement for a gross macroscopic inspection of the lungs would preclude reliance on reviewing physicians, who ordinarily review only the autopsy protocol and inspect tissue samples microscopically. The Department responded that only the autopsy itself must include the gross macroscopic inspection of the lungs; the requirement does not extend to opinions prepared by reviewing physicians. Finally, the Department rejected the recommendation of some commenters to adopt the standards for diagnosing pneumoconiosis by autopsy or biopsy set forth in Kleinerman *et al.,* ''Pathologic Criteria for Assessing Coal Workers'' Pneumoconiosis,'' in the *Archives of Pathology and Laboratory Medicine* (1979). The Department emphasized its historic reluctance to adopt specific standards for such diagnoses; the lack of evidence in the record that the medical community agrees on a particular standard; and the lack of evidence indicating the Kleinerman article reflects an accepted standard.

(b)(i) One comment again recommends adopting the criteria for diagnosing pneumoconiosis by autopsy or biopsy contained in the Kleinerman article as the ''accepted'' pathologic standard. The Department has previously noted that the record does not substantiate the existence of a consensus among physicians for making diagnoses using these criteria, or the acceptance of the Kleinerman article as representative of the medical community's views. 64 FR 54978 (Oct. 8, 1999). Indeed, two other commenters commend the Department for refusing to accept these criteria, noting that other pathologists do not agree that this article represents a universal or prevailing standard. One commenter suggests, for example, that Dr. Kleinerman's view that a two-centimeter lesion on autopsy or biopsy is necessary for a diagnosis of complicated pneumoconiosis is not universally accepted, and that other pathologists would require only a one-centimeter lesion. The commenter urging adoption of the Kleinerman criteria does not supply any additional information in support of its recommendation. The Department therefore has no basis in the record for adopting the suggested standard. (ii) One comment cites *Double B Mining, Inc.* v. *Blankenship,* 177 F.3d 240 (4th Cir. 1999), as legal authority for rejecting the Kleinerman article. In that case, the Court considered whether a biopsy diagnosis of a certain-sized fibrotic nodule amounted to a ''massive lesion'' for purposes of proving the miner had complicated pneumoconiosis under 30 U.S.C. 921(c)(3) (irrebuttable presumption of total disability due to pneumoconiosis invoked by proof of complicated pneumoconiosis). The Court cited, among other sources, the Kleinerman article as requiring a minimum two-centimeter nodule to constitute a ''massive lesion.'' The Court declined to adopt the two-centimeter rule because ''[t]he [Black Lung Benefits Act] does not mandate use of the medical definition of complicated pneumoconiosis.'' 177 F.3d at 244. Instead, the Court held the adjudicator must determine whether a particular nodule discovered by biopsy would be equivalent to a one-centimeter opacity if diagnosed by x-ray. The *Blankenship* decision rejects only the mandatory use of the medical community's standards for diagnosing complicated pneumoconiosis by biopsy in view of the court's statutory analysis. The Court does not accept or reject any specific clinical criteria for biopsy diagnoses, and the Department does not interpret the decision as repudiating the Kleinerman article in particular.

(c)(i) Three comments approve of the restored paragraph (c). (ii) Two comments approve of the Department's clarification in the second notice of proposed rulemaking that the § 718.106(a) requirement for a gross macroscopic inspection of the lungs applies only to the autopsy itself and not to a reviewing physician's opinion. 64 FR 54978 (Oct. 8, 1999).

(d) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.107

(a) In the initial notice of proposed rulemaking, the Department proposed a clarification of § 718.107 which addresses medical evidence not otherwise covered by the quality standards. 62 FR 3343 (Jan. 22, 1997). Proposed subsection (b) required the party submitting such evidence to establish that the evidence is medically acceptable and relevant to proving the existence or nonexistence of pneumoconiosis, the sequelae of pneumoconiosis or a ''respiratory impairment.'' The Department responded to comments received from the public in the second notice of proposed rulemaking. 64 FR 54978 (Oct. 8, 1999). The Department changed the reference in subsection (a) from ''respiratory impairment'' to ''respiratory or pulmonary impairment.'' The Department rejected as unnecessary a recommendation that disability and disability causation should be added to the relevant issues because the regulation adequately stated the purposes for which ''other medical evidence'' could be submitted. One comment approved of § 718.107 as proposed in the initial notice of proposed rulemaking.

(b) For purposes of the final rule, the Department emphasizes that § 718.107 as a whole is intended to permit any party to offer any medical test or procedure which may be relevant to any disputed medical issue relating to a claimant's entitlement to benefits provided the requirements of subsection (b) are met.

(c) No other comments were received concerning this section, and no other changes have been made in it.

Subpart C

20 CFR 718.201

(a) In the initial notice of proposed rulemaking, the Department proposed amending § 718.201. 62 FR 3343–44, 3376 (Jan. 22, 1997). The amendments were designed to clarify the regulatory definition and conform it to the statute, which broadly defines pneumoconiosis as ''a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.'' 30 U.S.C. 902(b). To that end, the Department proposed three revisions.

First, the Department inserted the terms ''clinical'' and ''legal'' pneumoconiosis into the regulation to conform it to the terminology uniformly adopted by the courts to distinguish between the two forms of lung disease compensable under the statute: pneumoconiosis, as that disease is defined by the medical community, and any chronic lung disease arising out of coal mine employment. Second, the Department proposed revising the definition to make clear that both restrictive and obstructive lung disease may fall within the definition of pneumoconiosis if shown to have arisen from coal mine employment. Third, the Department proposed a revision to recognize the latent and progressive nature of the disease. The last two changes, for which the Department cited scientific evidence in support, 62 FR 3343–44 (Jan. 22, 1997), were proposed as a result of recent litigation on these issues. The Department specifically sought comments on these revisions.

The Department received numerous favorable and unfavorable comments and testimony on the proposals. 64 FR 54978–79 (Oct. 8, 1999). One commenter objected to the revised definition because it would include all obstructive pulmonary diseases. A number of commenters complained that the Department lacked the statutory authority to implement the proposals, and that 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). Several commenters also argued that the Department's proposed definition was scientifically unsound, and presented testimony from a panel of pulmonary physicians at the Department's July 22, 1997 hearing in Washington, D.C., to substantiate their views. Two commenters contended that because Congress had rejected an amendment to the statutory definition of pneumoconiosis which would have included obstructive lung disorders, the Department could not accomplish the same change through regulation. The Department also received numerous comments in support of the revised definition. Among the favorable comments was one from NIOSH, transmitted by letter dated August 20, 1997 and signed by Dr. Paul A. Schulte, Director of NIOSH's Education and Information Division. Rulemaking Record, Exhibit 5–173. NIOSH supported the Department's proposal to amend the definition to include chronic obstructive pulmonary disease and to reflect the scientific evidence that pneumoconiosis is a progressive condition that may become detectable only after cessation of coal mine employment in some cases. The Department also received favorable comments and testimony from physicians with expertise in pulmonary diseases.

Given the widely divergent comments and testimony received from medical professionals on the proposed regulation, the Department sought additional guidance from NIOSH, notwithstanding the fact that NIOSH had already commented in support of the initial proposal. The Department transmitted a copy of all of the testimony and commentary it had received to Dr. Linda Rosenstock, the Director of NIOSH, and asked NIOSH to determine, in light of the then existing record, whether NIOSH continued to support the Department's proposal. Rulemaking Record, Exhibit 66. NIOSH responded, in a December 7, 1998 letter from Dr. Schulte, that ''[t]he unfavorable comments received by DOL do not alter our previous position: NIOSH scientific analysis supports the proposed definitional changes.'' Dr. Schulte provided additional medical references to support NIOSH's conclusion. Rulemaking Record, Exhibit 72.

The Department responded to the comments it had received in its second notice of proposed rulemaking. 64 FR 54978–79 (Oct. 8, 1999). The Department emphasized that the proposed revision was designed to make clear that obstructive lung disease may fall within the definition of pneumoconiosis, but only if it is shown to have arisen from coal mine employment; thus, the proposed definition would not alter the former regulations' (20 CFR 718.202(a)(4), 718.203 (1999)) requirement that each miner bear the burden of proving that his lung disease arose out of his coal mine employment. The Department also notified the public of NIOSH's December 7, 1998 response, including the additional evidence NIOSH cited. 64 FR 54978–79 (Oct. 8, 1999). Recognizing that Congress created NIOSH as a source of expertise in occupational disease and the analysis of occupational disease research, the Department concluded it saw no scientific or legal basis upon which to alter its proposed change to the definition of pneumoconiosis. The Department further stated its disagreement that Congressional inaction invalidated its proposed revision of the definition since it was acting within the scope of Congress' grant of regulatory authority. Accordingly, the Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 55012–13 (Oct. 8, 1999). The Department has now amended subsection (a)(1) by deleting a comma for grammatical reasons.

(b) The Department has again received both favorable and unfavorable comments on its proposed revision to the definition of pneumoconiosis. To the extent these comments are directed specifically to the Department's proposal to define pneumoconiosis as a latent and progressive disease, the Department's response is set forth in the preamble under § 725.309. The Department responds here to the remainder of the relevant comments, including those addressing the Department's proposal to include obstructive lung diseases arising out of coal mine employment within the definition of pneumoconiosis. Where a scientific article or treatise is cited, the Department has also cited to a Rulemaking Record Exhibit or, when appropriate, the **Federal Register,** where that source appears. This second citation is not an exhaustive list; thus, each source may appear at additional points in the Rulemaking Record.

(c) One comment objects to the Department's inclusion of the term ''legal pneumoconiosis'' in the revised definition because there is no such ''phenomenon.'' Another comment expresses the concern that the revised regulation would create a new medical diagnosis. The statute defines pneumoconiosis as ''a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.'' 30 U.S.C. 902(b). This broad definition encompasses not only coal workers' pneumoconiosis as that disease is contemplated by the medical community, but also any other chronic lung disease demonstrably related to coal mine employment but not typically denominated as pneumoconiosis in medical circles. Thus, the Department is making a legal distinction, rather than a medical one, by employing the phrase ''legal pneumoconiosis'' in order to

properly implement Congress' intent. In so doing, the Department is acknowledging the distinction already adopted by the circuit courts of appeals in construing and applying the statutory definition. *See, e.g., Gulf & Western Industries* v. *Ling,* 176 F.3d 226, 231–32 (4th Cir. 1999); *Bradberry* v. *Director, OWCP,* 117 F.3d 1361, 1368 (11th Cir. 1997); *Labelle Processing Co.* v. *Swarrow,* 72 F.3d 308, 315 (3d Cir. 1995); *Consolidation Coal Co.* v. *Hage,* 908 F.2d 393, 395–396 (8th Cir. 1990); *Campbell* v. *Consolidation Coal Co.,* 811 F.2d 302, 304 (6th Cir. 1987); *Peabody Coal Co.* v. *Lowis,* 708 F.2d 266, 268 n.4 (7th Cir. 1983).

(d) Several comments express concern over including obstructive pulmonary diseases in the definition of pneumoconiosis, believing such change will result in compensating miners for diseases caused by factors unrelated to coal mine employment. Whether coal mine dust exposure can cause chronic obstructive pulmonary disease is a question of medical and scientific fact that will not vary from case to case; thus, it is an appropriate question for the Department to answer by regulation. *See generally Peabody Coal Co.* v. *Spese,* 117 F.3d 1001, 1010 (7th Cir. 1997) (*en banc*); Davis, *Administrative Law Treatise,* § 6.7, 261–262 (3d ed. 1994). The revised definition will eliminate the need for litigation of this issue on a claim-by-claim basis, and render invalid as inconsistent with the regulations medical opinions which categorically exclude obstructive lung disorders from occupationally-related pathologies. The Department reiterates, however, that the revised definition does not alter the former regulations' (20 CFR 718.202(a)(4), 718.203 (1999)) requirement that each miner bear the burden of proving that his obstructive lung disease did in fact arise out of his coal mine employment, and not from another source. Thus, instead of attempting to force the conclusion, as one commenter contends, that all obstructive lung disorders are compensable, or to require responsible operators to compensate miners for non-occupationally related diseases, the language of the proposed regulation makes plain that only ''obstructive pulmonary disease arising out of coal mine employment'' falls within the definition of pneumoconiosis.

(e) Several comments criticize the Department's consultation with NIOSH. Calling the Department's solicitation of an opinion from NIOSH on the relevant medical questions a ''post-hoc attempt to rationalize the validity of its medical conclusions'' and a ''purely political act,'' one commenter states that Dr. Shulte's letter cannot substitute for ''genuine scientific review.'' Other commenters allege that NIOSH presented no serious medical or scientific analysis to support its position. To the extent these comments accuse the Department of obtaining assistance from NIOSH's information officer rather than its scientific staff, the Department's response is set forth in the preamble under § 725.309. NIOSH voluntarily submitted its first statement in support of the proposed revision to the definition of pneumoconiosis during the public comment period for the initial rulemaking proceeding. The Department then actively solicited an additional opinion from NIOSH in response to other comments the Department had received requesting such consultation and not, as the commenter suggests, to provide ''post-hoc'' rationalization for the proposed revisions to the regulation. NIOSH responded, and the Department set forth the substance of the response in the second notice of proposed rulemaking. 64 FR 54978–79. In response to the second notice, NIOSH once again submitted an unsolicited comment during the public comment period reaffirming its earlier statements that it had reviewed the proposed rule and supported it. Thus, NIOSH has supported the Department's proposal from the outset. Further, in each of its communications, NIOSH repeatedly provided concrete support for its comments by referencing appropriate studies and its own publication, National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard, Occupational Exposure to Respirable Coal Mine Dust* (1995). 62 FR 3343 (Jan. 22, 1997); Rulemaking Record, Exhibit 2–1. This publication provides the most exhaustive review and analysis of the relevant scientific and medical evidence through 1995, including its evaluation of the evidence regarding the role smoking plays in a coal miner's respiratory status. The conclusions NIOSH reached there as a result of its analysis fully support the position it has taken in commenting during these rulemaking proceedings. Accordingly, the Department rejects these broad-based attacks on NIOSH's conclusions as a basis for altering this regulation.

(f) Various comments state, without specificity, that the Department's proposed revisions to the definition of pneumoconiosis lack valid scientific or medical support. Other comments attack the scientific basis of the conclusions that the Department and NIOSH have drawn from the evidence of record. In support, these commenters have submitted an analysis of some of the available medical literature from Dr. Gregory Fino, a Board-certified physician in Pulmonary Diseases, and Dr. Barbara Bahl, who has a doctorate in nursing and biostatistics. Their review of the literature regarding obstructive lung disease and pulmonary dysfunction in coal miners led them to conclude that virtually all of the articles they reviewed are flawed, and that there is no evidence of a clinically significant reduction in lung function resulting from coal mine dust exposure. (Rulemaking Record, Exhibit 89–37, Appendix C). They elaborate:

> There are a number of statements that can and cannot be said about obstruction in coal miners. Some of the articles discussed in Table 1 above do demonstrate a reduction in the FEV1 in highly selected cohorts of miners. Because of selection bias, the results cannot be applied to all miners in general. Since the reductions in the FEV1 are averages, it is statistically impossible to state whether a given miner would have FEV1 reductions greater than or less than the stated amount. The articles do not say and do not show that coal mine dust inhalation causes a clinically significant reduction in the FEV1. Just because a statistically significant reduction was encountered in the selected cohorts, there is no evidence at all that the reductions would participate in any respiratory impairment or disability.
>
> While there is no doubt that some miners do have clinically significant obstruction as a result of coal mine dust inhalation, it occurs in cases of severe fibrosis where a combined obstructive and restrictive defect is present. However, there is no evidence that there is a clinically significant reduction in the FEV1 as a result of chronic obstructive lung disease due to coal mine dust inhalation. None of the studies show that. None of the studies can be generalized to the average coal miner. Moreover, statistical significance neither implies nor infers clinical significance. As the above studies demonstrate, statistical significance has created many numbers that are not applicable to the evaluation of coal miners. The conclusions reached by Morgan (1, 24, 35) and published over two decades [ago] still hold true: coal mine dust may cause slight, clinically insignificant decreases in the FEV1 in some miners. There is no evidence that these decreases cause or contribute to pulmonary disability and no support for the assumption in the Department's regulation that coal dust causes or contributed to any miner's obstructive lung disease.

Rulemaking Record, Exhibit 89–37, Appendix C at 24–25. In a separate review of literature relating to emphysema in particular, Drs. Fino and Bahl conclude that ''[t]he amount of emphysema in the lungs of miners increases with the severity of simple coal workers' pneumoconiosis.'' This increase in severity as shown by chest

X-ray or autopsy ''is not correlated with a worsening of lung function,'' and the relevant studies ''have not shown clinically significant deterioration in lung function as the emphysema worsens.'' Rulemaking Record, Exhibit 89–37, Appendix C at 32–33.

The Department has reviewed all of the medical and scientific evidence referenced in the rulemaking record, and does not agree that the record lacks valid support for the proposition that coal mine dust exposure can cause obstructive pulmonary disease. The Department's position is fully supported by NIOSH, the statutory advisor to the black lung benefits program, which responded favorably to the Department's proposed revisions. Rulemaking Record, Exhibits 5–173, 72, 89–26. The considerable body of literature documenting coal mine dust exposure's causal effect on the development of chronic bronchitis, emphysema and associated airways obstruction constitutes a clear and substantial basis for this aspect of the revised definition of pneumoconiosis.

The term ''chronic obstructive pulmonary disease'' (COPD) includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema and asthma. Airflow limitation and shortness of breath are features of COPD, and lung function testing is used to establish its presence. Clinical studies, pathological findings, and scientific evidence regarding the cellular mechanisms of lung injury link, in a substantial way, coal mine dust exposure to pulmonary impairment and chronic obstructive lung disease. In discharging its congressionally-mandated duty to recommend a permissible exposure limit for coal mine dust, NIOSH conducted a comprehensive review of the available medical and scientific evidence addressing the impact of coal mine dust exposure on coal miners. It published its findings in National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard, Occupational Exposure to Respirable Coal Mine Dust* (1995) (*Criteria*). 62 FR 3343 (Jan. 22, 1997); Rulemaking Record, Exhibit 2–1. NIOSH concluded that ''[i]n addition to the risk of simple CWP and PMF [progressive massive fibrosis], epidemiological studies have shown that coal miners have an increased risk of developing COPD.'' *Criteria* 4.2.3.2, Rulemaking Record, Exhibit 2–1 at 57.

Drs. Fino and Bahl disagree, but the Department believes that their opinions are not in accord with the prevailing view of the medical community or the substantial weight of the medical and scientific literature. For example, Seaton, in ''Coal Workers' Pneumoconiosis,'' in Morgan WKC, Seaton A, eds., *Occupational Lung Diseases* (WB Saunders Co., 3d ed. 1995) 374–406, *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 34, 42, reviewed much of the same published evidence and made the following analysis:

> Lung function, measured as the forced expiratory volume in 1 second (FEV1) has been shown both in cross-sectional and longitudinal studies to decline in relation to increasing underground dust exposure but not in relation to estimates of exposure to oxides of nitrogen. This decline occurs at a similar rate in smokers and nonsmokers, although the loss of lung function overall is greater in smokers, the two effects being additive.

Similarly, Becklake, in ''Pneumoconiosis,'' in Murray J, Nadel J, eds., *Textbook of Pulmonary Medicine* (1st ed. 1988) 1556–1592, *see also Criteria,* Rulemaking Record, Exhibit 2–1 at 204, concludes:

> Most evidence to date indicates that exposure to coal mine dust can cause chronic airflow limitation in life and emphysema at autopsy, and this may occur independently of CWP * * * The relationships between hypersecretion of mucus (chronic bronchitis) and chronic airflow limitation (emphysema) on the one hand and environmental factor of coal mining exposure on the other appear to be similar to those found for cigarette smoking.

Oxman and colleagues analyzed the available literature assessing the relationship between occupational dust exposures and COPD in 1993. Oxman AD, Muir DCF, Shannon HS, Stock SR, Hnizdo E, Lange HJ, ''Occupational dust exposure and chronic obstructive pulmonary disease: A systematic overview of the evidence,'' Am Rev Resp Dis, 148:38–48 (1993); see also Rulemaking Record, Exhibit 5–174, Appendix 8. Reports were analyzed for methodological criteria including dust exposure, control for smoking, exclusion of confounding pulmonary conditions, referral bias, and adequate follow-up. Thirteen reports that met their rigorous screening criteria were analyzed. They concluded that all of the studies found a statistically significant association between cumulative dust exposure and decline in lung function, and that coal mine dust can be a cause of chronic bronchitis. Unlike Drs. Fino and Bahl, the Oxman analysis concluded there was also a clinically significant loss of lung function in smokers and nonsmokers.

Drs. Fino and Bahl state that all of the studies identifying a decline in lung function ''are flawed because of selection bias. The results are not generalizable to the general population of miners.'' Rulemaking Record, Exhibit 89–37, Appendix C at 21. As recognized by many of the authors of these studies, the results are susceptible to a selection bias caused by miners leaving the industry between the time of initial pulmonary function measurement and those taken later during the follow-up period. Because of the ''healthy worker effect,'' it would be expected that workers more prone to the respiratory impairments caused by coal mine dust inhalation would leave mining and the healthier workers would continue working. Oxman concluded that ''[a]lthough it is impossible to estimate precisely the magnitude of this bias,'' its direction ''is towards underestimating the association between dust and loss of lung function, or failure to recognize a more susceptible subgroup of workers.'' Oxman at 46. Thus, this selection bias actually *underestimates* the association between inhalation of coal mine dust and loss of lung function. As Oxman explains, ''it is likely that the results underestimate the effect of occupational dust exposure on lung function, COPD, and chronic bronchitis. The magnitude of the bias is not clear, but it might, in some cases, result in estimates that are 50% or more of the true coefficients.'' Oxman at 47. Moreover, as Coggon and Newman Taylor remarked in the course of surveying the relevant medical literature, such selection effects are relatively unimportant because ''[t]here is no obvious reason why the relation of symptoms and lung function to dust should have been weaker in those omitted from investigation.'' Coggon D, Newman Taylor A, ''Coal mining and chronic obstructive pulmonary disease: a review of the evidence,'' Thorax 53:398–407, 400 (1998); *see also* 64 FR 54979 (Oct. 8, 1999) Simply stated, there is a clear relationship between coal mine dust and COPD and lung dysfunction, and that relationship is likely to be *stronger* than what we are able to measure.

Drs. Fino and Bahl conclude that any minimal obstruction resulting from coal mine dust exposure is not clinically significant. Marine's cross-sectional 1988 study of coal miners, however, found clinically significant decreases in pulmonary function in both smokers and nonsmokers. Marine WM, Gurr D, Jacobsen M, ''Clinically important respiratory effects of dust exposure and smoking in British coal miners,'' Am Rev Resp Dis, 137:106–112 (1988); *see also Criteria,* § 4.2.2.1, Rulemaking Record, Exhibit 2–1 at 52. This study also noted that the presence of chronic

bronchitis was clearly related to cumulative dust exposure. The table below summarizes the study's data:

Measure of respiratory dysfunction	Cumulative dust exposure (in percent)					
	Zero exposure		Intermediate exposure (174 ghm $^{-3}$)		High exposure (348 ghm $^{-3}$)	
	Smoker	Nonsmoker	Smoker	Nonsmoker	Smoker	Nonsmoker
FEV1 <80%	17.1	9.7	24.2	15.5	40.0	23.9
Chronic bronchitis	30.5	7.9	41.2	14.8	52.8	26.3
Chronic bronchitis+FEV1 <80%	7.6	1.5	14.9	3.9	27.3	9.8
FEV1 <65%	5.0	3.2	8.5	5.0	14.2	7.7

NOTE TO TABLE: *Percentages are estimates of prevalence of measures of respiratory dysfunction based on linear logistic models at an age of 47 years at varying amounts of cumulative dust exposure.*

As can be seen from this table, the incidence of nonsmoking coal miners with intermediate dust exposure developing moderate obstruction (FEV1 of less than 80%) is roughly equal to the incidence of moderate obstruction in smokers with no mining exposure (15.5% v. 17.1%). Similarly, the incidence of non-smoking miners with intermediate exposure developing severe airways obstruction (FEV1 of less than 65%) is equal to the incidence of severe obstruction in non-mining smokers (5.0% for both groups). Nonsmokers with high exposure are at greater risk for developing moderate or severe obstruction than unexposed smokers. Smokers who mine have additive risk for developing significant obstruction. The risk of chronic bronchitis clearly increases with increasing dust exposure; again smokers who mine have an additive risk of developing chronic bronchitis. The message from the Marine study is unequivocal: Even in the absence of smoking, coal mine dust exposure is clearly associated with clinically significant airways obstruction and chronic bronchitis. The risk is additive with cigarette smoking.

Drs. Fino and Bahl criticize the Marine study because it used the mean of each miner's three FEV1 values rather than the highest. Rulemaking Record, Exhibit 89–37, Appendix C at 17, 21. This, however, does not appear to be a significant problem given that a number of other studies which used the highest FEV1 value for analysis also showed the same adverse relationship between coal dust inhalation and pulmonary impairment. One such study was reported by Attfield and Hodous in 1992. Attfield MD, Hodous TK, ''Pulmonary function of U.S. coal miners related to dust exposure estimates,'' Am Rev Respir Dis 145:605–609 (1992); *see also* Criteria, § 4.2.2, Rulemaking Record, Exhibit 2–1 at 51. Attfield and Hodous analyzed pulmonary function data (specifically, FEV1, FVC and FEV1/FVC ratio) drawn from Round 1 of the National Study of Coal Workers' Pneumoconiosis, along with job-specific cumulative dust exposure estimates for U.S. underground coal miners, to determine whether there was an exposure-response relationship. This group of 7,139 miners worked both before and after 1970, when federally-mandated dust control standards were implemented. Allowing for decrements due to age and smoking history, Attfield and Hodous demonstrated a clear relationship between dust exposure and a decline in pulmonary function of about 5 to 9 milliliters a year, even in miners with no radiographic evidence of clinical coal workers' pneumoconiosis. These results were similar to those reached in studies of British coal miners.

Drs. Fino and Bahl (Rulemaking Record, Exhibit 89–37, Appendix C at 22), as well as other commenters, criticize this study and similar ones that are based on exposures prior to 1970, when federally-mandated dust control standards were implemented, on the grounds of selection bias. Their theory is that only those miners who worked in a dust-controlled environment are representative of the current adverse effects of coal mine dust exposure. This theory is flawed. While lower dust exposure should reduce both the occurrence and the severity of lung disease, the *kinds* of diseases will remain the same. Indeed, Attfield and Hodous specifically chose to use data from miners with presumably higher dust exposures so as to facilitate the detection of exposure-response relationships. Attfield and Hodous, Am Rev Respir Dis 145:605.

In any event, analysis of data from miners who worked only in dust-controlled conditions confirm the connection between coal mine dust exposure and obstructive lung disease. Seixas and colleagues considered a group of 1,185 miners who began working in 1970 or later. Seixas NS, Robins TG, Attfield MD, Moulton LH, ''Exposure-response relationships for coal mine dust and obstructive lung disease following enactment of the Federal Coal Mine Health and Safety Act of 1969,'' Am J Ind Med 21:715–732 (1992); *see also* Criteria, § 4.2.2.3.1, Rulemaking Record, Exhibit 2–1 at 54. The data they reviewed was collected during Round 4 of the National Study of Coal Workers' Pneumoconiosis, and included chest X-rays, ventilatory function tests (including FEV1, FVC and FEV1/FVC ratio), and relevant histories for each miner. The results of this cross-sectional analysis, when adjusted for age, race/ethnicity and smoking, demonstrated a declination in pulmonary function attributable to coal mine dust-induced obstructive lung disease.

Longitudinal studies have confirmed these results. *See generally Criteria,* § 4.2.2.3.1.2, Rulemaking Record, Exhibit 2–1 at 55. One noteworthy study is Attfield MD, ''Longitudinal decline in FEV1 in United States coalminers,'' Thorax 40:132–137 (1985); *see also Criteria,* § 4.2.2.3.1.2, Rulemaking Record, Exhibit 2–1 at 55. Using medical data from two National Coal Study surveys held nine years apart, Attfield evaluated the effects of dust exposure on a group of 1,072 miners aged 20–49 years. The data included chest X-rays, smoking and work histories, and spirometry, as well as dust exposure estimates. After accounting for age, height and smoking, Attfield found a coal mine dust-related FEV1 loss of 36 to 84 ml over 11 years, with an additional loss among smokers. Attfield's results confirmed similar studies analyzing data from miners in the U.K. *See, e.g.,* Love RG, Miller BG, ''Longitudinal study of lung function in coal-miners,'' Thorax 37:193–197 (1982); *see also* Criteria, § 4.2.2.3.1.2, Rulemaking Record, Exhibit 2–1 at 55.

Drs. Fino and Bahl contend, however, that the average decline shown in these studies, while perhaps statistically

relevant, is not clinically relevant and does not result in any impairment. Attfield and Hodous responded succinctly to such criticism, equating pulmonary function decrements in miners to the decline of lung function in non-mining smokers from the general population: ''If it is thought that a 5- to 9-ml decrement of FEV1 per year is clinically insignificant, it must be remembered that the average decrement for smokers was only 5 ml per pack year. This, in itself, is also a minor loss of lung function. However it is well known that smoking can cause severe effects in some smokers.'' Attfield and Hodous, Am Rev Respir Dis 145:608. Just as not all smokers develop COPD and pulmonary dysfunction, pulmonary impairment is not universal in coal miners. Drs. Fino and Bahl state that ''an average loss of FEV1 means that 50% of the miners will have losses in excess of the average and 50% will have losses smaller than the average.'' Rulemaking Record, Exhibit 89–37, Appendix C at 21. This conclusion does not stand up to scrutiny because it confuses the *average* with the *median.* As can be seen from Marine's table above, only a minority of miners will have significant decrements in pulmonary function. As the majority of miners may have small or, perhaps in some cases, no decline in pulmonary function, the average decline of the population studied can appear to be relatively small. Despite this, the individual miners affected can have quite severe disease, and statistical averaging hides this effect. The amended definition clarifies that these miners have a right to prove their case with evidence of a disabling obstructive lung disease that arose out of coal mine employment.

Pointing to Coggon and Newman Taylor's statement that ''some scientists have expressed doubts as to whether coal mine dust can cause clinically important loss of lung function,'' Coggon D, Newman Taylor A, ''Coal mining and chronic obstructive pulmonary disease: A review of the evidence,'' Thorax 53:398–407 (1998); *see also* 64 FR 54979 (Oct. 8. 1999); Rulemaking Record, Exhibit 89–37, Appendix C at 24, Drs. Fino and Bahl state that the studies have not shown this type of loss of pulmonary function. Rulemaking Record, Exhibit 89–37, Appendix C at 24. The implication that Coggon and colleague agree with this conclusion is misleading. The paragraph containing the quoted sentence notes that there is evidence connecting COPD with coal mining and that ''in view of this continuing controversy, it is helpful to review the evidence as it now stands.'' The authors reviewed data from the National Study of Coal Workers' Pneumoconiosis, the Pneumoconiosis Field Research Programme (U.K.), studies from Sardinia and Germany, and mortality and necropsy studies. They concluded:

> Reductions in lung function have been found in relation to coal mining with remarkable consistency. * * * Individually, all of the studies that have addressed the relation of coal mining to lung function have limitations, but these vary from one investigation to another and often would tend to obscure rather than exaggerate any effect of dust. The balance of evidence points overwhelmingly to impairment of lung function from coal mine dust exposure.

Coggon, Thorax 53:405. Coggon and Newman Taylor further concluded that: Coal mine dust inhalation can be disabling, and arguments against this thesis are ''unconvincing'; and ''the combined effects of coal mine dust and smoking on FEV1 appear to be additive.'' Coggon, Thorax 53:405–406. Thus, this study supports the Department's position.

Similarly, several of the medical treatises and studies cited by another commenter in support of its contention that there is no such causal link between coal mine dust exposure and obstructive lung disease do not negate (and, in fact, support) the conclusion the Department and NIOSH have reached. *See, e.g.*, Morgan WKC, ''Pneumoconiosis,'' in Brewis RAL, Corrin B, Geddes DM, Gibson GJ, eds., *Respiratory Medicine* (WB Saunders Co., 2d ed. 1995) 581; *see also* Rulemaking Record, Exhibit 89–21, attachment 1 (''it is clear that bronchitis induced by coal-mine dust, henceforth referred to as industrial bronchitis, leads to a reduction in ventilatory capacity''); Green FHY, Vallyathan V, ''Coal Workers'' Pneumoconiosis and Pneumoconiosis Due to Other Carbonaceous Dusts,'' in Chung A, Green FHY, eds., *Pathology of Occupational Lung Disease* (2d ed. 1998) 189; *see also* Rulemaking Record, Exhibit 89–21, attachment 2 (coal dust exposure is ''associated with significant deficits in lung function in the absence of [clinical] CWP, reinforcing the view that COPD and CWP have independent risk factors''); ''Occupational Lung Disease,'' in Hasleton PS, ed., *Spencer's Pathology of the Lung* (5th ed. 1996) 482; *see also* Rulemaking Record, Exhibit 89–21, attachment 4 (''A considerable body of evidence indicates that chronic bronchitis and emphysema in coal workers is directly related to tobacco usage and cumulative exposure to respirable dust during life.''); Roy TM *et al.,* ''Cigarette Smoking and Federal Black Lung Benefits in Bituminous Coal Miners,'' J Occ Med 31(2):100 (1989); *see also* Rulemaking Record, Exhibit 89–21, attachment 5 (''Well-designed investigations have now documented that coal dust exposure can cause reductions in FEV1 that are independent of age and cigarette smoking. * * * it appears that the major damage caused by cigarette smoking is additive to the minor damage which can be attributed to coal dust.''); Surgeon General, U.S. Department of Health and Human Services, ''Respiratory Disease in Coal Miners,'' *The Health Consequences of Smoking: Cancer and Chronic Lung disease in the Workplace*, 313 (1985); *see also* Rulemaking Record, Exhibit 89–21, attachment 11 (concluding that ''increasing coal dust exposure is associated with increasing airflow obstruction in both smokers and nonsmokers''). To the extent this commenter advocates that tobacco smoking, rather than coal mine dust exposure, causes the only significant obstructive disorders miners develop, and that the definition of pneumoconiosis ''must be tightened to deal with the truth of tobacco's role in causing what has been compensated as black lung,'' the Department reiterates that the studies cited above, as well as others, found a significant decrement in coal miners' pulmonary function in addition to that caused by smoking. Whether a particular miner's disability is due to his coal mine employment or smoking habit must be resolved on a claim-by-claim basis under the criteria set forth at § 718.204.

Drs. Fino and Bahl find no scientific support that clinically significant emphysema exists in coal miners without progressive massive fibrosis, Rulemaking Record, Exhibit 89–37, Appendix C at 31, but the available pathologic evidence is to the contrary. Cockcroft evaluated 39 coal workers and 48 non-coal worker controls dying of cardiac causes in 1979. Cockcroft A, Wagner JC, Ryder R, Seal RME, Lyons JP, Andersson N, ''Post-mortem study of emphysema in coalworkers and non-coalworkers,'' Lancet 2:600–603 (1982); *see also* Criteria, § 4.2.2.2, Rulemaking Record, Exhibit 2–1 at 52. Centrilobular emphysema (the predominant type observed) was significantly more common among the coal workers. The severity of the emphysema was related to the amount of dust in the lungs. These findings held even after controlling for age and smoking habits.

Similarly, Leigh and colleagues analyzed 886 miners who died between 1949 and 1982. Leigh J, Outhred KG, McKenzie HI, Glick M, Wiles AN,

''Quantified pathology of emphysema, pneumoconiosis and chronic bronchitis in coal workers,'' BR J Indust Med 40:258–263 (1983); *see also Criteria*, § 4.2.2.2, Rulemaking Record, Exhibit 2–1 at 53. They found that miners with more years of face work had worse emphysema pathologically. In a subsequent study of 264 underground coal miners exposed to mixed coal and silica dust, Leigh performed a multiple regression analysis to assess the effects of total lung coal content, total lung silica content, smoking history, and years at the coal face on pulmonary function, extent of emphysema, and extent of fibrosis. Leigh J, Driscoll TR, Cole BD, Beck RW, Hull BP, Yang J, ''Quantitative relation between emphysema and lung mineral content in coalworkers,'' Occ Environ Med 51:400–407 (1994); *see also Criteria*, § 4.2.2.2, Rulemaking Record, Exhibit 2–1 at 53. Multiple regression analysis is a powerful statistical tool used to identify which of a series of variables is responsible for an observed correlation, and to eliminate apparent correlations that can be explained by other true relationships. He made the following important findings: (1) The extent of emphysema was strongly related to the total coal content of the lung, age and smoking; (2) in miners who were lifelong non-smokers, the extent of emphysema was strongly related to coal content and age; (3) the extent of emphysema was unrelated to lung silica content; and (4) the extent of lung fibrosis was related to silica content. The authors concluded that ''these results provide strong evidence that emphysema in coalworkers is causally related to lung coal content.'' Leigh, Occ Environ Med 51:400.

Ruckley and colleagues achieved similar results in examining the lungs of 450 coal workers to determine the association between coal mine dust exposure and dust-related fibrosis and emphysema. Ruckley VA, Gauld SJ, Chapman JS, *et al.,* ''Emphysema and dust exposure in a group of coal workers,'' Am Rev Resp Dis 129:528–532 (1984); *see also Criteria*, § 4.2.2.2, Rulemaking Record, Exhibit 2–1 at 53. Emphysema was graded by standard techniques, smoking histories were obtained by questionnaire and Pneumoconiosis Panel records, and lung dust content was analyzed pathologically. Relationships between emphysema and possible explanatory variables were tested by multiple logistic regression models, which exclude confounding variables in analyzing causal effects. The authors found emphysematous changes in 72% of miners who smoked, 65% of ex-smokers, and 42% of nonsmoking miners; emphysema scores were higher in patients with increasing evidence of pneumoconiotic disease; and increasing coal lung dust was associated with the presence of emphysema. Forty-seven percent of miners with no fibrotic lesions had emphysema. Ruckley concluded that ''the results support the conclusion that the relationship observed between respirable dust and emphysema in coal workers is, in some way, causal.'' Ruckley, Am Rev Resp Dis 129:532.

Drs. Fino and Bahl point to several other sources in support of their view that clinically significant emphysema is not related to coal dust exposure in the absence of PMF. They quote Morgan's textbook, *Occupational Lung Diseases*, as saying that changes of focal emphysema cannot be equated with airways obstruction. The commenters fail to note additional comments in the same textbook:

> The increased risk of centriacinar emphysema in PMF cases away from the lesion, and, in simple pneumoconiosis, in relation to dust exposure supports the hypothesis that coal dust exposure sufficient to cause alveolar inflammation and fibrosis also initiates centriacinar emphysema. This seems a likely explanation for the consistent epidemiologic finding of decrements in FEV1 and FVC and a rise in residual volume in relation to the indices of dust exposure in coal miners.

Seaton, *Occupational Lung Diseases* at 400–401. Morgan's conclusions are also somewhat suspect because he has admitted that at least in commenting on the Cockcroft paper, some of his criticisms were inaccurate and not valid or fair. Judgement of Mr. Justice Turner, The British Coal Respiratory Disease Litigation, Jan. 23, 1998, Rulemaking Record, Exhibit 72. Dr. Fino and Bahl's citation to Snider, Snider GL, ''Emphysema: the first two centuries-and beyond. A historical overview, with suggestions for future reference,'' Am Rev Resp Dis 146:1333–1344 (Part 1) and 146:1615–1622 (Part 2) (1992); *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 34, is also unhelpful because the articles contain no opinion as to whether emphysema in coal miners can be clinically significant or affects pulmonary function. Coal dust exposure was plainly not the focus of these articles.

The Department's proposed revision to the definition of pneumoconiosis is also supported by the growing evidence of the adverse affects of coal mine dust exposure at the cellular level leading to obstructive lung disease. *Criteria*, 4.3, Rulemaking Record, Exhibit 2–1 at 65–69; *see generally* Coggon, Thorax 53:404. Alveolar macrophages are cells that are normally situated in the alveoli, or gas-exchange units of the lung. Their normal function is to recognize foreign substances, phagocytize (ingest) these substances, and activate other inflammatory cells. Coal dust, in turn, causes leakage of destructive protease and elastase enzymes from alveolar macrophages. These enzymes can destroy the network of elastin and collagen proteins that comprise the underlying support structure of the lung architecture; the release of these enzymes from inflammatory cells is thus associated with the production of emphysema. Lung lavage studies are performed by washing an area of lung with saline instilled through a fiberoptic bronchoscope placed through a subject's throat and wedged into the lung. These studies of nonsmoking coal miners with simple CWP showed activation of macrophages with evidence of ingestion of dust particles, a finding not present in normal controls. Takemura T, Rom WM, Ferrans VJ, Crystal RG, ''Morphologic characterization of alveolar macrophages from subject with occupational exposure to inorganic particles,'' Am Rev Resp Dis 140:1674–1685 (1989); *see also Criteria*, § 4.3.3, Rulemaking Record, Exhibit 2–1 at 69. A subsequent lavage study of nonsmoking coal miners found that the macrophages spontaneously released substances toxic to the lung, including reactive oxygen species and elastase. These substances were released in significantly higher quantities in miners than in non-mining smokers or in non-mining nonsmokers without lung disease. Rom WN, ''Basic mechanisms leading to focal emphysema in coal workers'' pneumoconiosis,'' Environ Res 53:16–28 (1990); *see also* Rulemaking Record, Exhibit 5–174, Appendix 8. As noted, the reactive oxygen species damage cell membranes, cell proteins, and DNA. Over-secretion of these substances may overwhelm the lung's natural defenses (such as anti-oxidants and anti-proteases). The unopposed proteases and elastases can destroy lung tissue, causing emphysema.

Reactive oxygen substances have been shown to damage anti-proteases in the lung. Anti-proteases are enzymes that protect the lung from proteases and elastases that are released during an inflammatory reaction (such as that produced by inhalation of coal mine dust). Without this protection, the proteases and elastases can destroy the elastin and collagen that comprise the structure of the lung, resulting in

emphysematous changes. This was demonstrated in an animal model of coal dust inhalation, where the coal dust was found to increase elastase levels and cause degradation of alpha-1 antitrypsin (one of the protective enzymes) in association with pathologic findings of emphysema. *In vitro* studies have also demonstrated that the protective anti-protease activity of alpha-1 antitrypsin is decreased by exposure to coal dust. These observations support the theory that dust-induced emphysema and smoke-induced emphysema occur through similar mechanisms—namely, the excess release of destructive enzymes from dust- (or smoke-) stimulated inflammatory cells in association with a decrease in protective enzymes in the lung.

Animal and human studies have also shown that coal mine dust inhalation can recruit neutrophils, another inflammatory cell, into the lung. Rom WN (1990). Activated neutrophils produce elastase as well as other inflammatory mediators. The recruitment of neutrophils and the activation of alveolar macrophages is greater in nonsmoking coal miners with pulmonary impairment than either non-miners or nonsmoking miners without pulmonary impairment. This suggests that a combination of coal mine dust exposure and host susceptibility may be required to produce disease. Thus, although many of the studies evaluating mechanisms of pathogenesis of coal mine dust exposure concentrate on the development of fibrosis, there is considerable basic scientific data linking coal mine dust to the development of obstructive airways disease.

Moreover, cytokines, which are chemical substances released from a number of cells in the lung, have been implicated in the development of lung disease in coal miners. *Criteria,* § 4.3.1, Rulemaking Record, Exhibit 2–1 at 65–69. Tumor necrosis factor-α (TNF) and Interleukin 6 (IL–6) are two of them. TNF is released by alveolar macrophages as well as other cells in response to coal dusts (as well as other mineral dusts). TNF stimulates lung fibrosis. Patients with progressive CWP have higher TNF release from lung monocytes. TNF release is also increased in coal miners with airflow obstruction. TNF has been demonstrated to be an important mediator in obstructive airways diseases including COPD and asthma. Alveolar macrophages have been shown to release IL–6 in response to exposure to coal mine dust. Increased IL–6 levels were noted in lungs of coal miners with CWP. IL–6 has been implicated in the creation of inflammatory changes of the lower respiratory tract in chronic bronchitis as well as reactive airways disease. In addition, other cellular mediators, including leukotriene B4, thromboxane A2, prostaglandin E2, and platelet activating factor, have been shown to be produced by alveolar macrophages or other pulmonary cells in response to coal mine dust and are well known to play a role in the production of reactive airways disease. Thus, there is considerable basic scientific data linking coal dust to the development of obstructive airways disease.

One commenter repeatedly accuses the Department of not supporting its definitional change with ''peer-reviewed'' scientific and medical studies, but does not point to any study or article in particular. The Department rejects this assertion. Each of the articles and studies cited above, as well as the majority relied upon by NIOSH in the Criteria document, appeared in a peer-reviewed journal: American Review of Respiratory Disease, American Journal of Industrial Medicine, Thorax, Journal of Occupational Medicine, Lancet, British Journal of Industrial Medicine, Occupational Environmental Medicine, Environmental Research, and others. The textbooks relied upon are authored and edited by highly respected professionals in the field. Textbook editors serve as peer-reviewers of the relevant published literature because they comprehensively survey, evaluate the validity of, and comment on, the literature. Seaton's review in Morgan and Seaton's *Occupational Lung Disease* is a good example. Moreover, the NIOSH *Criteria* document, Rulemaking Record, Exhibit 2–1, received extensive peer review prior to its publication. *See Criteria,* Rulemaking Record, Exhibit 2–1 at xxii–xxiv.

It bears repeating that in developing its recommended dust exposure standard, NIOSH carefully reviewed the available evidence on lung disease in coal miners. NIOSH also considered the strength of the evidence, including the sampling and statistical analysis techniques used, *Criteria,* § 7.3.4, Rulemaking Record, Exhibit 2–1 at 124, and concluded that the science provided a substantial basis for adopting a permissible dust exposure limit. NIOSH summarized its findings based on some of the studies detailed above, along with others, as follows:

> In addition to the risk of simple CWP and PMF, epidemiological studies have shown that coal miners have an increased risk of developing COPD. COPD may be detected from decrements in certain measures of lung function, especially FEV1 and the ratio of FEV1/FVC. Decrements in lung function associated with exposure to coal mine dust are severe enough to be disabling in some miners, whether or not pneumoconiosis is also present. A severe or disabling decrement in lung function is defined here as an FEV1 <65% of expected normal values; an impairment in lung function is defined as an FEV1 <80% of predicted normal values. An exposure-response relationship between respirable coal mine dust exposure and decrements in lung function has been observed in cross-sectional studies and confirmed in longitudinal studies.

Criteria, 4.2.3.2 (citations omitted), Rulemaking Record, Exhibit 2–1 at 57. That coal mine dust exposure can cause obstructive lung disease is now a well-documented fact.

Finally, the Department's position is consistent with the growing body of case law recognizing that obstructive lung diseases can arise from coal mine dust exposure. *See generally Labelle Processing Co.* v. *Swarrow,* 72 F.3d 308, 315 (3d Cir. 1995) (''Chronic bronchitis, as a chronic pulmonary disease, falls within the legal definition of pneumoconiosis.''); *Kline* v. *Director, OWCP,* 877 F.2d 1175, 1178 (3d Cir. 1989) (The legal definition of pneumoconiosis ''encompasses a wider range of afflictions than does the more restrictive medical definition of coal workers' pneumoconiosis.''); *Richardson* v. *Director, OWCP,* 94 F.3d 164, 166 n.2 (4th Cir. 1996) (''COPD, if it arises out of coal-mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis.''); *Warth* v. *Southern Ohio Coal Co.,* 60 F.3d 173, 175 (4th Cir. 1995) (''Chronic obstructive lung disease * * * is encompassed within the definition of pneumoconiosis for purposes of entitlement to Black Lung benefits.''); *Barber* v. *Director, OWCP,* 43 F.3d 899, 901 (4th Cir. 1995) (''physicians generally use 'pneumoconiosis' as a *medical* term that comprises merely a small subset of the afflictions compensable under the Act''); *Bethlehem Mines Corp.* v. *Massey,* 736 F.2d 120, 124 (4th Cir. 1984) (recognizing that emphysema can be aggravated by coal dust exposure); *Peabody Coal Co.* v. *Holskey,* 888 F.2d 440, 442 (6th Cir. 1989) (substantial evidence supported ALJ's decision to credit doctor who believed miner's chronic obstructive pulmonary disease was related to coal dust exposure over doctor who believed the disease was caused solely by cigarette smoking); *Campbell* v. *Consolidation Coal Co.,* 811 F.2d 302, 304 (6th Cir. 1987) (where miner had obstructive lung disease and no evidence demonstrated it was not

related to coal mine employment, employer failed to rebut interim presumption of entitlement); *Freeman United Coal Mining Co.* v. *OWCP,* 957 F.2d 302, 303 (7th Cir. 1992) (recognizing that the Act's definition of pneumoconiosis encompasses obstructive disease caused in whole or in part by exposure to coal dust); *Old Ben Coal Co.* v. *Prewitt,* 755 F.2d 588, 591 (7th Cir. 1985) (recognizing that chronic obstructive pulmonary disease ''fits the statutory definition'' of pneumoconiosis); *Associated Elec. Coop., Inc.* v. *Hudson,* 73 F.3d 845, 847 (8th Cir. 1996) (affirming award of benefits based on medical evidence of ''severe obstructive lung disease caused by coal dust exposure''); *Consolidation Coal Co.* v. *Hage,* 908 F.2d 393, 395 (8th Cir. 1990) (chronic obstructive lung disease ''constitutes a type of ailment which Congress deems sufficient to entitle a claimant to Black Lung benefits''); *Bradberry* v. *Director, OWCP,* 117 F.3d 1361, 1368 (11th Cir. 1997) (''COPD that arises from coal-mine employment falls within the legal definition of pneumoconiosis.''); *Stomps* v. *Director, OWCP,* 816 F.2d 1533, 1536 (11th Cir. 1987) (ordering award of benefits on strength of medical opinion that miner's totally disabling chronic obstructive pulmonary disease was caused in part by coal mine employment).

Contrary to the commenters' argument, then, the record does contain overwhelming scientific and medical evidence demonstrating that coal mine dust exposure can cause obstructive lung disease. The Department therefore declines to change the definition of pneumoconiosis as proposed.

(g) One comment suggests that the Department delete the term ''anthracosis'' from the definition of pneumoconiosis, contending that it is a term commonly used to denote anthracotic pigmentation, without associated disease process, on biopsy or autopsy of the lungs. The Department has accommodated this concern in the proposed revisions to § 718.202(a)(2). The revised version of § 718.202(a)(2) explicitly provides that ''[a] finding in an autopsy or biopsy of anthracotic pigmentation * * * shall not be sufficient, by itself, to establish the existence of pneumoconiosis.'' 64 FR 55013 (Oct. 8, 1999). Thus, the Department does not believe that a change to the definition of pneumoconiosis is necessary.

(h) Several comments suggest that the Department appoint an expert panel to review the scientific and medical evidence on the obstructive disease, latency and progressivity proposed revisions to the regulation. The Department declines to follow this suggestion. As set forth above, the relevant scientific and medical information available on these topics has been thoroughly reviewed by highly-qualified experts, including NIOSH, the advisor designated by Congress to consult with the Department in developing criteria for total disability due to pneumoconiosis under the Black Lung Benefits Act. 30 U.S.C. 902(f)(1)(D). Accordingly, to the extent these commenters note that ''since coal-workers'' pneumoconiosis is a medical condition, * * * this determination [establishing a proper definition of pneumoconiosis] should be left to the medical experts,'' the comment ignores both the statutory definition of pneumoconiosis and the large body of scientific evidence already reviewed by medical experts, as outlined above.

(i) One comment criticizes the Department for not considering two major sources of information regarding U.S. coal miners: the National Coal Study, which the commenter states has provided a wealth of longitudinal information about the health of miners, and the NIOSH X-ray Surveillance Program. The commenter is incorrect. The information from both of these programs is a major focus of NIOSH's *Criteria* document, Rulemaking Record, Exhibit 2–1, and is further analyzed in many of the articles considered by the Department and NIOSH in proposing the revisions.

(j) One comment generally objects to the proposed revisions and urges the Department to collect data developed by the Universities of Kentucky and Louisville since the 1996 comprehensive reform of the Kentucky state workers' compensation law, a program the commenter states is based on objective medical findings of ''certified B readers.'' The commenter believes that this data would more accurately reflect modern day dust control in coal mining than the studies relied upon by the Department. As discussed above, the Department's conclusions are fully supported by the ample data it has already reviewed, including data generated from time periods post-dating implementation of federally-mandated dust control measures. Moreover, the Department does not believe this information would be particularly relevant to the proposed revisions of the definition of pneumoconiosis. A ''certified B reader'' is a physician proved by examination to be proficient in assessing the quality of chest X-rays and in using the ILO–U/C system to classify X-rays for pneumoconiosis. 20 CFR 718.202(a)(1)(ii)(E) (1999). While this information may show the incidence of clinical pneumoconiosis in a given population of coal miners, it is not particularly relevant to the other subset of diseases compensable under the Black Lung Benefits Act, namely, any chronic lung disease arising out of coal mine employment.

(k) Another comment implies that the proposed definitional changes adopt arbitrary medical ''presumptions'' without consultation with any pulmonary experts. As discussed above, all of the scientific and medical evidence upon which the Department relies has been thoroughly reviewed and evaluated by experts in the field. It is not the Department's intent to create a ''presumption'' with the proposed revisions to the definition. Instead, the revisions are designed to define pneumoconiosis in accordance with the best science currently available to the Department while leaving with the miner the burden of persuading the factfinder that he has a lung disease falling within this definition.

(l) Two comments note that the proposed definition (at least insofar as it recognizes that both obstructive and restrictive lung disease may be caused by exposure to coal mine dust) was rejected by Congress and should not be adopted. The Department has already responded to this criticism. 64 FR 54972 (Oct. 8, 1999). No further discussion is necessary.

(m) Two comments, while supporting the proposed changes, ask the Department to amend the regulation further by requiring factfinders to categorically reject as non-conforming any physician's opinion stating either that coal dust cannot cause, or causes only trivial, obstructive lung impairments, or that coal dust-induced lung diseases cannot manifest themselves after a miner's exposure to coal mine dust ceases. The commenters state that such a change would forestall parties opposing miners' entitlement from needlessly prolonging litigation. A physician's opinion based on a premise fundamentally at odds with the statute and regulations is flawed, and the factfinder must weigh that physician's opinion accordingly. *See, e.g., Robinson* v. *Missouri Mining Co.,* 955 F.2d 1181, 1183 (8th Cir. 1992); *Penn Allegheny Coal Co.* v. *Mercatell,* 878 F.2d 106, 109–110 (3d Cir. 1989). This principle will continue to govern under the revised regulation. Thus, the Department does not believe a change to the proposed regulation is necessary.

(n) Several comments support the proposal, noting that the revisions to the

definition of pneumoconiosis are supported by the current state of medical knowledge.

(o) Two comments urge the Department to join the lawsuit filed by the Department of Justice to recover money from the tobacco industry for costs incurred by the black lung program for compensating and treating smoking-related disabilities. The comment is not directed to any regulatory proposal, and no response is warranted.

(p) No other comments were received concerning this section, and no further changes have been made in it.

20 CFR 718.202

(a) In the initial notice of proposed rulemaking, the Department proposed changing § 718.202 only to the extent of clarifying that a diagnosis of anthracotic pigment by biopsy, standing alone, is not equivalent to a diagnosis of pneumoconiosis. Former § 718.202(a)(2) imposed this limitation with respect to autopsy evidence only, and the Department noted there was no reason to treat the two types of evidence differently. 62 FR 3345, 3376 (Jan. 22, 1997). The Department did not propose any further changes to § 718.202 in the second notice of proposed rulemaking, although the regulation remained open for comment. 64 FR 54971 (Oct. 8, 1999).

(b) One comment supports the Department's proposed change as consistent with mainstream scientific findings. Several other comments support this change, but also advocate adopting the criteria for diagnosing pneumoconiosis by autopsy or biopsy developed by the American College of Pathologists and Public Health Service. For the reasons set out in the preamble to § 718.106, the Department cannot make this change.

(c) Two comments urge the inclusion of language stating that a negative chest x-ray cannot form the basis of a physician's reasoned finding of no pneumoconiosis as the disease is defined in the statute and regulations. The suggested addition is unnecessary for several reasons. The Black Lung Benefits Act already prohibits the denial of a claim solely on the basis of a negative x-ray. 30 U.S.C. 923(b). A physician's opinion ruling out the presence of the disease based solely on a negative x-ray would be similarly insufficient; such an opinion would amount to no more than a repetition of the x-ray findings. *See Worhach* v. *Director, OWCP,* 17 Black Lung Rep. 1–105, 1–110 (1993) (physician's opinion which merely restates x-ray findings is not a diagnosis of pneumoconiosis for purposes of § 718.202(a)(4)). Furthermore, § 718.202(a)(4) already recognizes that a diagnosis of pneumoconiosis may be made based on a documented and reasoned medical opinion despite a negative x-ray. *Warth* v. *Southern Ohio Coal Co.,* 60 F.3d 173, 174–75 n.* (4th Cir. 1995) (holding physician's opinion that pneumoconiosis cannot be diagnosed absent positive x-ray or tissue samples conflicts with § 718.202(a)(4) because physician's diagnosis may be based on other clinical evidence notwithstanding negative x-ray). Finally, only a physician can determine the diagnostic value of a negative x-ray in assessing the presence or absence of a respiratory or pulmonary disease in a particular miner. The law only prohibits making the negative x-ray the sole and conclusive basis for ruling out the disease.

(d) One comment would limit relevant radiological qualifications to board-certification in radiology and certification as a B-reader. Although these two qualifications may encompass most physicians' expert training, a rigid rule prohibiting consideration of any other aspect of a physician's background is undesirable. The adjudicator should consider any relevant factor in assessing a physician's credibility, and each party may prove or refute the relevance of that factor. *See Worhach* v. *Director, OWCP,* 17 Black Lung Rep. 1–105, 1–108 (1993) (holding adjudicator may properly consider physician's professorship in radiology in weighing radiological qualifications under § 718.202(a)(1)); *compare Melnick* v. *Consolidation Coal Co.,* 16 Black Lung Rep. 1–31, 1–37 (1991) (*en banc*) (holding adjudicator may not consider physician's ''prestigious teaching position'' outside the field of radiology under § 718.202(a)(1) in assessing physician's radiological competence).

(e)(i) Three comments favor language recognizing that CT scans are not reliable diagnostic tools for evaluating the presence or absence of pneumoconiosis because no standardized criteria exist for interpreting them. Another comment, however, argues that a negative CT scan effectively precludes a diagnosis of pneumoconiosis because of its level of clinical sophistication. General language accepting or rejecting the use of CT scans is not necessary. The Department did not propose any such language, or develop the record to ascertain the medical community's views. The comments take diametrically opposite views on the use of these tests, which provides no basis for adopting either view. Furthermore, the Department favors consideration of new and more accurate diagnostic technologies as they become available in the future. *See* preamble to § 718.107, 62 FR 3343 (Jan. 22, 1997). Any party may support or challenge the probative value of a particular test with expert opinions. No useful purpose would therefore be served by adopting a blanket exclusion of any particular type of testing. (ii) Based on the alleged unreliability of CT scans, two comments urge the Department to make clear that a claimant may refuse to undergo a CT scan without prejudicing the adjudication of his or her claim. The Department rejects this position. The adjudicator should determine whether a claimant's refusal to undergo a CT scan (or any other medical test) is reasonable in light of all relevant circumstances in the particular case. A general exoneration for all claimants refusing CT scans is not warranted, especially since the Department does not endorse the commenters' premise that this technology is necessarily unreliable in the absence of standardized criteria for interpreting it. (iii) One comment contends the CT scan is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis. The statutory definition of ''pneumoconiosis,'' however, encompasses a broader spectrum of diseases than those pathologic conditions which can be detected by clinical diagnostic tests such as x-rays or CT scans. *See generally Island Creek Coal Co.* v. *Compton,* F.3d, No. 98–2051, 2000 WL 524798, *4 (4th Cir. May 2, 2000) (reviewing medical and legal definitions of ''pneumoconiosis,'' the latter of which is broader). For purposes of the Black Lung Benefits Act, ''pneumoconiosis'' includes any ''chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.'' 30 U.S.C. 902(b). A CT scan may provide reliable evidence in a particular claim that the miner does not have any evidence of the disease which can be detected by that particular diagnostic technique. The record, however, does not contain any medical evidence demonstrating the capacity of CT scans to rule out the existence of all diseases ''arising out of coal mine employment.'' *See Compton,* F.3d, 2000 WL 524798, *4 (noting that a medical diagnosis of no pneumoconiosis is not equivalent to a diagnosis of no legal pneumoconiosis), *citing Hobbs* v. *Clinchfield Coal Co.,* 45 F.3d 819, 821 (4th Cir. 1995). The Department therefore cannot accept the commenter's

position that a negative CT scan is self-sufficient evidence that the miner does not have ''pneumoconiosis'' for purposes of the statute.

(e) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 718.204

(a)(i) The Department proposed several significant changes to § 718.204 in the initial notice of proposed rulemaking. 62 FR 3344–45, 3377–78 (Jan. 22, 1997). One revision clarified that ''total disability'' does not take into consideration any disabling non-respiratory conditions, *i.e.,* a miner may be totally disabled for purposes of the Black Lung Benefits Act (BLBA) notwithstanding the existence of any independently disabling non-respiratory/pulmonary impairments. This change emphasized the Department's disagreement with *Peabody Coal Co.* v. *Vigna,* 22 F.3d 1388 (7th Cir. 1994) (holding claimant's entitlement precluded by disabling stroke which was unrelated to coal mine employment and occurred before evidence of disability due to pneumoconiosis); *contra Youghiogheny & Ohio Coal Co.* v. *McAngues,* 996 F.2d 130 (6th Cir. 1993), *cert. den.* 510 U.S. 1040 (1994) (holding miner's disabling injuries from automobile accident irrelevant to disability determination under BLBA). Another revision codified holdings in two circuits that ''disability'' for purposes of the BLBA is a totally disabling respiratory or pulmonary impairment, and not ''whole person'' disability. The Department also proposed a definition for ''disability causation'' to harmonize the various formulations of that standard in circuit court decisions: a miner is totally disabled ''due to pneumoconiosis'' if the disease is a ''substantially contributing cause'' of the miner's disability. Similarly, the Department proposed recognizing that pneumoconiosis may worsen a totally disabling respiratory or pulmonary impairment which is itself unrelated to coal mine employment. Finally, the Department proposed a number of editorial changes to § 718.204 to rationalize its structure. 62 FR 3344–45 (Jan. 22, 1997). (ii) In the second notice of proposed rulemaking, the Department proposed a minor revision to § 718.204(b)(2)(iv) by restoring language from 20 CFR 718.204(c)(4) (1999), which had been omitted inadvertently. The language set forth the circumstances under which a medical report may establish the miner's total disability. 64 FR 54979, 55014 (Oct. 8, 1999). The Department also responded to numerous comments it had received concerning the proposed regulation. 64 FR 54979–80 (Oct. 8, 1999). Several comments expressed both support for, and opposition to, the Department's rejection of *Vigna's* holding that a pre-existing totally disabling impairment which is unrelated to coal mine employment precludes entitlement under the BLBA. The Department concluded the commenters had provided no reason for changing the proposed regulation. The Department also rejected comments which recommended adopting a ''whole person'' standard for total disability, rather than the proposed definition limiting disability to pulmonary and respiratory impairments. The commenters offered no rationale in support of the requested change other than a statutory interpretation of ''total disability'' previously rejected by two circuit courts in favor of the Department's position. With respect to ''disability causation,'' the Department rejected: challenges to its authority to define ''disability due to pneumoconiosis'' given the statute's broad grant of rulemaking authority and the ambiguity in the statutory term; various alternative formulations of the disability causation standard in place of ''substantially contributing cause'' inasmuch as the Department's definition reflected a general consensus in the existing caselaw; and arguments that the ''substantially contributing cause'' standard permitted awards based solely on smoking-related disability because such awards are contrary to both the BLBA and judicial precedent. Other than the restoration of language to § 718.204(b)(2)(iv), the Department did not propose any additional changes to § 718.204. 64 FR 54979–80 (Oct. 8, 1999).

(b) In both the first and second notices of proposed rulemaking, the Department proposed identical language defining total disability due to pneumoconiosis. 62 FR 3345, 3377; 64 FR 54979–54980, 55014. The Department explained its authority to define this statutory element of entitlement and proposed using a substantially contributing cause standard. Thus, a miner would be found totally disabled due to pneumoconiosis if he establishes that his pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. In both proposals, the Department explained that this standard was based on court of appeals precedent which had developed since 1989 and varied very little from circuit to circuit.

The Department also proposed that pneumoconiosis be considered a substantially contributing cause of the miner's disability if it either has an adverse effect on the miner's respiratory or pulmonary condition or worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i), 718.204(c)(1)(ii). In neither proposal did the Department describe the extent to which pneumoconiosis must have produced an adverse effect or worsened a totally disabling respiratory impairment. The Department did not mean to alter the current law through its proposals, however, or to suggest that *any* adverse effect, no matter how limited, was sufficient to establish total disability due to pneumoconiosis. Rather, the Department meant only to codify the numerous decisions of the courts of appeals which, in the process of deciding when a miner is totally disabled due to pneumoconiosis, have also ruled on what evidence is legally sufficient to establish that element of entitlement. In order to clarify this consistent intent, the Department has added the word ''material'' to § 718.204(c)(1)(i) and ''materially'' to § 718.204(c)(1)(ii). In so doing, the Department intends merely to implement the holdings of the courts of appeals. Thus, evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability.

The Department is also mindful, however, that Congress enacted the Act in large part to permit benefit awards to miners whose entitlement under state workers' compensation laws was precluded by burdensome causation requirements. *Adams* v. *Director, OWCP,* 886 F.2d 818, 825 (6th Cir. 1989); *Mangus* v. *Director, OWCP,* 882 F.2d 1527, 1530–1531 (10th Cir. 1989). Moreover, the courts have also recognized the difficulties that would confront a miner who must prove the relative amounts that various causal elements contribute to his totally disabling respiratory or pulmonary impairment. *See Compton* v. *Inland Steel Coal Co.,* 933 F.2d 477, 481–483 (7th Cir. 1991); *Adams,* 886 F.2d at 825; *Mangus,* 882 F.2d at 1530–1531. The courts have held that a claim will not be denied simply because a physician reasonably may be unwilling or unable to account, as a percentage or otherwise, for the exact degree of impairment caused by pneumoconiosis. *See, e.g., Barger* v. *Abston Constr. Co.,* 196 F.3d 1261 (11th Cir. 1999) (Table) (opinion

that pneumoconiosis was ''at least a partial contributing cause'' of miner's disability sufficient to prove disability due to pneumoconiosis); *Cross Mountain Coal Co.* v. *Ward,* 93 F.3d 211, 218 (6th Cir. 1996) (opinion that miner's ''impairment is due to his combined dust exposure, coal workers'' pneumoconiosis as well as his cigarette smoking history'' sufficient); *Benjamin Coal Co.* v. *McMasters,* 27 F.3d 555 (3d Cir. 1994) (Table) (opinions that (1) pneumoconiosis was the ''least significant'' factor contributing to miner's disability, and (2) coal dust exposure and cigarette smoking contributed to miner's impairment but doctor was unable ''to differentiate between the effects of the two causes'' sufficient); *Compton* v. *Inland Steel Coal Co.,* 933 F.2d 477, 479 (7th Cir. 1991) (opinion that ''pneumoconiosis * * * was one of the conditions that brought about the pulmonary impairment'' sufficient); *Robinson* v. *Pickands Mather & Co.,* 914 F.2d 35, 36 (4th Cir. 1990) (opinion that miner's ''disability was consistent with occupational pneumoconiosis'' sufficient); *Lollar* v. *Alabama By-Products Corp.,* 893 F.2d 1258, 1267 (11th Cir. 1989) (physician's diagnosis of ''restrictive pulmonary functions and pleural disease by chest x-ray with minimal parenchymal disease, all of which is consistent with coal workers' pneumoconiosis,'' sufficient); *Adams* v. *Director, OWCP,* 886 F.2d 818, 826 (6th Cir. 1989) (diagnosis of ''total disability resulting from a combination of pneumoconiosis, emphysema and chronic obstructive lung disease'' sufficient); *Bonessa* v. *United States Steel Corp.,* 884 F.2d 726 (3d Cir. 1989) (opinion that pneumoconiosis made a ''substantial contribution'' to miner's disability sufficient); *Mangus* v. *Director, OWCP,* 882 F.2d 1527 (10th Cir. 1989) (evidence that miner's pneumoconiosis caused complications requiring removal of entire lung during surgery intended to remove only part of lung as treatment of lung cancer, sufficient).

(c)(i) One comment states the Department has not justified its revision of § 718.204(a) making disabling non-pulmonary/respiratory impairments irrelevant in determining whether a miner is totally disabled under the BLBA. The Department has previously addressed this issue in both the initial and second notices of proposed rulemaking. 62 FR 3344–45 (Jan. 22, 1997); 64 FR 54979 (Oct. 8, 1999). In both instances, the Department cited *McAngues,* 996 F.2d 130, as authority for its view that non-pulmonary/respiratory impairments cannot be considered in a disability determination. *McAngues,* 996 F.2d at 134–35, quotes with approval the following language from *Twin Pines Coal Co.* v. *U.S. Dept. of Labor,* 854 F.2d 1212 (10th Cir. 1988):

> * * * [A] review of the cases, the statute, its legislative history, and its interpretation by the benefits review board * * * shows that the statute is intended to confer special benefits on miners who are disabled due to pneumoconiosis whether or not they are disabled from a different cause. Even when other causes are themselves independently disabling '[t]he concurrence of two sufficient disabling medical causes one within the ambit of the Act, and the other not, will in no way prevent a miner from claiming benefits under the Act.'

854 F.2d at 1215, *quoting Peabody Coal Co.* v. *Director, OWCP* [*Huber*], 778 F.2d 358, 363 (7th Cir. 1985); *see also Cross Mountain Coal Co.* v. *Ward,* 93 F.3d 211, 217 (6th Cir. 1996). This line of authority from three federal courts of appeals fully supports the Department's revision of § 718.204(a). Although *Vigna* adopts a contrary interpretation of the BLBA, the Seventh Circuit did not address its own precedent in *Huber* or the contrary decisions in *McAngues* and *Twin Pines.* Accordingly, the Department does not consider *Vigna* a sufficient basis for altering the regulation. (ii) Several comments support the Department's position.

(d) One comment contends the limitations on introducing evidence concerning non-respiratory or pulmonary impairments deprive the ''but for'' disability causation standard of any practical meaning in terms of proving that pneumoconiosis played little, if any, role in the miner's disability. The Department disagrees with the commenter's position for two reasons. First, the Department has adopted a ''substantially contributing cause'' standard, which is not the equivalent of a ''but for'' standard. ''Substantially contributing cause'' means pneumoconiosis has a material adverse effect on a miner's respiratory or pulmonary condition (§ 718.204(c)(1)(i)). This standard is less rigorous than a ''but for'' test. Second, only respiratory and pulmonary impairments are relevant to determining whether the miner is totally disabled for purposes of the Black Lung Benefits Act, and identifying the causes of that disability. The commenter's position effectively rests on the Seventh Circuit's interpretation of disability causation in *Peabody Coal Co.* v. *Vigna,* 22 F.3d 1388 (7th Cir. 1994). In that decision, the Court held a miner's entitlement to benefits was precluded by his disabling stroke because the stroke was unrelated to coal mine employment and occurred before any evidence the miner was disabled by pneumoconiosis. The Department disagrees with *Vigna.* Non-respiratory or pulmonary disabilities may co-exist with total disability due to pneumoconiosis, but the former are irrelevant for purposes of determining whether a miner is entitled to black lung benefits. Consequently, non-respiratory or pulmonary impairments have no relevance to the disability causation standard, and the limitation on introducing evidence concerning such conditions is appropriate.

(e) Three comments oppose the revised definition of ''total disability'' to the extent it requires proof of a totally disabling respiratory or pulmonary impairment. The commenters urge the Department to adopt a definition which incorporates a ''whole person'' definition of disability, *i.e.,* total disability based on a combination of pneumoconiosis and any other physical impairments which prevent the miner from performing his or her usual coal mine work or comparable and gainful work. The Department has previously rejected the ''whole person'' standard in both the initial and second notices of proposed rulemaking. 62 FR 3345 (Jan. 22, 1997); 64 FR 54979 (Oct. 8, 1999). The Department has consistently taken the position that proof of a totally disabling respiratory or pulmonary impairment is an essential element of a miner's claim for black lung benefits. *See, e.g., Beatty* v. *Danri Corp. & Triangle Enter.,* 49 F.3d 993, 1001 (3d Cir. 1995); *Jewell Smokeless Coal Corp.* v. *Street,* 42 F.3d 241, 243 (4th Cir. 1994); *Lollar* v. *Alabama By-Products Corp.,* 893 F.2d 1258, 1262–1263 (11th Cir. 1990); *Bosco* v. *Twin Pines Coal Co.,* 892 F.2d 1473, 1480 (10th Cir. 1989); *Adams* v. *Director, OWCP,* 886 F.2d 818, 820 (6th Cir. 1989). Adoption of a ''whole person'' definition of total disability would greatly expand the black lung benefits program and transform it into a general disability program for coal miners. The Department is convinced such a result has never been the intent of Congress. Moreover, unlike the Social Security Administration which has regulations, procedures, and personnel devoted to the evaluation of impairments from the ''whole person'' perspective, the Department simply is not equipped to evaluate such impairments. The Department's approach to the definition of total disability is not undermined by the allowance of survivors' claims where death was due in part to nonrespiratory or nonpulmonary

conditions but was actually hastened by pneumoconiosis.

Allowance of survivors' claims in such situations is consistent with the legislative history of the 1981 amendments to the BLBA. 62 FR 3345 (Jan. 22, 1997); 48 FR 24276–77 (May 31, 1983), In addition, the determination of whether pneumoconiosis actually hastened death in a given case does not require the types of regulations, procedures and personnel that would be required by a ''whole person'' disability definition.

(f) One comment opposes the requirement in § 718.204(b)(2)(iv) that a physician's opinion must be documented as well as reasoned in order to establish the existence of a totally disabling respiratory or pulmonary impairment. The commenter states that an opinion should be considered sufficient if it is ''reasoned.'' The commenter also criticizes the regulation for failing to define the requisite documentation. The commenter does not state a basis for changing the regulation. The most fundamental requirement for any physician's opinion is that it identify the information and data upon which the physician relies in order to form a judgment about the miner's pulmonary condition. Unless the adjudicator is aware of the documentation, (s)he is in no position to determine whether the opinion is ''reasoned.'' A physician provides a ''reasoned'' opinion by explaining conclusions in light of factual premises which consist of personal and occupational information about the miner and the results of clinical tests and a physical examination, *i.e.,* the ''documentation.'' *See generally Director, OWCP* v. *Rowe,* 710 F.2d 251, 255 (6th Cir. 1983). If one or more of the premises is faulty or inconsistent with the conclusions reached by the physician, the adjudicator may find the opinion not credible. Contrary to the commenter's position, a physician's reasoning cannot be divorced from the underlying documentation. As for defining the necessary documentation, § 718.104(a) sets forth the basic requirements for any report of physical examination obtained in connection with a claim for black lung benefits, and subsection (b) accommodates any additional testing the physician may consider useful.

(g) One comment challenges the Department's authority to promulgate a disability causation standard. The commenter also contends the Department cannot adopt a causation standard which permits a finding of total disability due to pneumoconiosis if the miner's pneumoconiosis worsens a totally disabling respiratory or pulmonary impairment which is itself unrelated to coal mine employment. § 718.204(c)(1)(ii). The Department rejects both positions. The Department has previously addressed comments contesting its authority to issue a regulation defining disability causation in the second notice of proposed rulemaking. 64 FR 54979–80 (Oct. 8, 1999). The Department cited the explicit rulemaking authority conferred by Congress in 30 U.S.C. 902(f)(1), which makes ''total disability'' subject to the meaning established by the Department through regulations. The Department also noted that benefits may be paid for total disability ''due to pneumoconiosis,'' 30 U.S.C. 922(a)(1), but that ''due to'' is ambiguous and therefore a valid subject for regulatory interpretation. With respect to the ''worsening'' standard, the Department adopted this definition in response to the Fourth Circuit's decision in *Dehue Coal Co.* v. *Ballard,* 65 F.3d 1189 (4th Cir. 1995). In that decision, the Court held that a miner who had totally-disabling lung cancer was not entitled to benefits because his pneumoconiosis, by definition, could not contribute to his disability. The Department believes a miner should not be denied benefits if the miner's pneumoconiosis causes further deterioration of a totally disabling (non-occupationally related) pulmonary or respiratory impairment. Although the effect is cumulative or additive, the pneumoconiosis nevertheless further diminishes the miner's already-compromised lung function. The Department stresses that this causation standard does not require an award of benefits simply because the miner has pneumoconiosis and the pneumoconiosis adversely affects his or her pulmonary condition. No award is permitted if there is not also present a totally disabling respiratory or pulmonary impairment. In such a case, the miner is entitled to benefits because (s)he is totally disabled and pneumoconiosis is a part of the overall disabling condition.

(h) Three comments contend generally that the disability causation standard promotes awards for smoking-induced disability. The Department has previously considered, and rejected, the same contention in the second notice of proposed rulemaking. 64 FR 54980 (Oct. 8, 1999). The BLBA, judicial precedent, and the program regulations do not permit an award based solely on smoking-induced disability. Because the commenters do not state any additional grounds for their contention, no further response is necessary.

(i) One comment suggests the role of smoking in causing disability undermines the regulatory presumptions by negating the validity of their factual premises. Specifically, the commenter argues that the rational connection between established and presumed facts is broken if the miner smoked. The Department disagrees with this analysis. The presumptions contained in §§ 718.302–718.306 are all derived from the BLBA. *See* 30 U.S.C. 921(c)(1) [implemented by § 718.302]; 921(c)(2) [implemented by § 718.303]; 921(c)(3) [implemented by § 718.304]; 921(c)(4) [implemented by § 718.305]; 921(c)(5) [implemented by § 718.306]. The regulatory presumptions are therefore authorized by the statute itself. The Supreme Court has upheld the constitutionality of 30 U.S.C. 921(c)(1)–(4) in *Usery* v. *Turner Elkhorn Mining Co.,* 428 U.S. 1, 22–31 (1976). In the 1981 amendments to the BLBA, Congress limited the applicability of 30 U.S.C. 921(c)(2) and (4) to claims filed before January 1, 1982, and 921(c)(5) to claims filed before June 30, 1982. Consequently, three of the statutory presumptions have little effect on the adjudication of black lung claims at this time. The Department also does not accept the commenter's premise that allegedly widespread cigarette smoking among miners has effectively destroyed the basis for the presumptions. If any individual miner's smoking is proven the sole cause of his or her disability, death or disease, the party opposing entitlement has rebutted the presumption (except with respect to § 718.304, which is irrebuttable). The presumption itself is not invalid if the presumed fact is disproved; rather, the evidence simply establishes that the presumed facts are not true in the particular case. Accordingly, the Department rejects the commenter's view that the incidence of smoking among miners necessarily causes constitutional infirmities in the regulatory presumptions.

(j) One comment urges the Department to join the lawsuit filed by the Department of Justice to recover money from the tobacco industry for benefits approved by the Department based on disability caused by cigarette smoking. The comment is not directed to any regulatory proposal, and no response is warranted.

(k) One comment supports the ''substantially contributing cause'' standard.

(l) No other comments have been received concerning this section, and no changes have been made in it.

20 CFR 718.205

(a) In the initial notice of proposed rulemaking, the Department proposed codifying its position, unanimously supported by circuit court precedent, that recognizes a causal relationship between a miner's death and pneumoconiosis if the disease hastened the miner's death. 62 FR 3345–46, 3378 (Jan. 22, 1997). The Department responded to the comments received when it issued the second notice of proposed rulemaking. 64 FR 54980 (Oct. 8, 1999). Several comments urged the Department to reinstate automatic entitlement for survivors of miners who were totally disabled by pneumoconiosis, but did not die from that disease (so-called ''unrelated death benefits''); one comment concluded the Department had effectuated that result by adopting the ''hastening death'' standard in § 718.205(c)(5). The Department rejected the first suggestion because the 1981 amendments to the Black Lung Benefits Act (BLBA) allow benefits in survivors' claims filed after January 1, 1982, only if the miner died due to pneumoconiosis. Similarly, the Department disagreed with the commenter's interpretation of the ''hastening death'' standard, citing its universal acceptance by the six circuits with jurisdiction over 90 percent of black lung claims litigation. The Department also rejected a recommendation that it make applicable to claims filed after January 1, 1982, a more lenient regulatory standard applicable to claims filed before 1982, since the standard was based on a statutory presumption (30 U.S.C. 921(c)(2)) repealed by Congress in the 1981 amendments. The Department did not propose any further changes to § 718.205 in the second notice of proposed rulemaking, although the regulation remained open for further comment. 64 FR 54971 (Oct. 8, 1999).

(b) One comment opposes the ''hastening death'' standard because it reinstates survivors' ''unrelated death benefits.'' The commenter states broadly that any lingering, non-traumatic, death will be affected by every disease process present in the individual. The Department disagrees. The commenter does not cite any medical support for its position, and it does not respond to the Department's explanation rejecting any similarity between the ''hastening death'' standard and ''unrelated death benefits'' in the second notice of proposed rulemaking. 64 FR 54980 (Oct. 8, 1999). Moreover, the commenter's premise overlooks the role of the claims adjudication process, which requires the claimant to submit credible medical evidence establishing a detectable hastening of the miner's death on account of pneumoconiosis. The party opposing entitlement has ample opportunity in each survivor's claim to submit evidence proving pneumoconiosis played no role in the miner's death.

(c) One comment argues that at least half of approved survivors' claims are based on deaths attributable to the adverse health effects of smoking. The commenter recommends reallocating the costs of these claims to the tobacco industry. The comment is not directed toward any regulatory proposal, and no response is warranted.

(d) Two comments generally assert the ''hastening death'' standard cannot be implemented by the Department because the regulation violates the notice and comment provisions of the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.* The commenters do not indicate in what manner these APA requirements have been violated. Assuming the commenters are asserting the Department improperly adopted the ''hastening death'' standard in litigation rather than through rulemaking, the Department disagrees. The Department promulgated 20 CFR 718.205 in 1983, after complying with the APA's notice and comment provisions, in response to the 1981 amendments to the BLBA. 48 FR 24272 (May 31, 1983). Under those amendments, a deceased miner's survivor who filed a claim on or after January 1, 1982, is eligible for benefits only if the miner's death was due to pneumoconiosis. Based on the legislative history of the 1981 amendments, the Department provided that death will be considered ''due to pneumoconiosis'' where pneumoconiosis was at least ''a substantially contributing cause or factor.'' 20 CFR 718.205(c)(2) (1999). In later litigation, the Department set forth its interpretation of the regulatory phrase ''substantially contributing cause or factor,'' and consistently maintained that this standard is met by evidence proving pneumoconiosis actually hastened the miner's death. The ''hastening death'' standard gives practical meaning to the phrase ''substantially contributing cause.'' *See Bradberry* v. *Director, OWCP,* 117 F.3d 1361, 1365–66 (11 Cir. 1997) *and* cases cited therein. The Department is the administrator of the BLBA and, in that role, has the authority to interpret its own regulations. Indeed, because the Department's interpretation is reasonable and consistent with the regulatory language, every court of appeals to have considered the question has deferred to the Department's interpretation. *Bradberry,* 117 F.3d 1361, 1366–67; *Northern Coal Co.* v. *Director, OWCP,* 100 F.3d 871, 874 (10th Cir. 1996); *Brown* v. *Rock Creek Mining Co.,* 996 F.2d 812, 816 (6th Cir. 1993); *Peabody Coal Co.* v. *Director, OWCP,* 972 F.2d 178, 183 (7th Cir. 1992); *Shuff* v. *Cedar Creek Coal Co.,* 967 F.2d 977, 980 (4th Cir. 1992), *cert. den.* 506 U.S. 1050 (1993); *Lukosevicz* v. *Director, OWCP,* 888 F.3d 1001, 1006 (3d Cir. 1989). Accordingly, the ''hastening death'' standard is a permissible interpretation of § 718.205(c)(2), which was promulgated after public notice and comment in accordance with the APA.

(e) Two comments contend the Department cannot apply § 718.205(c)(5) to pending claims without violating a prohibition on retroactive rulemaking. (i) The Department previously addressed the retroactivity issue in the initial notice of proposed rulemaking. 62 FR 3347–48 (Jan. 22, 1997). The Department acknowledged the Supreme Court's holding in *Bowen* v. *Georgetown University Hospital,* 488 U.S. 204, 208 (1988), which limits the retroactive applicability of agency regulations unless Congress has expressly authorized such regulations. Although the Black Lung Benefits Act (BLBA) does not contain the express statutory authority required by *Bowen,* the Department concluded many of the proposed regulations could nevertheless apply to pending claims. These regulations, or revisions to regulations, principally clarify the Department's interpretation of the BLBA and the current program regulations. Revised regulations which could significantly change the regulated community's existing obligations and expectations, however, apply only prospectively to claims filed after the effective date of the final regulations. The Department reiterated this position in the second notice of proposed rulemaking. 64 FR 54981–82 (Oct. 8, 1999). It rejected recommendations to make all of the revisions either fully retroactive or entirely prospective. The Department adhered to its earlier explanation in the initial notice of proposed rulemaking: some regulations could apply to pending claims because they codify existing agency interpretations of the BLBA and regulations, while other regulations must be limited to prospective application because they involve significant changes to the existing program which could disrupt the parties' interests. The Department therefore declined to adopt a single approach for all of the revisions. Finally, the Department rejected arguments against retroactive

rulemaking premised on the Contract Clause of the United States Constitution, art. I, § 10, cl. 1, and the impairment of contracts. 64 FR 54981–82 (Oct. 8, 1999). (ii) The most recent comments do not cite any legal authority contradicting the Department's extensive analysis of the retroactivity issues in the initial and second notices of proposed rulemaking. In any event, the Department's analysis remains valid. An agency regulation does not run afoul of *Bowen* simply because it may operate retroactively. ''So long as a change in a regulation does not announce a new rule, but rather merely clarifies or codifies an existing policy, that regulation can apply retroactively. A rule clarifying an unsettled or confusing area of the law 'does not change the law, but restates what the law according to the agency is and has always been' * * * [.]'' *Orr* v. *Hawk,* 156 F.3d 651, 654 (6th Cir. 1998), *reh'g en banc den.,* 172 F.3d 411 (6th Cir. 1999), *quoting Pope* v. *Shalala,* 998 F.2d 473, 483 (7th Cir. 1993). *See also First National Bank of Chicago* v. *Standard Bank & Trust,* 172 F.3d 472, 478 (7th Cir. 1999) (noting *Bowen's* ban on retroactivity is inapplicable if rule is clarification rather than legislative change); *compare National Mining Assoc.* v. *U.S. Dept. of Interior,* 177 F.3d 1, 8 (D.C. Cir. 1999) (agency rule interpreting statute to impose liability for pre-rule acts gives retroactive effect which *Bowen* prohibits absent express statutory authority). As the Department explained in both the initial and second notices of proposed rulemaking, § 718.205(c)(5) simply codifies the Department's longstanding interpretation of the legal standard for proving a miner's pneumoconiosis was a ''substantially contributing cause'' of his or her death under the BLBA and part 718 regulations. 62 FR 3345–46 (Jan. 22, 1997); 64 FR 54980 (Oct. 8, 1999). Six circuit courts have adopted this interpretation while no court has disagreed. *Bradberry* v. *Director, OWCP,* 117 F.3d 1361, 1365–66 (11th Cir. 1997); *Northern Coal Co.* v. *Director, OWCP,* 100 F.3d 871, 874 (10th Cir. 1996); *Brown* v. *Rock Creek Mining Co.,* 996 F.2d 812, 816 (6th Cir. 1993); *Peabody Coal Co.* v. *Director, OWCP,* 972 F.2d 178, 183 (7th Cir. 1992); *Shuff* v. *Cedar Creek Coal Co.,* 967 F.2d 977, 980 (4th Cir. 1992), *cert. den.* 506 U.S. 1050 (1993); *Lukosevicz* v. *Director, OWCP,* 888 F.2d 1001, 1006 (3d Cir. 1989); *but see Tackett* v. *Armco, Inc.,* 16 Black Lung Rep. 1–88, 1–93 (1992), *vacated on remand* 17 Black Lung Rep. 1–103, 1–104 (1993) (rejecting ''hastening death'' standard, but vacating opinion on remand in light of controlling decision in *Shuff*). Section 718.205(c)(5) therefore represents a clarifying regulation which the Department may validly implement with retroactive effect for claims pending on the date the regulation becomes effective. (iii) Based on the foregoing analysis, the Department also rejects one commenter's position that the BLBA requires a ''direct cause and effect relationship'' between the miner's pneumoconiosis and death in order for a survivor to be entitled to benefits, at least insofar as the commenter would require that pneumoconiosis be the immediate, sole and proximate cause of the miner's death. Pneumoconiosis may be the direct, or proximate, cause of a miner's death (§ 718.205(c)(1)), but entitlement may also be premised on the lesser ''hastening death'' standard (§ 718.205(c)(2), (5)). The circuit court precedents cited above have unanimously upheld this interpretation. In both cases, a ''direct'' effect links the pneumoconiosis to the miner's death, *i.e.,* either as the leading, or contributing, cause of the miner's death. The Department's interpretation reflects Congressional intent that benefits be awarded if the survivor establishes that pneumoconiosis was a contributing cause of the miner's death, although not the sole and immediate cause. *See* 45 FR 13690 (Feb. 29, 1980); 48 FR 24276–78 (May 31, 1983).

(f) The Department received written comments and expert hearing testimony from physicians on the role pneumoconiosis may play in a miner's death. (i) *Expert Comments.* Drs. Ben V. Branscomb, Distinguished Professor Emeritus, University of Alabama (Birmingham), and William C. Bailey, Professor of Medicine and Eminent Scholar, Chair in Pulmonary Disease, University of Alabama (Birmingham), (Rulemaking Record Ex. 5–174, Appendix 8), comment that the medical literature does not substantiate any hastening effect of simple pneumoconiosis on the timing of a miner's death. They do acknowledge that severe complicated pneumoconiosis could have an additive effect in some instances, but only by reducing the miner's lifespan marginally. The physicians conclude that pneumoconiosis usually does not affect a miner's death from non-lung disease conditions, nor does mild or moderate stable pulmonary insufficiency affect other diseases leading to death. At the Department's Washington, D.C., public hearing, Dr. Branscomb also observed that simple pneumoconiosis has no effect on the common causes of death, and does not otherwise influence the course of a miner's death. Rulemaking Record (Ex. 35), Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), pp 47–48. At the same hearings, Dr. Robert Cohen, Chief, Division of Pulmonary Medicine, Cook County (IL) Hospital, generally described the means by which impairment of lung function from pneumoconiosis could weaken the body's defenses to infections and increase susceptibility to other disease processes. Rulemaking Record (Ex. 35), Transcript (July 23, 1997), pp 421–23. Dr. Gregory J. Fino, board-certified in Internal Medicine and in the subspecialty of Pulmonary Disease, (Rulemaking Record, Ex. 89–37, Appendix C), notes several studies which have shown that complicated pneumoconiosis is a cause of death, while other studies provide less authoritative evidence that simple pneumoconiosis may be a cause of death. This physician concludes that pneumoconiosis may be implicated in a miner's death provided the death is respiratory-related and the pneumoconiosis has caused respiratory dysfunction during the miner's life. With respect to non-respiratory deaths, Dr. Fino states that the medical literature does not document any contributory relationship between death and pneumoconiosis. (ii) *Scientific literature.* One of the principal scientific documents cited by the Department in both the initial and second notices of proposed rulemaking is the National Institute of Occupational Safety and Health's (NIOSH) *Criteria for a Recommended Standard, Occupational Exposure to Respirable Coal Mine Dust* (1995) (*Criteria*). 62 FR 3343 (Jan. 22, 1997); 64 FR 54978–79 (Oct. 8, 1999); Rulemaking Record, Exhibit 2–1. NIOSH cited studies from the United States and the United Kingdom which documented increases in mortality among miners from lung diseases related to respirable dust. *Criteria,* § 4.2.5.1, Rulemaking Record, Exhibit 2–1 at 63–64, *citing* Miller BG, Jacobsen M, ''Dust exposure, pneumoconiosis, and mortality of coal miners,'' Br J Ind Med 42:723–733 (1985), and Keumpel ED, *et al.,* ''An exposure-response analysis of mortality among U.S. miners,'' Am J Ind Med 28(2):167–184 (1995). Miller and Jacobson noted ''significant'' increases in mortality among U.K. miners with radiographic evidence of progressive massive fibrosis, and ''slightly decreased'' survival rates among miners with radiographic evidence of simple pneumoconiosis compared to miners without pneumoconiosis. Kuempel *et*

al. found increases in pneumoconiosis mortality among U.S. miners with progressive massive fibrosis, simple pneumoconiosis and exposure to dust of higher-rank coals. Based on these studies, NIOSH concluded: ''[M]iners with working lifetime exposures to respirable coal mine dust at a mean concentration of 2 mg/m^3 have an increased risk of dying from pneumoconiosis, chronic bronchitis, or emphysema.'' *Criteria,* § 4.2.5.1, Rulemaking Record, Exhibit 2–1 at 64. In the second notice of proposed rulemaking, the Department referenced another study which NIOSH had cited to the Department, Coggon D, *et al.,* ''Coal mining and chronic obstructive pulmonary disease: a review of the evidence,'' Thorax 53:398–407 (1998); *see also* 64 FR 54979 (Oct. 8. 1999). The authors reviewed studies on mortality in coal miners and reported that mortality attributed to chronic obstructive pulmonary disease was higher in miners than the general population. Among the studies submitted by one commenter is Green FHY, Vallyathan V, ''Coal Workers' Pneumoconiosis and Pneumoconiosis Due to Other Carbonaceous Dusts,'' in Chung A, Green FHY, eds., *Pathology of Occupational Lung Disease* (2d ed. 1998) 129; *see also* Rulemaking Record, Exhibit 89–21, attachment 2. Green and Vallyathan state that ''[a]pproximately 4% of coal miner deaths are directly attributable to pneumoconiosis,'' but note that the ''excess mortality rate from pneumoconiosis'' is primarily attributable to progressive massive fibrosis. (p. 137). The authors further note, however, that ''[d]eath from pneumoconiosis, chronic bronchitis, and emphysema has been related to cumulative dust exposure,'' citing Miller and Jacobson, and Kuempel *et al.* In contrast, Parker and Banks conclude, ''a series of mortality reports have not convincingly shown that simple [coal workers' pneumoconiosis] is associated with premature mortality, but that [progressive massive fibrosis] adversely affects survival * * *.'' Parker, Banks, ''Lung diseases in coal workers,'' *Occupational Lung Disease* (1998); *see also* Rulemaking Record, Exhibit 89–21, attachment 3. Parker and Banks also cite the results of the study by Kuempel *et al. See also* Morgan WKC, ''Dust, Disability, and Death,'' Am Rev Resp Dis 134:639, 641 (1986); Rulemaking Record, Exhibit 89–21, attachment 8 (concluding more emphasis should be placed on reducing cigarette smoking among miners than dust levels in mines to reduce mortality). (iii) By incorporating the ''hastening death'' standard into the regulation, the Department is clarifying the applicable statutory standard: a survivor is entitled to benefits if the miner's death was due to pneumoconiosis. This standard, in the Department's view as well as in the unanimous view of the circuit courts of appeals that have considered it, accords with Congress' intent to compensate survivors of miners whose deaths were in some way related to pneumoconiosis, as that term is broadly defined by the statute. The Department emphasizes, however, that the survivor must establish that the miner's death was hastened by pneumoconiosis in each case. The Rulemaking Record, including the variety of expert medical comments, studies and opinions on the potential contributory role of pneumoconiosis in the deaths of coal miners, does not demonstrate the necessity to depart from the hastening death legal standard. These views appear relatively consistent in stating that complicated pneumoconiosis (also called progressive massive fibrosis) may contribute to a miner's death given the severity of the disease. While opinions differ as to the possibility that simple pneumoconiosis can adversely affect the mortality process, the Department is persuaded by NIOSH's conclusion that the mortality studies it reviewed substantiate an increased risk of death from respiratory diseases which may be encompassed within the BLBA's definition of ''pneumoconiosis.'' NIOSH is the government agency charged with conducting research into occupationally-related health problems. In that capacity, the Department has previously consulted with NIOSH concerning issues related to the proposed definition of pneumoconiosis in § 718.201. 64 FR 54978–79 (Oct. 8, 1999); *see also* 30 U.S.C. 902(f)(1)(D) (Department to consult with NIOSH on criteria for tests which establish total disability in miners). The Department therefore considers NIOSH's view particularly significant in evaluating the conflicting medical opinions concerning the ''hastening death'' standard, especially since its views are consistent with other studies submitted into the record. To the extent the commenters express the view that simple pneumoconiosis can never cause death, such views are inconsistent with the BLBA. The statute contemplates an award of benefits based upon proof of pneumoconiosis as defined in the statute (which encompasses simple pneumoconiosis), and not just upon proof of complicated pneumoconiosis. *See, e.g., Penn Allegheny Coal Co.* v. *Mercatell,* 878 F.2d 106, 109–110 (3d Cir. 1989); *Wetherill* v. *Director, OWCP,* 812 F.2d 376, 382 (7th Cir. 1987). Similarly, regarding the connection between simple pneumoconiosis and non-respiratory deaths in particular, the comments from Drs. Bailey and Branscomb, along with those of Dr. Fino, focus on clinical pneumoconiosis as opposed to pneumoconiosis as more broadly defined by the statute; thus, they do not address whether, for instance, chronic obstructive pulmonary disease induced by coal mine dust exposure can, in certain circumstances, contribute to a non-respiratory death. Moreover, while Drs. Bailey and Branscomb indicate that a causal nexus between pneumoconiosis and a non-respiratory death would be unusual, they do not rule it out as a medical possibility. Dr. Cohen explained how such a cause and effect relationship could occur. Even though non-respiratory deaths hastened by pneumoconiosis may occur relatively infrequently, the survivor should nevertheless be given the opportunity to prove that pneumoconiosis had a tangible impact on the miner's death in those instances. Thus, the Department believes the ''hastening death'' standard sets a reasonable benchmark for proving, in any particular case, that pneumoconiosis contributed to the miner's death. Of course, the burden of persuasion remains with the survivor to prove that the miner's death was due to pneumoconiosis.

(g) One comment supports the ''hastening death'' standard.

(h) No other comments have been received concerning this section, and no changes have been made in it.

Subpart D

20 CFR 718.301

(a) In the initial notice of proposed rulemaking, the Department proposed deleting 20 CFR 718.301(b) (1999), which defined ''year'' for purposes of calculating the length of a miner's coal mine employment. 62 FR 3346 (Jan. 22, 1997). The Department proposed replacing subsection (b) and a separate provision in 20 CFR 725.493(b) (1999) (defining ''year'' of coal mine employment for identifying responsible operator) with a single definition of ''year'' in § 725.101(a)(32). The Department concluded that a single definition with general applicability was appropriate since the calculation of the length of a miner's employment is the same inquiry under both §§ 718.301 and 725.493(b). The Department proposed no additional changes to this regulation in the second notice of

proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section, and no other changes have been made in it.

20 CFR 718.307

(a) In the initial notice of proposed rulemaking, the Department proposed moving the content of § 718.307(a) to § 725.103 to establish a regulation of general applicability concerning burdens of proof. 62 FR 3346 (Jan. 22, 1997). The Department also proposed deleting § 718.307(b) because it duplicated proposed § 725.103. The Department did not discuss § 718.307 in its second notice of proposed rulemaking, although the regulation remained open for public comment. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section. It has therefore been removed.

20 CFR 718.401

(a) The Department proposed deleting 20 CFR 718.401 (1999) in the initial notice of proposed rulemaking because the provision duplicated material in proposed §§ 725.405 and 725.406. Former § 718.401 addressed each miner's statutory right to a complete pulmonary evaluation at no expense to the miner, a right outlined in proposed § 725.406. *See* 30 U.S.C. 923(b). Former § 718.401 also addressed the development of additional medical evidence necessary for the adjudication of a claim, subject matter that has been relocated to proposed § 725.405. Since both proposed § 725.405 and § 725.406 are regulations with program-wide applicability, the Department noted that no comparable regulation was necessary in part 718. 62 FR 3346 (Jan. 22, 1997). The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section. It has therefore been removed.

20 CFR 718.402

(a) The Department proposed deleting 20 CFR 718.402 (1999) in the initial notice of proposed rulemaking because its content duplicated provisions of proposed § 725.414, which addressed a claimant's unreasonable refusal to cooperate in the medical development of his claim. 62 FR 3346 (Jan. 22, 1997). The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section. It has therefore been removed.

20 CFR 718.403

(a) The Department proposed deleting 20 CFR 718.403 (1999) in the initial notice of proposed rulemaking and placing its provisions in part 725 as proposed § 725.103. Section 718.403 dealt with a party's burden of proof, and part 725 did not contain a comparable provision of program-wide applicability. 62 FR 3346 (Jan. 22, 1997). The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section. It has therefore been removed.

20 CFR 718.404

(a) The Department proposed deleting 20 CFR 718.404 (1999) in the initial notice of proposed rulemaking and placing its provisions in part 725 as proposed § 725.203(c) and (d). Former § 718.404(a) addressed a miner's obligation to inform the Department if (s)he returns to coal mine employment; subsection (b) recognized the Department's authority to reopen a miner's final award during his or her lifetime and develop additional evidence if any issue arises concerning the continuing validity of the award. 62 FR 3346 (Jan. 22, 1997). The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments were received concerning this section. It has therefore been removed.

Appendix B to Part 718

(a) In the initial notice of proposed rulemaking, the Department proposed eliminating the option of taking an initial inspiration from the open air before commencing the pulmonary function maneuver. 62 FR 3346 (Jan. 22, 1997). The Department noted that open-air inspiration could not be recorded on the spirogram, which precluded any confirmation by a reviewing physician that the miner had taken a full breath. Thus, the test could yield spurious abnormal values. In the second notice of proposed rulemaking, the Department proposed Appendix changes to implement a requirement that physicians use the flow-volume loop in reporting pulmonary function test results. 64 FR 54981 (Oct. 8, 1999). The Department also responded to numerous comments. Some comments considered the requirement that the two highest FEV1 results vary by no more than 5 percent or 100 ml to be overly restrictive, and suggested either eliminating the requirement or liberalizing it to allow a variability limit of 10 percent or 200 ml. The Department was reluctant to eliminate the variation standard completely because it provided a baseline for ensuring the validity of the test. The Department acknowledged, however, that some individuals might be unable to provide pulmonary function results within the 5 percent variance standard. The Department therefore invited comment on alternative criteria which would guarantee reproducibility of the FEV1 and FVC values while permitting consideration of valid FEV1 results exceeding the 5 percent standard. Other comments criticized the disability table values as too stringent. The Department declined to consider any changes to the tables because it did not propose revising them in the initial notice of proposed rulemaking, and the commenters did not provide medical support for any revisions.

(b) Three comments oppose limiting the acceptable variation between the two largest FEV1's of the three acceptable tracings to 5 percent of the largest FEV1 or 100 ml, whichever is greater. *See* Appendix B(2)(ii)(G), of part 718. One comment urges the Department to raise the acceptable percentage of variability from 5 percent to 10 percent. A second comment states the 5 percent variation is too specific. This commenter recommends the physician reporting the study be allowed to use his judgment as to whether the test is acceptable. The third comment, submitted by the National Institute of Occupational Safety and Health (NIOSH), does not identify a specific percentage of increased acceptable variability, but recommends the Department include a provision permitting consideration of pulmonary function studies which exceed the 5 percent limit provided the failure of the test to comply with the standard is noted in the report. The Department agrees with the suggested revision recommended by NIOSH, and has amended Appendix B(2)(ii)(G) to adopt that suggestion with one addition. The Department has added the phrase ''by the physician conducting or reviewing the test.'' This language will ensure that a physician certifies the results of the pulmonary function test while recognizing that it does not meet the 5 percent variability requirement. The amended language will provide the adjudicator with greater flexibility in determining whether the pulmonary

function study actually substantiates the presence of a significant pulmonary impairment, despite the lack of reproducible spirometric curves within the 5 percent range.

(c) One comment recommends the Department revise the disability tables and adopt the more liberal pulmonary function disability criteria used by the Department of Justice for the Radiation Exposure Compensation Program. Although the Department received comments criticizing the table values as too stringent in response to its initial notice of proposed rulemaking, the Department did not propose any revisions to the tables in the second notice of proposed rulemaking, in part, because the commenters failed to provide any medical support for their recommendation that the tables be modified. 64 FR 54981, 55009 (Oct. 8, 1999). The Department does not consider the present comment to provide a sufficient basis for revision of these disability criteria. It constitutes the only comment the Department has received which included medical evidence suggesting alternate table values. Thus, the Department cannot determine whether the proffered evidence represents a consensus within the medical community about disability as measured by pulmonary function studies. The Department does not have an adequate record upon which to formulate a judgment about the validity of the current tables or the proposed changes. No change in the Appendix B table values is made.

(d) No other comments have been received concerning this section, and no other changes have been made in it.

Appendix C to Part 718

(a) The Department proposed amending Appendix C in the initial notice of proposed rulemaking to state that arterial blood gas studies should not be administered to a miner during, or soon after, an acute respiratory illness. 62 FR 3346, 3381 (Jan. 22, 1997). In the preamble to § 718.105 in the second notice of proposed rulemaking, the Department stated that one comment had noted the correct nomenclature for partial pressure of oxygen and carbon dioxide is an upper-case ''P,'' not the lower-case ''p'' then in use. The Department changed the references in § 718.105(c)(6) in the second proposal, but neglected to change the Appendix C table headings. Those changes have now been made. 64 FR 54971, 54977, 55012, 55017–18 (Oct. 8, 1999).

(b) No other comments were received concerning Appendix C, and no further changes have been made in it.

20 CFR Part 722—Criteria for Determining Whether State Workers' Compensation Laws Provide Adequate Coverage for Pneumoconiosis and Listing of Approved State Laws

20 CFR Part 722

(a) In its initial notice of proposed rulemaking, the Department proposed removing many of the regulations in 20 CFR Part 722 because they were obsolete. 62 FR 3346–47 (Jan. 22, 1997). Since 1973, Part 722 has set forth a procedure under which any state may request that the Secretary certify that its workers' compensation laws provide ''adequate coverage'' for occupational pneumoconiosis. Such a certification would prevent any claim for benefits arising in that state from being adjudicated under the Black Lung Benefits Act. 30 U.S.C. 931. In addition, Part 722 has provided a set of specific criteria that states were required to meet in order to obtain the requested certification. Because the Part 722 regulations had not been amended since 1973 although the statute had been amended in both 1978 and 1981, the Department proposed replacing the specific Part 722 criteria with a general statement of the statutory criteria for certification and the statement that in the future, the Department would review the workers' compensation laws of any state that applies for certification in light of the then-current statutory requirements. The Department stated that it would certify adequate coverage only if state law guaranteed at least the same compensation, to the same individuals, as is provided by the Act. The Department did not address Part 722 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has replaced a comma in the second sentence of § 722.3(a) with a semicolon to correct the punctuation of that sentence. In addition, the Department has added the word ''relevant'' to qualify the phrase ''administrative or court decision'' in the same sentence. This revision clarifies the Department's intent that states submit only relevant administrative or court decisions.

(c) One comment, in the context of setting forth alternatives for the Department to consider under the Regulatory Flexibility Act, urges the Department to establish specific criteria the Department will use to determine when a state black lung program provides adequate coverage for pneumoconiosis. This revision, the commenter suggests, would allow state legislatures to make reasoned decisions about whether to amend their workers' compensation laws in an attempt to provide the ''adequate coverage for pneumoconiosis'' the federal statute requires. In addition, the commenter suggests that the Department establish a formal, ongoing review of state workers' compensation laws to determine whether or not they provide adequate coverage.

Although no state has applied for certification in the 27 years that the Department has administered the program, the Department accepts the commenter's suggestion that the publication of specific criteria would be helpful to state legislators who wish to amend their state's laws in order to obtain Secretarial certification and thereby preclude the application of federal law to their state's coal mine operators. Publication of a current set of criteria, however, will require considerable study and additional drafting, and would needlessly delay final promulgation of the remaining regulations in the Department's proposal. Following completion of that work, the Department will issue a new notice of proposed rulemaking in order to ensure that interested parties have an opportunity to comment upon possible Secretarial certification criteria. The Department believes that in the interim the revised Part 722 will accommodate any state seeking certification.

The Department does not believe, however, that it would be productive to engage in a formal, ongoing review of each state's laws in order to determine whether they provide adequate coverage for occupational pneumoconiosis. States that revise their workers' compensation laws to meet the Department's criteria will do so in order to preempt the application of the Black Lung Benefits Act. Those states will have a clear incentive to submit an application to the Department for the appropriate certification. Relying on states to initiate the certification process thus makes the most efficient use of government resources at both the state and federal levels.

(d) The Department has not received any specific comments relevant to the individual regulations in Part 722, and no changes have been made in them.

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

20 CFR 725.1

(a) In its first notice of proposed rulemaking, the Department proposed adding subsection (k) to § 725.1 to

describe the incorporation into the Black Lung Benefits Act of a number of provisions of the Social Security Act. In addition, the new subsection noted the Department's authority to vary the application of the incorporated provisions. 62 FR 3347 (Jan. 22, 1997). The Department did not discuss section 725.1 in its second notice of proposed rulemaking, *see* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment submitted in connection with the Department's first notice of proposed rulemaking and renewed in connection with the Department second notice of proposed rulemaking criticizes subsections (j) and (k) as confusing and inconsistent. The comment states that the subsections are confusing because they do not identify the individual instances in which the Department has altered the incorporated provisions of the Longshore and Harbor Workers' Compensation Act (LHWCA) and the Social Security Act (SSA). The comment also argues that the two subsections are inconsistent because subsection (j) limits the instances in which the BLBA departs from the LHWCA, while subsection (k) implies other departures may be contemplated. With respect to the first criticism, the Department believes that specific enumeration of the departures from incorporated LHWCA provisions is unnecessary. The objective of subsection (j) is simply to acknowledge that certain LHWCA provisions are incorporated into the Black Lung Benefits Act (BLBA) and that the BLBA confers specific authority on the Department to promulgate regulations which vary the terms of these incorporated provisions. *See* 30 U.S.C. § 932(a). Subsection (k) fulfills the same objective by acknowledging that there are also SSA provisions incorporated into the BLBA. Most of those provisions were incorporated into Part B of the BLBA, governing the adjudication of claims filed with the Social Security Administration prior to July 1, 1973, when Congress amended the BLBA in 1972 and 1977. *See, e.g.,* 30 U.S.C. 922(a)(5)(1)(B), incorporating the SSA definition of the term ''disability.'' These provisions are also incorporated into Part C, governing the adjudication of claims filed with the Labor Department, by 30 U.S.C. 940, but only ''to the extent appropriate.'' Subsection (k) recognizes the Department's authority to determine the extent to which the use of these incorporated provisions is appropriate. Furthermore, subsection (k) is consistent with subsection (j) because it notes that the Department may resolve conflicts which arise from the incorporation of inconsistent provisions of the two statutes. Thus, for example, the Department may choose to depart from an incorporated LHWCA provision (subsection (j)) because it has determined that a comparable but inconsistent SSA provision, which is also incorporated, better serves the interests of the program.

The Department acknowledges that, as originally proposed, subsection (k) did not contain any reference to the SSA excess earnings offset, 42 U.S.C. 403(b)–(1), incorporated into section 422(g). The Department's original explanation of subsection (k), 62 FR 3385 (Jan. 22, 1997), also inadvertently omitted specific mention of section 422(g). Section 430 gives the Department the authority to determine the extent to which application of incorporated SSA provisions into Part B of the Act is appropriate in the context of adjudicating claims under Part C. Section 422(g), however, provides no similar authority. It is located in Part C of the Act, and the Department applies the incorporated SSA offset provision as if it were a part of the BLBA. *See* 20 CFR 725.536 (1999). The Department has added an additional sentence to the end of subsection (k) to describe this incorporation. In addition, the Department has revised the first sentence of subsection (k) to recognize that section 402 of the BLBA is contained in Part A. The Department has also revised the fourth and seventh sentences of subsection (k) to clarify their meaning.

(c) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 725.2

(a) In its first notice of proposed rulemaking, the Department proposed revising section 725.2 in order to distinguish between revisions that would affect pending claims and revisions that would be applied prospectively only, *i.e.*, only to claims filed after the effective date of the revised regulations. The Department drew a distinction between revisions that merely clarified the Department's interpretation of the statute and existing regulations or were procedural regulations, and those that altered the obligations and expectations of the parties or could not easily be applied to pending claims. 62 FR 3347–48 (Jan. 22, 1997). The Department also explained the legal basis for its decision to apply certain regulations retroactively. In its second notice of proposed rulemaking, the Department added a regulation, § 725.351, to the list of revised regulations which would apply only prospectively. 64 FR 54981–82 (Oct. 8, 1999). In addition, the Department answered several comments, reiterating its belief that it lacked the statutory authority to make the final rule applicable, in its entirety, to all pending claims and rejecting the argument that the Department lacked the authority to apply any of the regulations to pending claims.

(b) One of the comments received in connection with section 725.367 contends that the Department's regulation governing the payment of attorneys' fees by responsible operators should not be applied retroactively. The Department agrees; section 725.367 was inadvertently omitted from the list of revised regulations in the Department's second notice of proposed rulemaking that should apply only to claims filed after the effective date of these revisions. As revised, the regulation significantly alters the attorneys' fees that are payable by the responsible coal mine operator. *See* 64 FR 54987 (Oct. 8, 1999) (discussing the Fourth Circuit's decision in *Clinchfield Coal Co.* v. *Harris*, 149 F.3d 407 (4th Cir. 1998)). In addition, because section 725.367 may increase the amount of attorneys' fees an operator has to pay in a contested case, it may influence the operator's decision to controvert the claimant's entitlement to benefits. In these circumstances, the Department agrees that the revised version of § 725.367 should not be applied to claims filed before the effective date of the Department's rulemaking. The Department also inadvertently omitted §§ 725.409, which governs denials of a claim by reason of abandonment, 725.416, which governs informal conference proceedings, and 725.458, which governs deposition testimony, from the list of revised regulations that should be applied prospectively only.

Similarly, section 725.465 was not open for comment in the Department's first notice of proposed rulemaking, 62 FR 3340–41 (Jan. 22, 1997). The Department proposed revising § 725.465 in its second notice of proposed rulemaking, 64 FR 54971, 54997 (Oct. 8, 1999), and has revised the regulation again in the final rule. As revised, § 725.465 prohibits the dismissal of the responsible operator finally designated by the district director from the adjudication of claims without the consent of the Director. The revision is an integral part of the new rules governing the identification, notification, and adjudication of which of the miner's former employers, if any, should be held liable for the payment of

his benefits (§§ 725.407–725.408, 725.415, 725.418, 725.491–725.495). The Department has also revised § 725.421(b), which governs the referral of a claim to the Office of Administrative Law Judges and the evidence to be transmitted to that Office for admission into the record at the hearing. The revisions to § 725.421(b) reflect the new rules governing the identification, notification and adjudication of the responsible operator. Because the revisions of those rules are prospective only, the revised version of sections 725.421(b) and 725.465 should be treated similarly. The Department has amended subsection (c) to add §§ 725.367, 725.409, 725.416, 725.421(b), 725.458, and 725.465 to the list of regulations which may be applied only prospectively.

(c) A number of comments continue to insist that the Department's regulations are impermissibly retroactive, and that the Department's proposal violates the Supreme Court's decisions in *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204 (1988) and *Eastern Enterprises* v. *Apfel*, 524 U.S. 498 (1998). In *Bowen*, the Supreme Court held that, absent an explicit statutory grant of authority, administrative agencies could not promulgate retroactive rules. In its first notice of proposed rulemaking, the Department acknowledged that the Black Lung Benefits Act did not give the Department authority to promulgate regulations with a retroactive effect. 62 FR 3347 (Jan. 22, 1997). *Eastern Enterprises* did not involve the regulatory authority of administrative agencies; in that case, a majority of the Court held the Congress had violated the due process clause of the Fifth Amendment to the Constitution by improperly imposing retroactive burdens on coal mine operators in enacting certain provisions of the Coal Industry Retiree Health Benefit Act. For purposes of analyzing the Department's regulations, *Bowen* is the more restrictive decision. Because Congress did not grant the Department specific authority to engage in retroactive rulemaking under the Black Lung Benefits Act, the regulations will be permissible under *Bowen* only if they do not have a true retroactive effect. *Eastern Enterprises*, a case in which the retroactive effect of the legislation was clear, is inapposite to this analysis.

The Department addressed the retroactivity issue in its earlier notices of proposed rulemaking, 62 FR 3347–48 (Jan. 22, 1997) and 64 FR 54981–82 (Oct. 8, 1999). The Department observed that the issue of what constitutes a retroactive effect is complex. With respect to rules that clarify the Department's interpretation of former regulations, the Department quoted *Pope* v. *Shalala*, 998F.2d 473 (7th Cir. 1993), *overruled on other grounds, Johnson* v. *Apfel*, 189 F.3d 561, 563 (7th Cir. 1999), for the proposition that an agency's rules of clarification, in contrast to its rules of substantive law, may be given retroactive effect. The Sixth Circuit issued a similar holding in *Orr* v. *Hawk*, 156 F.3d 651, 654 (1994).

Underlying both the *Pope* and *Orr* decisions is the Supreme Court's opinion in *Manhattan General Equipment Co.* v. *Commissioner*, 297 U.S. 129 (1936). Both the Sixth and Seventh Circuits quote *Manhattan General* for the proposition that a rule clarifying an unsettled or confusing area of law ''is no more retroactive in its operation than is a judicial determination construing and applying a statute to a case in hand.'' 297 U.S. at 135, quoted at 998 F.2d at 483; 156 F.3d at 653. Both courts thus recognized that the Supreme Court's decision in *Bowen*, which was issued in 1988, did not overrule its 1936 decision in *Manhattan General* with respect to what constitutes a retroactive rule. *See First National Bank of Chicago* v. *Standard Bank & Trust*, 172 F.3d 472, 478 (7th Cir. 1999) (stating that if the regulation at issue ''was merely a clarification, rather than a legislative change, *Bowen*'s ban on retroactivity is inapplicable'').

The Department's rulemaking includes a number of such clarifications. For example, the revised versions of §§ 718.201 (definition of pneumoconiosis), 718.204 (criteria for establishing total disability due to pneumoconiosis) and 718.205 (criteria for establishing death due to pneumoconiosis) each represent a consensus of the federal courts of appeals that have considered how to interpret former regulations. *See* preamble to §§ 718.201 (citing cases recognizing an obstructive component to pneumoconiosis); 725.309 (citing cases recognizing the progressive nature of pneumoconiosis); 718.204; and 718.205. Moreover, none of the appellate decisions with respect to these regulations represents a change from prior administrative practice. Thus, a party litigating a case in which the court applied such an interpretation would not be entitled to have the case remanded to allow that party an opportunity to develop additional evidence. *See Betty B Coal Co.* v. *Director, OWCP*, 194 F.3d 491, 501 (4th Cir. 1999) (''* * * we are reluctant to compel reopening as a matter of constitutional law any time debatable questions of law are resolved by the BRB or the courts. When such open questions are answered, the law has been declared, not changed.''). Any party to litigation must assume the risk that a law or regulation will be interpreted in a manner other than that which it had hoped. The Department's embodiment of those decisions in regulatory form should not insulate the parties from their application to pending claims.

Similarly, the regulations in Part 725 that the Department intends to apply to pending claims represent clarifications of unsettled or confusing areas of the law. In particular, one commenter has objected to the application of §§ 725.502, 725.537, and 726.8 to pending claims. Section 725.502 provides parties to a claim with knowledge of when each benefit payment is due. In the first notice of proposed rulemaking, the Department observed that the revisions are consistent with the Department's current practice, and with appellate decisions interpreting section 21(a) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 921(a), as incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a). 62 FR 3365 (Jan. 22, 1997). Section 725.537 codifies the Department's position, upheld in litigation, with respect to the payment of benefits in cases in which the miner is survived by more than one surviving spouse. The revision ensures the proper implementation of 42 U.S.C. 416(d)(1) and (h)(1), Social Security Act provisions that are incorporated into the Black Lung Benefits Act by 30 U.S.C. 902(a)(2). As *Pope* and *Orr* recognize, *Bowen* does not prohibit the Department from promulgating regulations to codify its position with respect to these issues. Finally, the Department has responded to the contention that retroactive liability is imposed by § 726.8 in the preamble to § 726.8.

The same commenter has also argued that §§ 725.542–.544, 725.547, and 725.548 should not be retroactively applied to coal mine operators. Section 725.2, however, explicitly makes § 725.547 applicable to newly filed claims only. Sections 725.542 through 725.544 are applicable to operators only by operation of section 725.547; they are therefore also applicable only to claims filed after the effective date of these regulations. Finally, § 725.548 represents a renaming and renumbering of a part of the former regulation at § 725.547. 64 FR 55003 (Oct. 8, 1999). The Department does not believe that its decision to rename and renumber a previous regulation should be considered in any way retroactive.

By contrast, where the revision represents a clear change in the Department's interpretation, such as the regulation governing the payment of attorneys' fees by responsible operators, *see* 64 FR 54987 (Oct. 8, 1999) (discussing the Fourth Circuit's decision in *Clinchfield Coal Co.* v. *Harris,* 149 F.3d 407 (4th Cir. 1998)), the Department has made the change prospective only. Similarly, the revised procedures governing the processing and adjudication of claims, sections 725.351, 725.406 through 725.418, 725.423, 725.454 through 725.459, and 725.465, the regulations governing the identity of the responsible operator liable for the payment of benefits, sections 725.491 through 725.495, and the revised regulation governing operator overpayments, section 725.547, are expressly limited in their applicability to newly filed claims. In addition, the revisions of sections 725.309 and 725.310, governing additional claims and modification, respectively, are prospective only. The Department has thus taken considerable care to ensure that its revisions do not violate the Supreme Court's general prohibition against retroactive regulations.

(c) One commenter urges that the Department's prospective revisions not be made applicable to subsequent claims. Instead, the commenter suggests, they should be applied only to first-time claims filed by new claimants. The Department does not agree that a subsequent claim differs from a first-time claim for purposes of applying the revised regulations. In 1983, the Department considered a similar request when it promulgated regulations to implement the Black Lung Benefits Amendments of 1981, which transferred liability for certain claims from coal mine operators to the Black Lung Disability Trust Fund. A number of commenters suggested that a ''claim'' should be defined as a cause of action, so that an individual would only ever have one ''claim'' for benefits. The Department rejected the suggestion:

> The Department believes that the claims as cause of action analogy is misplaced. The more correct analogy would be to a complaint or other preliminary pleading which is filed to initiate an adjudication of the nature of the right or the validity of the cause of action which is being asserted. Throughout its various versions, the Act has been consistent in requiring that a claim must be filed before any determination of eligibility for benefits could be undertaken.

48 FR 24283 (May 31, 1983). Similarly, the Department has always required that a subsequent claim be adjudicated according to the standards in effect at the time the new application is filed. For example, a miner whose 1977 claim was adjudicated and denied under the interim presumption, 20 CFR § 727.203 (1999), is not entitled to have a 1987 claim adjudicated under the same criteria. Instead, that claim must be adjudicated under the more restrictive Part 718 criteria. *See Peabody Coal Co.* v. *Spese,* 117 F.3d 1001, 1007 (7th Cir. 1997). The Department does not believe that it should alter its consistent treatment of subsequent claims in order to exclude those claims from consideration under the Department's revised regulations.

(d) One commenter urges the Department to alter its definition of a ''pending'' claim, which allows a claim to be considered ''pending'' for up to one year after it is denied. The commenter suggests that the definition violates the jurisdictional rules governing finality set forth in 33 U.S.C. § 921. The Department does not agree that its definition violates any principles of finality. Currently, a claimant may file a request for modification at any time within one year after the denial of a claim. 20 CFR § 725.310 (1999). In fact, even a new claim filed during the one-year period will serve to reopen the existing claim. *See Betty B Coal Co.* v. *Director, OWCP,* 194 F3d 491, 497 (4th Cir. 1999). Consequently, an employer has no expectation that a denied claim has been fully and completely resolved until after the one-year period has passed.

The Department's definition of a ''pending claim'' is intended to prevent the application of certain regulatory revisions (those which will be applied only on a prospective basis) to any claim that was filed before the date on which those revisions take effect. The definition includes claims pending at various stages of adjudication (*i.e.,* before the district directors, the Office of Administrative Law Judges, the Benefits Review Board, or the federal courts). In addition, some claims that have been finally denied prior to the effective date of the revisions can be revived by a subsequent request for modification. For example, a claim may have been finally denied three months before the rules became effective, and the claimant may file a request for modification nine months later (or six months after the revised regulations took effect). The Department does not intend that the revised regulations that are prospective only (including, for example, the limitation on evidence) be used to adjudicate such a claim, and has drafted the definition of a ''pending claim'' to ensure that result.

20 CFR 725.4

(a) In its first notice of proposed rulemaking, the Department proposed revising subsection (d) to reflect the Department's decision to discontinue publication of the Part 727 regulations in the Code of Federal Regulations. 62 FR 3348 (Jan. 22, 1997). Subsection (d) therefore referred parties interested in reviewing the Part 727 regulations to the **Federal Register** or the most recent version of the Code of Federal Regulations containing the rules. The Department did not discuss § 725.4 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Three comments urge the Department to continue publishing the Part 727 regulations because some claims governed by those regulations are still in litigation. It remains the Department's position, however, that future publication of Part 727 is unnecessary, in part because these regulations do not apply to any claim filed after March 31, 1980. Thus, more than twenty years have passed since claims were filed to which these regulations apply. In addition, the Code of Federal Regulations has printed these regulations annually for twenty years. Consequently, access to Part 727 is readily available in the public domain for the relatively few claims still subject to those regulations.

(c) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.101

(a)(i) The Department proposed amending the definition of ''benefits'' (§ 725.101(a)(6)) in the initial notice of proposed rulemaking to include the cost of the initial complete pulmonary examination of the claimant authorized by the statute, 30 U.S.C. 923(b); § 725.406, and subsidized by the Trust Fund. 62 FR 3386 (Jan. 22, 1997). Several commenters opposed the change because they believed the revised definition would impose liability for the examination's cost on the claimant if the claim were ultimately denied or withdrawn. In response, the Department assured the commenters that the cost could not be shifted to the claimant despite its classification as a ''benefit.'' 64 FR 54982 (Oct. 8, 1999). The Department also proposed adding a reference to augmented benefits and a cross-reference to its definitional regulation (§ 725.520(c)). 64 FR 55023 (Oct. 8, 1999). The Department intended this change for the convenience of parties looking for a comprehensive

definition. 64 FR 54982 (Oct. 8, 1999). (ii) Citing the Department's representations concerning the exclusion of the complete pulmonary examination from costs recoverable from the claimant, two comments now support the amended definition. (iii) One comment opposes the change because it shifts the cost of the examination to the responsible operator if the claim is approved. The Department responded to this argument in the second notice of proposed rulemaking by noting its disagreement; since 1978, the regulations (20 CFR 725.406(c)) have required the operator found liable for the claimant's benefits to reimburse the Fund for the expenses associated with the initial pulmonary examination. 64 FR 54982 (Oct. 8, 1999). The present comment states the Department does not have the authority to shift the cost of the examination, citing *West Virginia University Hospitals, Inc.* v. *Casey,* 499 U.S. 83 (1991). At issue in *Casey* was the authority of a federal court to shift liability from one party to its opponent for the fees of experts retained to perform nontestimonial services. The Supreme Court held the fee shifting must be limited to the specific categories of expenses enumerated in the statute which authorized the trial court to award fees. Because nontestimonial expert services did not come within the ambit of any statutory category of reimbursable expenses, the Court held the district court could not reallocate fee liability. In so holding, the Court rejected the argument that such expenses could be considered part of an ''attorney's fee,'' liability for which did shift.

The Department considers *Casey* inapposite to the redefinition of ''benefits.'' That decision establishes only that fees for nontestimonial expert services cannot be considered ''attorney fees'' for purposes of a statute which shifts attorney fee liability to a prevailing party's opponent. *Casey* does not preclude the Department from defining a particular nontestimonial expert service—the § 725.406 medical examination—as a ''benefit,'' liability for which does shift to the responsible operator if the claim is ultimately approved. (iv) The Department has the statutory authority to define ''benefits'' to include the cost of the initial medical examination, and to require a responsible operator to pay for the examination in the event the claim is ultimately approved. The Black Lung Benefits Act (BLBA) incorporates section 7 of the Longshore and Harbor Workers' Compensation Act (LHWCA). 33 U.S.C 907, as incorporated by 30 U.S.C 932(a). Section 7(e) provides:

> In the event that medical questions are raised in any case, the Secretary shall have the power to cause the employee to be examined by a physician employed or selected by the Secretary and to obtain from such physician a report containing his estimate of the employee's physical impairment * * * The Secretary shall have the power in his discretion to charge the cost of examination or review under this subsection to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk, in appropriate cases, or to the special fund * * *.

33 U.S.C. 907(e). Each miner's claim filed under the Black Lung Benefits Act (BLBA) raises ''medical questions'' because the status of the miner-claimant's pulmonary condition is the primary issue in every claim. Section 7(e) authorizes the Department to provide each miner-claimant with a complete pulmonary examination, and therefore address the ''medical questions'' raised by the claim. Thus, Section 7(e) provides the Department with the method for fulfilling its obligation under 30 U.S.C. 923(b) to provide each miner with the opportunity to substantiate his claim by undergoing a complete pulmonary evaluation. Section 7(e) also authorizes the Department, at its discretion, to charge the cost of the examination to the responsible operator. The Department's regulations have recognized this statutory authority since 1972, when section 7 was first incorporated into the BLBA, without regard to whether the claimant ultimately prevailed. 20 CFR 725.139, 37 FR 25466 (Nov. 30, 1972) (deputy commissioner has discretion to assess the operator or its insurer for the cost of a physician's examination conducted to resolve medical questions raised); 725.133 (1978) (deputy commissioner has the authority to assess a notified operator or its insurer for the cost of the miner-claimant's initial medical examination). The Department promulgated its current regulation implementing section 7(e) for BLBA purposes (20 CFR 725.406(c)) in 1978 after Congress amended section 413(b) to provide for complete pulmonary examinations. It requires the operator adjudged liable for the claimant's benefits to reimburse the Fund for the expenses associated with the examination. The Department has determined that such assessments are appropriate in those cases in which the award of benefits for which an individual operator is liable has become final. In the remaining cases, the Department believes the cost of the examinations should be absorbed by the coal mining industry as a whole by imposing the costs on the Trust Fund. 26 U.S.C. 9501(d)(1). As money payable under section 932(a), which incorporates section 7, the pulmonary examination cost is properly classified as a ''benefit'' and the liable operator must reimburse the Trust Fund for such cost under 30 U.S.C. 934. The responsible operator is required to secure the payment of benefits for which it is liable under section 932. 30 U.S.C. 933(a). The Department accordingly rejects the comment's position that it lacks the authority to define ''benefits'' to include the cost of the pulmonary examination required by 30 U.S.C. 923(b). (v) No other comments were received concerning this definition, and no changes were made in it.

(b)(i) In the initial notice of proposed rulemaking, the Department proposed amending § 725.101(a)(13), ''Coal Preparation,'' and (a)(19), ''Miner or Coal Miner,'' to specify that coke oven workers are excluded from coverage under the BLBA. 62 FR 3386, 3387 (Jan. 22, 1997). The Department received three comments supporting the proposed change, which were noted in the preamble to the second proposed rulemaking, 64 FR 54982 (Oct. 8, 1999). The Department further clarifies the intended scope of these definitions. In the initial notice of proposed rulemaking, the Department noted a long held position that ''the preparation activities undertaken at coke ovens are not covered by the BLBA.'' 62 FR 3348 (Jan. 22, 1997). The Department now believes this language may have been too broad, and accordingly amends the language of § 725.101(a)(19) to effectuate its intention that the definition of ''Miner'' exclude from coverage only those workers in the coke industry who are actually employed as coke-oven workers, *i.e.,* those at the coke-producing ovens. *See, e.g., Sexton* v. *Mathews,* 538 F.2d 88, 89 (4th Cir. 1975) (holding an individual who loaded coke ovens with coal, leveled the coal inside the oven, and shoveled finished coke for shipment, was not a ''coal miner'' under the BLBA). The Department, however, does not intend for the identity of the individual's employer as a coke manufacturer to be the determinative inquiry. In some cases, coke industry employees may be otherwise employed in activities which amount to custom coal preparation or come within the types of activities enumerated in § 725.101(a)(13). Those workers should not be excluded from BLBA coverage solely because they are employed by a coke producer. *See Hanna* v. *Director,*

OWCP, 860 F.2d 88, 92 (3d Cir. 1988) (stating: ''[T]he appropriate characterization of [the claimant's] work for purposes of entitlement under the Act is determined by evaluation of what he did, and not by who employed him''). The plain language of the statutory and regulatory definitions of ''miner'' focuses on what work the individual performed and where (s)he performed that work, and not who employed the individual. With respect to ''Coal preparation,'' the Department has deleted the reference to coke oven workers because the phrase is redundant in view of the language in ''Miner.'' (ii) No other comments were received concerning these definitions. (iii) The Department has changed § 725.101(a)(19) by substituting the words ''coal mine dust'' for ''coal dust.'' This change makes the regulation consistent with the Department's long-held position that the occupational dust exposure at issue under the BLBA is the total exposure arising from coal mining and not only exposure to coal dust itself. The Department previously explained this position in the second notice of proposed rulemaking. There the Department made the same change to § 725.491(d). 64 FR 54998 (Oct. 8, 1999). A comment responding to the initial notice of proposed rulemaking, 62 FR 3409 (Jan. 22, 1997), had identified an inconsistency between the reference to ''coal mine dust'' in the definition of a ''miner'' (§ 725.202) and the reference to ''coal dust'' in § 725.491. The Department agreed that a consistent reference to ''coal mine dust'' should be used throughout the regulations. ''Coal mine dust'' means any dust generated in the course of coal mining operations, including construction. The Department noted that this interpretation is consistent with Congressional intent to compensate for a broad array of dust-related lung diseases which can be linked to coal mining. 64 FR 54998 (Oct. 8, 1999). Finally, by making the change in § 725.101(a)(19), the Department expresses its disagreement with the result reached by the Tenth Circuit in *Bridger Coal Co./Pac. Minerals, Inc.* v. *Director, OWCP [Harrop],* 927 F.2d 1150 (10th Cir. 1991), which held that ''coal dust'' means only dust actually containing coal particulates. 927 F.2d at 1154. In the Department's view, *Harrop* represents too narrow a reading of Congress' intent. *See William Bros., Inc.* v. *Pate,* 833 F.2d 261, 264 (11th Cir. 1987); *Williamson Shaft Contracting Co.* v. *Phillips,* 794 F.2d 865, 870 (3d Cir. 1986) (both cases agreeing with the Department that ''coal mine dust'' is a permissible interpretation of BLBA).

(c) The Department proposed amending § 725.101(a)(16), ''District Director,'' in the initial notice of proposed rulemaking to substitute that title for ''Deputy Commissioner,'' and ensure that any actions taken by a district director would be afforded the same legal force as any action of a deputy commissioner. 62 FR 3348, 3386 (Jan. 22, 1997). No comments were received concerning this definition, and no changes were made in it.

(d) The Department proposed amending § 725.101(a)(17), ''Division or DCMWC,'' in the initial notice of proposed rulemaking to identify the agency within the Department which contains the Office of Workers' Compensation Programs and the Division of Coal Mine Workers' Compensation. 62 FR 3348, 3386 (Jan. 22, 1999). No comments were received concerning this definition, and no changes were made in it.

(e)(i) In the initial notice of proposed rulemaking, the Department proposed amending the definition of ''workers' compensation law'' (725.101(a)(31)) to exclude certain benefits paid from a state's general revenues. 62 FR 3387 (Jan. 22, 1997). The proposal responded to decisions from the Benefits Review Board and Third Circuit rejecting the Department's longstanding interpretation of the term. *O'Brockta* v. *Eastern Associated Coal Co.*, 18 Black Lung Rep.1–72, 1–79/1–80 (1994), *aff'd sub nom Director, OWCP* v. *Eastern Associated Coal Co.*, 54 F.3d 141, 148–150 (3d Cir. 1995). 62 FR 3348–49 (Jan. 22, 1997). The Department received comments to its initial proposal opposing the change and, in the second notice of proposed rulemaking, explained that the Third Circuit had suggested the Department alter the regulation to reflect accurately the Department's intended meaning. 64 FR 54982–83 (Oct. 8, 1999). (ii) Two new comments support the Department's change. (iii) One comment opposes the amended definition because it will adversely affect the Trust Fund financially by making certain state benefits unavailable for offset against corresponding federal benefits. The commenter notes the change will therefore indirectly affect the coal producers who finance the Fund. The comment, however, overlooks the fact that any adverse effect on operators is expected to be minimal because of the very small number of claims which would be affected by the exclusion of state-funded benefits. This effect is also spread across the entire industry since the industry as a whole pays the coal excise tax. Finally, using state benefits entirely funded by state general revenues to offset federal benefits would confer a windfall on responsible operators, at least in those few cases in which such state payments may be available concurrently with a period of federal entitlement. If such were the case, an individual operator would be able to offset its monthly federal benefits liability by an amount of money the state paid the claimant from its own general revenues. Thus, the operator would profit by using state benefits which it had not paid to reduce its federal liability. The proposed definition of ''workers' compensation law'' eliminates this windfall. (iv) One comment opposes the change because it codifies an alleged political agreement between the Department and one congressman, and favors only Pennsylvania residents. The commenter also states that the change will not affect pending or new claims from that state, but may have unintended consequences elsewhere. Neither point provides any basis for changing the Department's proposal, the purpose of which is to clarify long-standing policy. With respect to the first point, the comment fails to consider the historical basis of the Department's policy and its grounding in the legislative history of the BLBA. Part B of the BLBA contains a ''maintenance of effort'' provision, 30 U.S.C. 924(d), which states that no federal benefits shall be paid to the resident of any State which reduces the resident's state worker's compensation benefits because of a federal award. Both Parts B and C also each require federal benefits to be reduced by the amount of any payments received by a claimant under a state workers' compensation program for disability caused by pneumoconiosis. 30 U.S.C. 922(b), 932(g). On the eve of the BLBA's enactment in 1969, the House Managers of the bill explained in the joint conference report: ''Benefit payments made under State programs funded by general revenues are not included in the maintenance of effort provision in the House amendment for the reason that they are not to be considered workmen's compensation, unemployment compensation, disability insurance programs as such programs are generally understood, and as they are intended to be understood within the context of this benefit program.'' H.R. Rep. No. 761, 91st Cong., 1st Sess. (1969), *reprinted in* Senate Comm. on Labor and Public Welfare, *Legislative History of the Federal Coal Mine Health and Safety Act of 1969*, 1507, 1530 (1975). Congressman Dent of Pennsylvania

reinforced this understanding in his discussion of the offset provisions and which state benefits could be used to offset the federal benefits:

> We are not talking about State programs funded through general revenues. Any State that has such programs could reduce benefits payable to persons eligible to receive them under this provision. If the State did not so reduce the benefits, such benefits could not be offset or deducted from payments under this provision.

115 Cong. Rec. 39713 (1969). No contrary expression of understanding appears in the legislative history. Consequently, the Department fairly understood Congressional intent to exclude state-funded disability benefits being used to reduce federal benefits. The Third Circuit did not invalidate the Department's policy or contradict its understanding of Congressional intent; the Court merely held that the Department's regulation was inconsistent with its policy, and therefore the policy could not be sustained. As for the limited impact of proposed § 725.101(a)(31) on Pennsylvania residents, the Department acknowledges that Pennsylvania enacted legislation in 1970 to suspend state benefits paid from general revenues if the claimant received a federal award. 77 P.S. 1401(k). Those benefits therefore become unavailable for offset against federal payments in any event. The possibility remains that Pennsylvania may change its law in the future. Because the *O'Brockta* decision raises doubt concerning the Department's interpretation of ''workers' compensation law,'' the Department believes the regulation should be clarified to implement Congressional intent to exclude state benefits funded by general revenues. Finally, the potential impact of the change on states other than Pennsylvania is speculative at best, but all states, like the public as a whole, are entitled to a clear statement of governmental policy. In the event any other State enacts legislation comparable to the Pennsylvania program in the future, the legislature will have a clear understanding of the Department's position on the meaning of ''workers' compensation law.'' (v) No other comments were received concerning this definition, and no changes were made in it.

(f)(i) The Department initially proposed a uniform definition of ''year'' (§ 725.101(a)(32)) for computing the length of coal mine employment when required in the adjudication of claims. 62 FR 3387 (Jan. 22, 1997). Under the proposed definition, a ''year'' encompassed either a calendar year or partial periods totaling a year, during which the miner must have received pay for work as a miner for at least 125 days; computing a year included periods when the miner received pay while on an approved absence, *e.g.* vacation or sick leave. The Department proposed that, to the extent the evidence permitted, the beginning and ending dates of all periods of coal mine employment be ascertained. In the event the evidence was insufficient to establish such dates or if the miner's employment lasted less than a year, the Department proposed a formula for computing the length of coal mine employment based on the miner's annual earnings compared to average wage statistics for miners compiled by the Bureau of Labor Statistics (BLS). In response to a comment opposing the inclusion of approved absences from work in computing the length of coal mine employment, the Department cited judicial decisions upholding its position. 64 FR 54983 (Oct. 8, 1999). In the second notice of proposed rulemaking, the Department altered the regulation to account for leap years by adding ''366 days'' to the definition. 64 FR 55024 (Oct. 8, 1999). The Department now has amended the language of § 725.101(a)(32) to clarify that periods of approved absences count only towards the miner's ''year'' of employment, and not to the actual 125 ''working days'' during which the miner must have worked and received pay as a miner. Thus, in order to have one year of coal mine employment, the regulation contemplates an employment relationship totaling 365 days, within which 125 days were spent working and being exposed to coal mine dust, as opposed to being on vacation or sick leave. (ii) In response to the second notice of proposed rulemaking, two comments support the new definition because it does not afford definitive weight to Social Security Administration records. The Department emphasized in its second notice of proposed rulemaking that § 725.101(a)(32) does not place special weight on any particular type of evidence in determining how long an individual worked as a coal miner. 64 FR 54983 (Oct. 8, 1999). Rather, § 725.101(a)(32)(ii) recognizes that factual findings concerning a miner's work history should be based on all of the credible evidence available to the adjudicator. (iii) One comment opposes the proposed formula for computing a year because it may underestimate a miner's employment if the miner worked in a low-wage geographic area. The commenter urges crediting a Social Security earnings quarter of coverage as a calendar quarter of coal mine employment, particularly for periods of coal mine employment that occurred many years ago. Although this comment raises a legitimate concern, no change in the regulation is necessary. The proposed formula provides a default means of determining the length of time an individual worked as a coal miner. This method may be used when the beginning and ending dates of the miner's work cannot be ascertained from the existing evidence, or the miner worked less than a year as a miner. Moreover, the Department notes that the regulation allows a party to introduce any relevant evidence concerning the miner's employment. In any individual case, the miner may prove that the wages he received were below the industry average. (iv) One comment opposes the inclusion of non-work periods of employment when calculating a year of employment because the miner is not exposed to any occupational hazard during such periods. The Department disagrees, at least with respect to determining whether the miner worked a ''year.'' Judicial precedent has firmly established the legitimacy of counting periods of absence from the workplace for sickness or vacations as part of the miner's year(s) of employment. *See* 64 FR 54983 (Oct. 8, 1999). Despite the lack of actual exposure to coal mine dust during these periods, the employment relationship between the miner and his employer remains intact. Consequently, such periods of non-exposure may be included in the computation of the miner's work history. The Department agrees, however, that such absences should not be included when determining whether the miner actually worked at least 125 days during the year. The 125-day requirement means days of actual employment as a coal miner, and the regulation has been clarified to make the Department's position clear. *See generally Director, OWCP* v. *Gardner*, 882 F.2d 67, 69–70 (3d Cir. 1989) (noting ''[t]he 125 day limit [in 20 CFR 725.493(b)] relates to the minimum amount of time the miner may have been exposed to coal dust while in employment by [the] operator.''); *but see Thomas* v. *BethEnergy Mines, Inc.,* 21 Black Lung Rep. 1–10 (1997) (holding sick leave may be counted in determining whether miner worked 125 days during year). Thus, the periods of approved absence from the workplace may be counted only towards the miner's calendar year of work. (v) One comment generally opposes the definition contending it is based on outmoded concepts and

science. The commenter notes that miners today are exposed to less dust as a result of more hygienic working conditions. The Department, however, believes the definition provides a rational methodology for determining the length of a miner's employment relationship with an operator. The essential issues are the period(s) of time the coal mine operator employed the miner, and the number of days during a year of employment that the individual actually worked as a coal miner. If the miner actually worked at least 125 days during a calendar year or partial periods of different years totaling a 365-day period, then the miner has worked one year for purposes of the program regulations. Whether the miner was exposed to reduced levels of coal mine dust during the working days is irrelevant to this computation. Rather, such evidence may be relevant to an operator's attempt to rebut the presumption of regular and continuous exposure to coal mine dust found in § 725.491(d). With respect to the 125-working day issue, the Department notes its disagreement with *Landes* v. *Director, OWCP*, 997 F.2d 1192, 1197–98 (7th Cir. 1993), and *Yauk* v. *Director, OWCP*, 912 F.2d 192, 195 (8th Cir. 1989) (both cases decided under 20 CFR 718.301(b)). In both cases, the court held that a miner should receive credit for a full year of employment for each partial period of each calendar year during which the miner worked at least 125 days. The Department believes the partial periods must be aggregated until they amount to one year of coal mine employment comprising a 365-day period. Only then should the factfinder determine whether the miner spent at least 125 working days as a coal miner during the year. *See Croucher* v. *Director, OWCP*, 20 Black Lung Rep. 1–67 (1996) (holding ''year'' means calendar year or partial periods totaling calendar year; opposing party may establish irregular employment by showing miner worked fewer than 125 days during year). Consequently, no basis has been provided for abandoning the proposed definition of a ''year.'' (vi) No other comments were received concerning this definition, and no changes were made in it.

20 CFR 725.103

(a) In the initial notice of proposed rulemaking, the Department proposed § 725.103 as a regulation of general applicability to delineate the general burdens of proof for the parties to a claim. 62 FR 3388 (Jan. 22, 1997). The comments opposing this regulation challenged the Department's authority to adjust the burdens of proof among the parties. The Department responded with a detailed analysis of the relevant precedent and its own authority. 64 FR 54972–74 (Oct. 8, 1999). For a number of reasons, the Department concluded that the Administrative Procedure Act (APA), 5 U.S.C. 556(d), does not preclude it from incorporating presumptions into the regulations which reallocate the burden of proving certain facts. First, the statute itself places limitations on the operation of the APA while conferring on the Secretary broad regulatory authority. The Federal Mine Safety and Health Act (FMSHA), which includes the Black Lung Benefits Act (BLBA) as title IV, generally exempts its provisions from the APA. 30 U.S.C. 956. The BLBA, however, incorporates section 19 of the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 919(d), thereby making the APA applicable to the adjudication of claims. The incorporation of the APA is subject to one important constraint: Congress conferred on the Secretary the authority to vary the terms of the incorporated provisions by regulation. 30 U.S.C. 932(a) (provisions of LHWCA apply to BLBA ''except as otherwise provided * * * by regulations of the Secretary''). *See generally Director, OWCP* v. *National Mines Corp.,* 554 F.2d 1267, 1273–74 (4th Cir. 1977); *Patton* v. *Director, OWCP,* 763 F.2d 553, 559–60 (3d Cir. 1985). Second, the Department noted that the Supreme Court's decision in *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994), did not address, much less restrict, the Department's statutory authority to alter the applicability of the APA. In *Greenwich Collieries,* the Supreme Court addressed only whether the Department had promulgated a regulatory presumption (20 CFR 718.3) that required a finding for the claimant if the evidence for and against a claimant on a particular issue was evenly balanced. The Court considered § 718.3(c) too ambiguous to operate as an exception to the APA's requirement that the party who bears the burden of persuasion must prevail by a preponderance of the evidence. Because the Court's interpretation of the regulation resolved the issue, the Court did not reach the Department's argument that it has statutory authority to override 5 U.S.C. 556(d) by regulation and shift the burden of persuasion as well. Furthermore, the Court did not decide which party bears the burden of persuasion; rather, it determined only what standard of proof must be met by the party bearing the burden of persuasion. The Department therefore concluded *Greenwich Collieries* does not prohibit the Department from assigning burdens of proof to parties other than the claimant if necessary to achieve the goals of the BLBA. 64 FR 54973 (Oct. 8, 1999). Finally, the Department surveyed other decisions which upheld the authority of an agency to allocate the burden of persuasion by means of factual presumptions. This caselaw lent additional support for the Department's conclusion that its general rulemaking authority permitted it to adjust the burdens of proof among the parties, provided a rational basis existed between the proven facts and those presumed.

(b) One comment contends the Department has no authority under the APA to allocate burdens of proof in a proceeding before an administrative law judge (ALJ). The comment cites no authority, statutory or otherwise, for this proposition. For purposes of responding to the comment, the Department assumes the reference to ALJ proceedings means a reference to a proceeding governed by the APA, including 5 U.S.C. 556(d) (allocating burden of persuasion to proponent of a rule or order). In the second notice of proposed rulemaking, the Department examined the statutory authority which permits it to vary the terms of the APA by regulation. 64 FR 54973 (Oct. 8, 1999). The comment provides no refutation of the conclusions drawn from this analysis. Because the Department has already responded to the substance of the comment's objection, no further response is warranted.

(c) One comment suggests the Supreme Court's decision in *Allentown Mack Sales & Service, Inc.* v. *NLRB,* 522 U.S. 359 (1998), prohibits the Department from reallocating burdens of proof absent statutory authority. As an initial matter, the Department addressed this decision in its second notice of proposed rulemaking. 64 FR 54973 (Oct. 8, 1999). The Department quoted *dicta* from the majority opinion which explicitly supports the authority of an agency to promulgate ''counterfactual evidentiary presumptions * * * as a way of furthering legal or policy goals[.]'' 522 U.S. at 378. The comment does not respond to this analysis, or explain in what manner the Department has erroneously interpreted the decision. In any event, the Department believes *Allentown Mack* provides no precedential basis for limiting the Department's authority to assign burdens of production and persuasion to parties other than the claimant. That case involved a dispute over the evidentiary showing a company must

make to deny recognition to an incumbent union. According to NLRB case law, the company must establish a ''reasonable doubt'' that the union enjoys the majority support of its members. The NLRB held that Allentown Mack had not established the existence of such doubt by a preponderance of the evidence. The Supreme Court ultimately overturned the Board's factual findings because the Court concluded the Board had applied in actuality a higher burden of proof than it had announced in its decisions. 522 U.S. at 378–80. Although the comment depicts this decision as an extension of *Greenwich Collieries, Allentown Mack* has no bearing on an agency's authority to vary the terms of the APA or reallocate the burden of persuasion to a party other than the proponent of a rule or order. *Allentown Mack* establishes only the proposition that an agency cannot announce one standard of proof in principle and apply a higher standard of proof in practice. The Department therefore rejects the comment's position.

(d) No other comments were received concerning this definition, and no changes were made in it.

Subpart B

20 CFR 725.202

(a) The Department proposed changing the definition of ''miner'' in the initial notice of proposed rulemaking. 62 FR 3388–89 (Jan. 22, 1997). Specifically, the Department proposed creating a rebuttable presumption that any individual working in or around a coal mine or coal preparation facility was a ''miner'' within the meaning of the Black Lung Benefits Act (BLBA). The party liable for benefits could rebut the presumption by proving the individual did not perform coal extraction, preparation or transportation work while at the mine site, or did not engage in mine maintenance or construction. The presumption could also be rebutted by demonstrating that the individual was not regularly employed around a coal mine or coal preparation facility. The Department also proposed restructuring the existing regulation (20 CFR 725.202) to differentiate special provisions applicable only to transportation and construction workers. *See generally* 64 FR 3349 (Jan. 22, 1997). The Department did not propose any further changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) Two comments generally object to the revised definition of ''miner,'' arguing that it forces operators to defend against claims from employees only peripherally involved in the coal mining process. The revisions primarily rearrange the component parts of 20 CFR 725.202(a), and segregate special provisions involving construction and transportation workers. The regulation does include a rebuttable presumption that any on-site worker at a coal mine or coal preparation facility is a ''miner.'' This presumption reflects the rational assumption that an individual working in or around a coal mine is involved in the extraction, preparation or transportation of coal, or in the construction of a mine site; these functions are enumerated by the statutory definition of a ''miner.'' The operator may rebut the presumption by disproving either the required nexus between the worker's duties and coal mining, or any regular employment at a coal mine facility. This burden is not onerous given the operator's access to information about the use and duties of the workers at its facilities.

(c) One comment objects to coverage for coal mine construction workers whose jobs are integral to the construction of a coal mine site or facility. The commenter argues that coverage should include only those construction workers whose jobs are integral to the extraction or preparation of coal, citing *William Bros., Inc.* v. *Pate,* 833 F.2d 261 (11th Cir. 1987), and *Bridger Coal Co./Pac. Minerals, Inc.* v. *Director, OWCP [Harrop],* 927 F.2d 1150 (10th Cir. 1991), and only if those individuals are also exposed to coal dust as a result of their work. The Department, however, believes the focus on mine construction, rather than coal extraction or preparation, is consistent with Congressional intent in extending coverage to construction workers. The Fourth Circuit has identified the flaw in using the traditional ''situs/function'' test for coal mine construction workers: ''Coal mine construction * * * involves neither the extraction nor preparation of coal. If, therefore, we apply the two-step test to coal mine construction workers, they would rarely, if ever, qualify as miners under the Act.'' *The Glem Co.* v. *McKinney,* 33 F.3d 340, 342 (4th Cir. 1994). The logical inquiry concerning the construction workers' activities must therefore look to coal mine construction, which inevitably (and generally) involves the pre-extraction work of building the mine facility itself. That such work is consistent with work at a coal mine is evident from the statutory definition of ''coal mine:'' ''an area of land and all structures, facilities, * * * shafts, slopes, tunnels * * * and other property, real or personal, * * * used in, *or to be used in,* the work of extracting'' coal. 30 U.S.C. 802(h)(2) (emphasis supplied); *see also* 20 CFR 725.101(a)(23) (renumbered as § 725.101(a)(12)). A construction worker who builds the ''coal mine'' is a ''miner'' to the extent work at the covered site exposes him or her to ''coal mine dust.'' Moreover, the fact that the claimant worked at non-operational mines is not, by itself, sufficient to establish a lack of coal mine dust exposure. The construction process itself may expose the miner to coal mine dust. In addition, a coal mine construction worker exposed to coal mine dust from an operating coal mine in the vicinity of the construction site is a ''miner'' under the Black Lung Benefits Act (BLBA). *R&H Steel Buildings* v. *Director, OWCP,* 146 F.3d 514, 516–17 (7th Cir. 1998).

Pate and *Harrop,* cited by the commenter, do not provide compelling authority to depart from the proposed regulation. In *Pate,* the Court stated that ''construction workers are covered only if they have been exposed to dust arising from the extraction or preparation of coal.'' 833 F.2d at 266 (footnote omitted). Limiting covered construction activities to work involving dust exposure from coal extraction and preparation, however, incorrectly combines two independent elements of the definition of ''miner'': the ''function'' requirement for qualifying as a miner under the BLBA, *i.e.,* working in the extraction or preparation or transportation of coal or in coal mine construction, and the exposure requirement for a construction worker. The two are unrelated. The only plausible explanation for separately including construction workers in the statutory definition of ''miner'' is Congress' recognition of their unique functional status. Construction workers generally perform their work before a mine becomes operational. Consequently, they generally will not be involved in the extraction or preparation of coal, or exposed to dust from such activities. While rejecting this position, the Court did acknowledge the Department's authority to implement its views through regulation: ''If the Secretary has a position he wishes to express, he can do it through the proper forum, i.e., the implementation of new, clarifying regulations.'' 833 F.2d at 265. Section 725.202 represents the exercise of that authority.

In *Harrop,* the Court held that the exposure to ''coal mine dust,'' required by 20 CFR 725.202(a) for coverage of a construction worker, involves exposure to ''dust containing coal.'' 927 F.2d at 1154, citing *Pate.* It interpreted the

statutory coverage of construction workers to reach only those individuals who are exposed to actual coal dust, despite acknowledging the variety of other (non-coal) dusts which may be inhaled at a mine construction site. The Department has consistently taken the position that ''coal mine dust'' means any dust generated at a coal mine site, and that exposure to coal mine dust is sufficient to meet the statutory definition of ''miner''for construction workers. 20 CFR 725.202(a); *see generally Williamson Shaft Contracting Co.* v. *Phillips,* 794 F.2d 865, 869 (3d Cir. 1986) (upholding validity of 20 CFR 725.202(a) because Congress understood ''coal dust'' to mean ''the various dusts around a coal mine''). The interpretation of coverage reached by the Court in *Harrop* would effectively exclude most, if not all, construction workers from the definition of ''miner'' after Congress explicitly changed the definition to include them. The Department declines to adopt the more restrictive standard suggested by the Tenth Circuit and the commenter.

(d) One comment objects to the application to construction workers of the rebuttable presumption that any on-site worker is a ''miner.'' For the reasons expressed in paragraph (b), the Department believes any individual whose employment requires him or her to perform work at a coal mine can logically be presumed to be involved in a covered coal mine function. The commenter has provided no reason to exclude construction workers from that presumption, and the Department declines to do so.

(e) One comment received after publication of the initial notice of proposed rulemaking and referenced again after publication of the second notice objects to subsection (d), which describes the elements of entitlement for a miner and references the specific regulatory criteria in Part 718 for establishing those elements. The comment links its objection to criticisms of the specific Part 718 regulations rather than any aspect of subsection (d). The Department's responses to those criticisms are discussed under the particular Part 718 sections. No further response in the context of this regulation is necessary.

(f) Two comments support the revised section 725.202.

(g) No other comments concerning this section have been received, and no changes have been made in it.

20 CFR 725.203

(a)(i) The Department proposed changing § 725.203 in the initial notice of proposed rulemaking to eliminate the filing of a claim as an element of entitlement for a miner. 62 FR 3389 (Jan. 22, 1997). This change clarified that a miner is entitled to benefits for all periods of compensable disability, including any period which occurred prior to the filing of the claim. 62 FR 3349 (Jan. 22, 1997). The Department also incorporated into § 725.203 provisions from 20 CFR 718.404, which was deleted. These provisions require an entitled miner to notify the Department if (s)he returns to coal mining or comparable work, and authorize the Department to reopen a final miner's award in appropriate circumstances for the development of additional evidence and the reevaluation of entitlement. 62 FR 3349, 3389 (Jan. 22, 1997). Finally, § 725.203(b)(2) now refers to § 725.504, which is the renumbered version of § 725.503A. 62 FR 3341 (Jan. 22, 1997). The Department proposed no further changes to § 725.203 in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999). (ii) The Department has now further amended § 725.203(d), however, to restore language requiring the beneficiary to submit ''medical reports and other evidence'' if the Office determines the evidence is necessary to resolve any question concerning the validity of the award. This phrase appears in 20 CFR 718.404(b), and was inadvertently omitted in the earlier proposal to change § 725.203. The Benefits Review Board has since interpreted the phrase in § 718.404(b) to involve discovery requests. *Stiltner* v. *Westmoreland Coal Co.,* Black Lung Rep., BRB No. 98–0337, slip op. at 5 (Jan. 31, 2000) (en banc). The Department did not intend the changes to § 725.203(d) to foreclose evidentiary development other than medical examinations of the miner. The Department therefore adds the language formerly in § 718.404(b) to § 725.203(d), and clarifies its intent that the miner may be required to submit to medical examinations, produce medical evidence and answer discovery requests when the circumstances raise any issue concerning the validity of the award after the award becomes final.

(b)(i) One comment suggests the revision of subsection (a) improperly extends the eligibility period. The Department rejects this interpretation. The change merely harmonizes that provision with § 725.503, and ensures the miner's entitlement to benefits for any period of eligibility which predates the filing of a claim. *See* 62 FR 3349 (Jan. 22, 1997). (ii) Two comments approve of the change to subsection (a).

(c) Three comments oppose subsection (d) because it permits the Department to reopen an approved claim if issues arise concerning its validity. Subsection (d) simply recognizes the Department's authority to investigate any finally approved miner's claim if circumstances raise an issue pertaining to the validity of the award. Such authority is necessary in order to monitor a miner's continuing eligibility and prevent the payment of benefits to any claimant whose eligibility ceases. The Department rejects the suggestion that this authority should be limited to cases involving fraud or the miner's return to coal mining. Limiting the reopening authority under subsection (d) in this manner would be inconsistent with the Department's statutory authority to modify an award based on a factual mistake or change in condition at any time within one year after the last payment of benefits. 33 U.S.C. 922, as incorporated by 30 U.S.C. 932(a); 20 CFR 725.310. Furthermore, such a limitation would impinge on the right of responsible operator to petition for modification and request a medical examination if circumstances call into question the entitlement of the miner. The Department emphasizes that the responsible operator does not have an absolute right to compel the claimant to submit to a medical examination for purposes of the modification petition. *Selak* v. *Wyoming Pocahantas Land Company,* 21 Black Lung Rep. 1–173, 1–178 (1999); *see also Stiltner* v. *Westmoreland Coal Co.,* Black Lung Rep., BRB No. 98–0337, slip op. at 5 (Jan. 31, 2000) (en banc) (holding operator does not have absolute right to compel claimant to respond to discovery request under 20 CFR 718.404(b) in connection with modification petition). Upon production of reasonable evidence justifying the request, however, the district director (or administrative law judge) may order the claimant to submit to a medical examination. *Selak,* 21 Black Lung Rep. at 1–179.

(d) One comment urges the Department to limit its authority to reopen awards under subsection (d) to the first year after the award becomes final. Such a limitation, however, is inconsistent with the Department's statutory authority to modify. 33 U.S.C. 922, as incorporated. In the case of an award, that authority extends to ''one year after the date of the last payment of compensation.'' Furthermore, the limitation would also adversely affect the responsible operator's right to request modification if it became aware of circumstances which call into question the validity of the award. *See* response to comments (c).

(e) In response to the initial notice of proposed rulemaking, one comment opposed subsection (d) because the provision did not expressly acknowledge that a claim may be reopened if the miner's condition improved. The Department previously rejected a similar suggestion when it promulgated the final version of 20 CFR 718.404 in 1980. The Department initially proposed § 718.404 with a requirement that an entitled individual contact the Office of Workers' Compensation Programs if ''[h]is or her respiratory or pulmonary condition improves[.]'' 43 FR 17727 (Apr. 25, 1978). The requirement was deleted in the final version ''in response to comments and testimony stating that pneumoconiosis does not, in fact, improve.'' 45 FR 13694 (Feb. 29, 1980). The same commenter submitted an additional response to the second notice of proposed rulemaking, and now approves of subsection (d) because it does not preclude the right of a liable party to challenge a final award at a later date. The Department therefore declines to incorporate any language affirmatively citing improvement in a miner's health as grounds for reopening an award.

(f) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.204

(a) The Department proposed amending § 725.204 in the initial notice of proposed rulemaking to conform the regulatory criteria for marital relationships to intervening changes in the law since the regulation was issued in 1978. 62 FR 3349–50 (Jan. 22, 1997). The Department provided a detailed statutory analysis in the initial notice. To summarize: the Black Lung Benefits Act (BLBA) incorporates the definition of a dependent ''wife'' used by the Social Security Act (SSA), 42 U.S.C. 416(h)(1), as incorporated by 30 U.S.C. 902(a)(2), (e). The SSA recognizes both ''legal'' and ''deemed'' spouses; the latter is an individual who married the wage earner while ignorant that some legal impediment existed to deny validity to the marriage. Before 1990, § 416(h) contained a provision preventing a ''deemed spouse'' from receiving benefits if a ''legal'' spouse existed and was receiving benefits on the wage earner's account. 42 U.S.C. 416(h)(1)(B). The Department included this limitation in the dependency criteria when it promulgated § 725.204. 20 CFR 725.204(d)(1). In 1990, Congress amended the SSA to remove the prohibition on ''deemed spouse'' entitlement if a legal spouse existed and was receiving benefits. 104 Stat. 1388–278 to 1388–280 (1990). Legislative history clearly established Congressional intent to permit both the ''deemed'' spouse and the legal spouse to receive concurrent benefits. *See* H.R. Rep. No. 101–964, 1990 U.S.C.C. & A.N. 2649, 2650 (conference report). Accordingly, the Department proposed similar changes to § 725.204 to delete the regulatory bar to ''deemed'' spouse entitlement under the BLBA. The Department proposed no additional changes to this regulation in its second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) Two comments approve of the change to this section acknowledging the eligibility of a spouse to receive benefits despite the existence of a legal impediment to the validity of the marriage to the miner unless the individual entered into the marriage with knowledge it was not valid.

(c) No other comments concerning this section were received, and no changes have been made in it.

20 CFR 725.209

(a) In the initial notice of proposed rulemaking, the Department erroneously proposed changing § 725.209(a)(2)(ii) to state that, in order to be considered a dependent, a child who is at least 18 and not a student must be under a disability that commenced before the age of 22. 62 FR 3390 (Jan. 22, 1997). The purpose of the change was to reflect in the regulation itself the age by which certain children's disabilities must commence, a requirement imposed by an incorporated provision of the Social Security Act. 42 U.S.C. 402(d)(1)(B)(ii), as incorporated into the BLBA by 30 U.S.C. 902(g). 62 FR 3350 (Jan. 22, 1997). After further consideration, however, the Department reproposed the regulation without the new language. 64 FR 55026 (Oct. 8, 1999). Eliminating the age by which the disability must have begun for a dependent child harmonizes § 725.209 with the statutory definition by preserving the distinction between a child/augmentee and a child/beneficiary (*see* § 725.221). A child who claims benefits in his or her own right based on personal disability (child/beneficiary) must prove the disability arose before age 22 as required by 30 U.S.C. 902(g). 30 U.S.C. 922(a)(3). A dependent child who is an augmentee of a beneficiary, however, is exempt from this requirement because the statutory definition of ''dependent'' explicitly exempts a ''child'' from the requirement that disability begin by a certain age. 30 U.S.C. 902(a)(1). *See generally* 64 FR 54983 (Oct. 8, 1999).

(b) Reference should be made to the Department's response to comments concerning § 725.219 to determine the effect of marriage on a child's dependency status under § 725.209(a)(1).

(c) No comments concerning changes to this section were received in response to either the initial notice of proposed rulemaking or the second notice of proposed rulemaking, and no further changes have been made in it.

20 CFR 725.212

(a) In the initial notice of proposed rulemaking, the Department proposed amending § 725.212 to codify the right of each surviving spouse of a deceased miner to receive a full monthly benefit without regard to the existence of any other entitled surviving spouse. 62 FR 3390 (Jan. 22, 1997). The Department concluded that both statutory analysis and Congress' intent compelled this result, and explained at length the reasoning behind the conclusion. 62 FR 3350–51 (Jan. 22, 1997). *See also* § 725.537, and response to comments. The Department proposed no further changes to this regulation in its second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) Five comments object to subsection (b) because it permits each surviving spouse of a deceased miner to receive full monthly benefits if (s)he establishes eligibility regardless of the existence of any other entitled surviving spouse. The commenters assert that the change will increase the cost of paying survivors' benefits. Increased costs alone do not justify denying eligible individuals the benefits to which they are entitled by law.

(c) Two comments argue the change is not permitted by the relevant statutes; one comment disputes the Department's conclusion that its earlier procedure was adopted in error, citing undocumented representations by the Social Security Administration (SSA) to the Department in 1978. In the initial notice of proposed rulemaking, the Department provided a detailed legal analysis of the pertinent statutory authorities and legislative history, all of which support awarding full monthly benefits to more than one surviving spouse. *See* 62 FR 3350–51 (Jan. 22, 1997). Congress amended the Social Security Act in 1965 to allow benefits to a divorced surviving spouse as a ''widow'' of the miner. Pub. L. No. 89–97, § 308(b)(1), 79 Stat. 286 (1965). The legislative history of the amendment clearly established Congress' intent that payment of benefits to two (or more) ''widows'' would not reduce the benefits paid to either of the widows. S.

Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S.C.C. & A.N. 1943, 2047. In 1972, Congress amended the BLBA definition of ''widow'' to adopt the Social Security Act definition. 30 U.S.C. 902(e). The legislative history is equally clear that Congress intended to conform the BLBA definition to the Social Security Act definition. S. Rep. No. 743, 92nd Cong., 2d. Sess., *reprinted in* 1972 U.S.C.C. & A.N. 2305, 2332. The BLBA also reinforces this interpretation because it requires a ''widow'' to receive benefits at prescribed rates and makes no allowance for a reduction based on the existence of more than one widow. 30 U.S.C. 922(a)(2). To date, two courts of appeals and the Benefits Review Board have accepted the Department's position. *Peabody Coal Co.* v. *Director, OWCP [Ricker],* 182 F.3d 637, 642 (8th Cir. 1999); *Mays et al.* v. *Piney Mountain Coal Co.,* 21 Black Lung Rep. 1–59, 1–65/1–66 (1997), *aff'd* 176 F.3d 753, 764–765 (4th Cir. 1999). No court has reached a contrary result, and no comment has addressed the substance of this analysis. Consequently, the Department has no basis for changing the regulation. Finally, the Department cannot respond to the alleged communication between SSA and the Department because the comment provides no detailed evidence as to the nature or content of the communication. In any event, an undocumented assertion concerning another agency's intention cannot form the basis for displacing a proper interpretation of the pertinent statutes, especially when courts have unanimously upheld that interpretation.

(d) One comment states that the SSA regulations implementing part B of the BLBA do not permit more than one surviving spouse to receive full benefits. SSA's program regulations (20 CFR part 410) are silent on the entitlement of multiple surviving spouses. In any event, the Department has independent authority to issue regulations for part C of the BLBA, 30 U.S.C. 936(a), and § 725.212 is consistent with the applicable provisions of the BLBA and the SSA as incorporated.

(e) One comment states that the current Coal Mine (BLBA) Procedure Manual is consistent with the position that full monthly benefits cannot be paid to each surviving spouse when more than one spouse qualifies for one deceased miner. This statement is simply erroneous. Since at least 1994, the Procedure Manual has unequivocally provided that ''[w]hen a surviving spouse and a surviving divorced spouse both qualify as primary beneficiaries, each is entitled to full basic benefits plus full augmentation.'' Coal Mine (BLBA) Procedure Manual, ch. 2–900, ¶ 8.f (Sept. 1994).

(f) One comment contends the Department lacks the authority to require an operator to pay the same benefit twice. The Department rejects this contention. As discussed above, the BLBA unequivocally requires the payment of full monthly benefits to each surviving spouse who fulfills the eligibility criteria. The statute does not recognize any limitation on the liability for these benefits, or any reduction in the amount to which the eligible surviving spouse is entitled.

(g) Two comments support the change in subsection (b).

(h) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.213

(a) The Department proposed amending § 725.213 in the initial notice of proposed rulemaking to harmonize that regulation with changes to § 725.204, which now recognizes the independent eligibility of a ''deemed'' spouse to receive benefits notwithstanding the existence of a legal spouse who is also receiving benefits. 62 FR 3351 (Jan. 22, 1997) The Department also proposed adding paragraph (c) to codify the right of a surviving beneficiary, who loses eligibility through some legal impediment, to resume eligibility upon the cessation of that impediment. The Department did not propose any further changes to the regulation in its second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) Two comments object to reentitlement for a surviving spouse who loses eligibility, but later reestablishes all the requirements. The commenter states in general terms that the provision is contrary to the Social Security Act (SSA), represents an unwarranted increase in benefits liability, and should be abandoned. The commenter cites no specific authority for its argument. The legislative history of 30 U.S.C. 902(e), the statutory definition of ''widow'' which § 725.213 implements, establishes congressional intent to afford a miner's widow the same right to resumption of black lung benefits upon termination of a remarriage as exists for a widow receiving SSA benefits.

The Black Lung Benefits Act (BLBA), as enacted in 1969, defined ''widow'' to mean

> the wife living with or dependent for support on the decedent at the time of his death, or living apart for reasonable cause or because of his desertion, *who has not remarried.*

Pub. L. 91–173, § 402(e), 83 Stat. 793 (1969) (emphasis supplied). The emphasized language excluded from coverage any miner's survivor who later remarried, without regard to the subsequent termination of the marriage. In 1972, Congress amended the definition of 'widow' by enacting the current version. In pertinent part, the phrase ''who is not married'' replaced ''who has not remarried.'' The Senate report accompanying the proposed amendments states that ''[t]he term 'widow' in § 402(e) is likewise redefined to conform to the Social Security Act definition.'' S. Rep. No. 743, 92nd Cong., 2d. Sess. 30, *reprinted in* 2 Comm. On Labor and Pub. Welfare, 94th Cong., 1st Sess., *Legislative History of the Federal Coal Mine Health and Safety Act of 1969,* at 1974 (1975). The legislative history therefore unequivocally establishes congressional intent to define ''widow'' for purposes of the Black Lung Benefits Act and SSA in the same manner.

At the time of the 1972 amendments to the BLBA, the SSA defined a ''widow'' as an individual who ''is not married.'' 42 U.S.C. 403(e)(1)(A). Congress had previously amended the SSA definition in 1965 by replacing the phrase ''has not remarried'' with ''is not married.'' Pub. L. 89–97, § 308(b)(1), 79 Stat. 286, 376 (1965). The legislative history of the amendment indicates that Congress intended an aged divorced wife, widow or surviving divorced wife, who was not married at the age of eligibility, to retain ''whatever rights to benefits she has ever had, regardless of intervening marriages, which have ended in death, divorce or annulment.'' S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C. & A.N. 1943, 2048. The legislative history therefore underscores the congressional intention to permit restoration of SSA eligibility to a widow whose intervening marriage has terminated. The Social Security Administration regulations implementing Part B of the BLBA confirm this view:

> An individual is entitled to benefits as a widow, or as a surviving divorced wife, for each month beginning with the first month in which all of the conditions of entitlement * * * are satisfied. If such individual remarries, payment of benefits ends with the month before the month of remarriage * * *. Should the remarriage subsequently end, payment of benefits may be resumed * * *.

20 CFR 410.211(a). The Sixth Circuit and the Benefits Review Board have also adopted the Department's position, and no circuit has taken a contrary view. *Wolf Creek Collieries* v. *Robinson,* 872 F.2d 1264, 1266 (6th Cir. 1989); *Luchino* v. *Director, OWCP,* 8 Black Lung Rep. 1–

453, 1–456 (1986). The commenter's objection must be rejected.

In promulgating § 725.213, the Department recognizes that permitting reentitlement of surviving spouses and children (§ 725.219) treats these classes of beneficiaries more generously than surviving brothers and sisters of the deceased miner (§ 725.223). One comment notes it is appropriate to end benefit entitlement permanently when a brother or sister marries, and implies the same treatment should be accorded all other classes of beneficiaries and augmentees, including surviving spouses and children. The Department believes the difference in treatment is required by the BLBA. Section 412(a)(5) states that ''[n]o benefits to a sister or brother shall be payable under this paragraph for any month beginning with the month in which he or she * * * marries.'' 30 U.S.C. 922(a)(5). This provision terminates eligibility if a miner's brother or sister who is receiving benefits marries. Unlike the statutory definitions of ''widow'' and ''child,'' 30 U.S.C. 902(e), (g), section 412(a)(5) focuses on the occurrence of an event when ineligibility commences rather than the individual's status. The widow's or child's marriage status can change over time; once the event of marriage occurs for a brother or sister, ''no benefits shall be payable.'' The regulations therefore exclude brothers and sisters from reentitlement once they marry.

(c) One comment states that reentitling a surviving spouse after the termination of his or her intervening marriage is contrary to the SSA regulations implementing part B of the BLBA. The comment is incorrect. Section 410.211(a) provides that payment of benefits terminates if a surviving spouse or divorced wife remarries while receiving benefits; however, ''[s]hould the remarriage subsequently end, payment of benefits may be resumed * * * .'' 20 CFR 410.211(a). Sections 725.213 and 410.211 are therefore entirely consistent.

(d) Two comments support the new subsection (c).

(e) No other comments concerning this section were received, and no changes have been made in it.

20 CFR 725.214

(a) The Department proposed amending § 725.214 in the initial notice of proposed rulemaking to conform the regulatory criteria for marital relationships to intervening changes in the law since the regulation was issued in 1978. 62 FR 3349–50 (Jan. 22, 1997). Specifically, the Department intended this regulation (as well as § 725.204) to reflect statutory changes which now permit the surviving spouse of a miner, whose marriage is invalid due to a legal impediment, to receive benefits notwithstanding the existence of a legally-married spouse who also is receiving benefits. Consequently, the Department proposed eliminating language in 20 CFR 725.214(d) which required the termination of benefits for the surviving spouse whose marriage is invalid upon the entitlement of the legal spouse. The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999). For purposes of this rule, the Department has corrected one typographical error and made minor grammatical changes. The first and second notices of proposed rulemaking used the word ''interstate'' in § 725.214(c) to describe a miner's personal property. 62 FR 3391 (Jan. 22, 1997); 64 FR 55027 (Oct. 8, 1999). The correct word is ''intestate,'' and that word has been substituted in the regulation. In § 725.214(d), the Department has deleted the word ''and'' which immediately followed the phrase ''in a purported marriage between them,'' and added commas, as appropriate, to clarify the meaning of the provision.

(b) One comment objects to permitting a surviving spouse, whose marriage to the deceased miner may be invalid due to certain legal impediments, to maintain eligibility despite another person's eligibility as the miner's surviving spouse. The commenter states generally that the provision is contrary to the Social Security Act (SSA) and imposes an unwarranted increase in benefits liability. Neither objection demonstrates any basis for abandoning the revision. The Department proposed the same change in connection with § 725.204, and provided a detailed legal analysis of the reasons supporting the revision in its initial notice of proposed rulemaking. *See* 62 FR 3349–50 (Jan. 22, 1997). The Black Lung Benefits Act (BLBA) incorporates the definition of a dependent ''wife'' used by the SSA, 42 U.S.C. 416(h)(1), as incorporated by 30 U.S.C. 902(a)(2), (e). The SSA recognizes both ''legal'' and ''deemed'' spouses as potentially eligible for benefits on a single wage earner's record. The ''deemed'' spouse is an individual who married the wage earner while unaware that some legal impediment existed to the marriage. Before 1990, § 416(h) prohibited a ''deemed spouse'' from receiving benefits if a ''legal'' spouse existed and was receiving benefits on the wage earner's account. 42 U.S.C. 416(h)(1)(B). The Department imposed a similar limitation in the dependency criteria when it promulgated 20 CFR 725.204(d)(1). In 1990, Congress amended the SSA to remove the prohibition on ''deemed spouse'' entitlement if a legal spouse existed and was receiving benefits. 104 Stat. 1388–278 to 1388–280 (1990). Legislative history clearly established Congressional intent to permit both the ''deemed'' spouse and the legal spouse to receive concurrent benefits. *See* H.R. Rep. No. 101–964, 1990 U.S.C.C. & A.N. 2649, 2650 (conference report). Accordingly, the Department proposed similar changes to § 725.214 to delete the regulatory bar to ''deemed'' spouse entitlement under the BLBA. The comment does not respond to this analysis with any specific reasoning demonstrating the alleged inconsistency with the SSA or refuting the Department's authority to implement this change. Finally, increased benefits liability alone is not a legitimate basis for denying benefits to eligible claimants under the BLBA.

(c) No other comments concerning this section were received, and no other changes have been made in it.

20 CFR 725.215

(a) In the initial notice of proposed rulemaking, the Department proposed clarifying the intended operation of § 725.215(g)(3) by changing a reference in that regulation from ''section'' to ''paragraph.'' 62 FR 3391 (Jan. 22, 1997). The change ensures that the exception to the nine-month marriage rule is confined to subsection (g) rather than applicable to the entire regulation. 62 FR 3351 (Jan. 22, 1997). The Department proposed no additional changes to this regulation in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999).

(b) No comments concerning this section were received, and no changes have been made in it.

20 CFR 725.219

(a) In the initial notice of proposed rulemaking, the Department proposed changing § 725.219 to account for a change in the age of onset of disability in the Social Security Act (SSA), 42 U.S.C. 402(d)(1)(B), which is incorporated into the Black Lung Benefits Act's (BLBA) definition of ''child,'' 30 U.S.C. 902(g). 62 FR 3350 (Jan. 22, 1997). The Department did not propose any additional changes in the second notice of proposed rulemaking. 64 FR 54971 (Oct. 8, 1999). The Department, however, did assert in general terms that marriage is a

permanent bar to future entitlement for any individual other than a miner's surviving spouse or surviving divorced spouse. 64 FR 54983–84 (Oct. 8, 1999). Based on this position, the Department withdrew a proposed change to § 725.223 which extended reentitlement to a miner's surviving dependent brother or sister if the sibling married while receiving benefits, but the marriage later ended.

(b) Two comments recommend adopting a provision (analogous to § 725.213(c)) which would allow a deceased miner's surviving disabled child, whose entitlement terminates upon marriage, to regain eligibility when that marriage ends. Formerly, the regulations permitted a child whose entitlement terminated at age 18 to apply for reinstatement if the child was a student, younger than age 23, and was not married. 20 CFR 725.219(c). The regulations did not make any provision for reentitling a disabled child whose entitlement is terminated by marriage. The Department agrees with the comments that such a provision is appropriate, and therefore has added subsection (d). This provision enables a child whose entitlement terminates upon marriage to apply for reinstatement of benefits once the marriage terminates. Subsection (d) also excuses the child-beneficiary from any requirement to reestablish the deceased miner's total disability or death due to pneumoconiosis.

The BLBA provides that survivor's benefits ''shall only be paid to a child for so long as he meets the criteria for the term 'child' contained in section 402(g).'' 30 U.S.C. 922(a)(3). Section 402(g) defines ''child'' to mean a:

child or a stepchild who is—

(1) unmarried; and

(2)(A) under eighteen years of age, or

(B)(i) under a disability as defined in section 423(d) of title 42

(ii) which began before the age specified in section 402(d)(1)(B)(ii) of title 42, or, in the case of a student, before he ceased to be a student; or

(C) a student.

30 U.S.C. 902(g). The literal language of the statute does not preclude a child's eligibility for all time based upon the existence of a marriage. Rather, the two statutory provisions authorize the payment of benefits to an eligible child survivor ''for so long as'' (s)he ''is unmarried.'' If a marriage terminates prior to any period of eligibility, the child is nevertheless unmarried when (s)he becomes entitled to benefits. *See Adler* v. *Peabody Coal Co.,* Black Lung Rep., BRB No. 98–1513 BLA (Feb. 4, 2000). If the child marries while receiving benefits, (s)he cannot continue as an eligible survivor for the duration of the marriage. *Sullenberger* v. *Director, OWCP,* Black Lung Rep., BRB No. 99–0449 BLA (March 8, 2000) Upon cessation of the marital relationship, however, the child again ''is unmarried,'' which complies with the statutory requirement. Assuming all other conditions for eligibility are met, an ''unmarried'' child retains his or her status as a ''child'' under the plain language of the statute notwithstanding the occurrence of the marriage. In this regard, the Department disagrees with the broad statement in *Reigh* v. *Director, OWCP,* 20 Black Lung Rep. 1–44 (1996), that a surviving child of a miner cannot revive her status as the unmarried dependent of her parents upon the death of her husband. 20 Black Lung Rep. at 1–48.

The Department's interpretation of the plain language of § 402(g) gains support from Congress' decision to omit certain provisions of 42 U.S.C. 402(d) (the Social Security Act) from the BLBA. Significantly, Congress did not incorporate § 402(d)(6), which permits a child to become reentitled to benefits after turning 18 if the child is a student under age 22 or disabled, ''provided no event specified in paragraph (1)(D) has occurred.'' 42 U.S.C. 402(d)(6). Section 402(d)(1)(D) states that a child's benefits terminate ''the month preceding * * * the month in which such child dies or marries[.]'' In *McMahon* v. *Califano,* 605 F.2d 49 (2d Cir. 1979), *cert. den.* 444 U.S. 847 the Court held that ''the only reasonable interpretation of [§ 402(d)(6) and (d)(1)(D)] is that any marriage occurring subsequent to a child's initial entitlement to benefits terminates those benefits and prevents re-entitlement in the future.'' 605 F.2d at 53; *see also Downs* v. *D.C. Police & Firefighters Retirement and Relief Bd.,* 666 A.2d 860 (D.C.C.A. 1995) (holding disabled child's annuity permanently terminated when child married and later divorced). Otherwise, the Court concluded, the proviso language of § 402(d)(6) would be superfluous because no other interpretation would afford it any meaning. Congress therefore has implemented a policy determination that a disabled child receiving SSA benefits should become permanently ineligible if the child marries, regardless of the subsequent termination of the marriage. By omitting the incorporation of these provisions into the BLBA definition of ''child,'' however, the Department concludes that Congress did not intend to adopt the same policy for the BLBA.

The legislative history of the definition of ''child'' does not support a contrary interpretation. The BLBA originally defined ''dependent'' to mean a dependent wife or child within the meaning of 5 U.S.C. 8110; ''wife'' and ''child'' were not defined separately. 30 U.S.C. 902(a) (1969). Section 8110 defined a dependent child as an ''unmarried child'' living with, or receiving regular contributions from, the employee if the child is under 18 years of age; over that age but incapable of self-support because of a physical or mental impairment; or a student. 5 U.S.C. 8110(a)(3). In 1972, Congress amended the BLBA to include a new definition of ''dependent'' and separate definitions of ''child'' and ''widow.'' 30 U.S.C. 902(a), (g), (e) (1972). The legislative history of the 1972 amendments simply states that the statutory definition of ''child'' conformed to the SSA definition. S. Rep. No. 743, 92nd Cong., 2nd Sess. (1972), *reprinted in* Senate Subcommittee on Labor, Committee on Labor and Public Welfare, 94th Cong., 1st Sess., *History of the Federal Coal Mine Health and Safety Act of 1969,* as amended through 1974, Part 2—Appendix at 1946, 1974 (1975). That conformance extended only to the specific adoption of SSA eligibility criteria for age, disability, and student requirements, but did not include provisions such as the permanent ban on reentitlement for a child who marries in § 402(d)(6). Consequently, the Department is free to depart from the SSA eligibility scheme contained in § 402(d)(6) by permitting reentitlement.

The effect of marriage on a claimant's eligibility has also arisen in connection with a miner's surviving spouse. 30 U.S.C. 902(e). Since the 1972 amendments, the statutory definition of ''widow'' has limited eligibility to a miner's surviving spouse or surviving divorced spouse ''who is not married.'' Legislative history linking the 1972 amendment of 30 U.S.C. 902(e) to changes in the parallel SSA definition clearly establish Congress' intention to permit reentitlement for a widow who remarried after the beneficiary's death and later became unmarried. *See generally Wolf Creek Collieries* v. *Robinson,* 872 F.2d 1264, 1266 (6th Cir. 1989); *Luchino* v. *Director,* OWCP, 8 Black Lung Rep. 1–453, 1–456 (1986). The statutory definitions of ''widow'' and ''child'' are alike in that both require the individual to be unmarried as a condition of eligibility. The legislative history of the Black Lung Benefits Act's 1972 amendments strongly supports limiting the effect of an intervening marriage on a surviving spouse's eligibility, and does not contradict affording the same treatment

to a child. In the absence of such contradictory evidence of Congress' intentions, both statutory definitions should be construed alike given the similarities in their language. Accordingly, a presently unmarried child of a miner is eligible for benefits notwithstanding any prior marriage. The marriage merely suspends the child's eligibility for benefits for the duration of the marriage if the child marries during a period of entitlement. Eligibility then resumes upon termination of the marriage, assuming all other conditions of eligibility can be satisfied. If the child's marriage terminates prior to any period of entitlement, the marriage has no effect upon the child's eligibility.

(c) No other comments concerning this section were received, and no other changes have been made in it.

20 CFR 725.221

(a) The Department proposed changing the date of onset of disability in § 725.221 from 18 to 22 years of age to conform the regulation to the same change in 42 U.S.C. 423(d). 62 FR 3350, 3392 (Jan. 22, 1997). The Department proposed no additional changes in the second notice of proposed rulemaking. 64 FR 54791 (Oct. 8, 1999).

(b) One comment supported the change in the age by which disability must commence.

(c) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.222

(a) The Department proposed changing the date of onset of disability in § 725.222 from 18 to 22 years of age to conform the regulation to the same change in 42 U.S.C. 423(d). 62 FR 3350, 3392 (Jan. 22, 1997). The Department proposed no additional changes in the second notice of proposed rulemaking. 64 FR 54791 (Oct. 8, 1999).

(b) One comment recommends that subsection (b) allow a deceased miner's parent, brother or sister to claim benefits unless the miner's surviving spouse or child has established entitlement. The Department rejects this change because it is inconsistent with the Black Lung Benefits Act. Section 412 of the Act provides guidelines for the payment of benefits to eligible beneficiaries. 30 U.S.C. 922. Section 412(a)(5) states, in pertinent part, that a dependent parent of a deceased miner ''who is not survived at the time of [the miner's] death by a widow or a child'' is eligible for benefits. 30 U.S.C. 922(a)(5). The same provision also states that a dependent surviving sibling of the deceased miner ''who is not survived at the time of [the miner's] death by a widow, child, or parent'' is eligible for benefits. The current language in 20 CFR 725.222(b) follows the statutory language, and no change in that subsection is appropriate. The statutory provisions are unequivocal: the existence of a surviving spouse or child is sufficient to preclude entitlement for other survivors even if the spouse or child is not receiving benefits.

This interpretation is further supported by another provision of section 412. Paragraph (a)(3) states that ''no entitlement to benefits as a child shall be established under this paragraph (3) for any month for which entitlement to benefits as a widow is established under paragraph (2).'' 30 U.S.C. 922(a)(3). Under this provision, a child may receive benefits even if a surviving spouse exists unless (or until) the spouse establishes his or her own entitlement and supersedes the child as the primary beneficiary. By using different eligibility criteria within the same statutory provision, Congress drew a clear distinction between the circumstances in which the existence of an eligible surviving spouse could preclude any potential beneficiary with lesser standing from obtaining benefits. The child may therefore constitute a primary beneficiary until such time as the spouse asserts (and proves) his or her own entitlement; at that time, the spouse replaces the child as the beneficiary. The mere existence of a surviving spouse or child, however, does preclude an otherwise eligible parent or sibling from claiming benefits. The commenter's recommended change would violate the distinction between classes of eligible beneficiaries which Congress has drawn. The recommendation must be rejected.

(c) One comment supported the change in age, from 18 to 22, by which disability must commence.

(d) No other comments concerning this section were received, and no changes have been made in it.

20 CFR 725.223

(a) In the initial notice of proposed rulemaking, the Department proposed revising § 725.223 to adopt the change in age limits for disability specified by 42 U.S.C. 402(d)(1)(B), as incorporated by the Black Lung Benefits Act (BLBA), 30 U.S.C. 922(a)(5). 62 FR 3351, 3393 (Jan. 22, 1997). The Department also proposed adding subsection (d) to permit reentitlement for a miner's dependent brother or sister whose eligibility had terminated upon marriage, provided the marriage ended and the individual again fulfilled all the eligibility criteria. The Department thereafter reconsidered this proposal, and suggested its removal in the second notice of proposed rulemaking. 64 FR 55029 (Oct. 8, 1999). The Department concluded that the proposed subsection (d) contradicted longstanding agency policy, which permitted reentitlement upon cessation of marriage only in the case of a surviving spouse. Because the Department stated it considered a miner's children permanently barred from reentitlement upon the cessation of marriage, it declined to afford preferential treatment to the miner's siblings. In the case of a married sibling who becomes the miner's dependent, the Department concluded that eligibility should not be precluded by the existence of the marriage if the sibling's spouse provided no support. Once a married sibling received support or an unmarried dependent married, however, the Department relied on the assumption that the married sibling would receive support from the spouse and a sibling whose marriage terminated would rely on savings or property from the marriage, etc. 64 FR 54983–84 (Oct. 8, 1999).

(b) The Department has changed its position that reentitlement for beneficiaries after resumption of unmarried status must be confined to surviving spouses and surviving divorced spouses. *See* § 725.219(d) above, with respect to children. Although the Department recognizes reentitlement for children as well as spouses, the Department has not changed its views about the effect of marriage as a permanent bar to reentitlement for a miner's brother or sister. The BLBA supports this policy. Section 412(a)(5) states that ''[n]o benefits to a sister or brother shall be payable under this paragraph for any month beginning with the month in which he or she * * * marries.'' 30 U.S.C. 922(a)(5). This provision is unequivocal. Once a brother or sister who is receiving benefits marries, eligibility terminates. That the termination is permanent may be inferred from the phrasing of the provision: upon marriage, no benefits are payable to the sibling ''for *any* month'' starting with the month of the marriage. Section 412(a)(5) does not include any qualifying language which would suggest that benefits are not payable simply for the duration of the marriage. Rather, it identifies a point when ineligibility commences, with no provision for restoring eligibility. In this regard, section 412(a)(5) differs from the statutory definitions of ''widow'' and ''child,'' 30 U.S.C. 902(e), (g). Section 412(a)(5) links the occurrence of an event to the termination of eligibility

while the ''widow'' and ''child'' definitions focus on the individual's status. The widow's or child's marriage status can change; consequently these individuals can move in or out of eligibility. Once a brother or sister marries, ''no benefits shall be payable * * *.'' The BLBA therefore requires that a miner's brothers and sisters be excluded from reentitlement upon the dissolution of marriage.

(c) One comment endorses the withdrawal of proposed subsection (d), and a return to current practice with respect to the marriage of a miner's brothers and sisters.

(d) No other comments concerning this section were received, and no changes have been made in it.

Subpart C

20 CFR 725.306

(a) In its first notice of proposed rulemaking, the Department proposed revising § 725.306(a)(3) by cross-referencing § 725.522 so that an unrelated revision of the term ''benefits'' in section 725.101(a)(6) would not adversely affect a claimant's ability to withdraw his claim for benefits. The Department specifically noted its intention not to require reimbursement of the amount spent on the claimant's complete pulmonary evaluation as a condition for withdrawal of a claim, notwithstanding its proposal to include the complete pulmonary evaluation within the definition of ''benefits.'' 62 FR 3351 (Jan. 22, 1997). The Department did not discuss section 725.306 in its second notice of proposed rulemaking. *See* list of changes in the Department's second proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Several comments opposed the revised definition of ''benefits,'' § 725.101(a)(6), because it includes the cost of the miner's complete pulmonary examination for which the Department is liable in the absence of a final award of benefits. The commenters believe the revised definition will impose liability on the miner under § 725.306 for repayment of the cost of the examination if he should decide to withdraw his claim. For the reasons stated in the Department's initial notice of proposed rulemaking, 62 FR 3351 (Jan. 22, 1997), and in response to comments received in connection with § 725.101(a)(6), 64 FR 54982 (Oct. 8, 1999), the Department has not made reimbursement of the examination ''benefit'' a price for withdrawing a claim. No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.308

Although the Department received comments relevant to this section, the regulation was not open for comment, *see* 62 Fed. Reg. 3341 (Jan. 22, 1997); 64 Fed. Reg. 54971 (Oct. 8, 1999). It was repromulgated only for the convenience of readers. Accordingly, no changes are being made in this section.

20 CFR 725.309

(a) In its first notice of proposed rulemaking, the Department proposed revising § 725.309 to clarify the rule governing subsequent claims. 62 FR 3351 (Jan. 22, 1997). A subsequent claim is an application filed by the same individual after final denial of a prior claim. The Department observed that a majority of the federal appellate courts that had considered the issue had deferred to the Department's interpretation of the former regulation governing such claims. That regulation required a claimant to establish that he had suffered a material change in condition since the denial of his earlier claim in order to escape the denial of the later claim on the grounds of the prior denial. 20 CFR 725.309 (1999). The Department's interpretation of that rule allowed miners to establish the necessary material change in condition by introducing new evidence that demonstrated a change in one of the necessary elements of entitlement, such as the existence of pneumoconiosis. The Department proposed to codify its interpretation by creating a rebuttable presumption that the miner's condition had changed if new evidence established one of the elements of entitlement previously resolved against the miner. An operator could rebut the presumption by establishing that the earlier denial was erroneous, *i.e.*, that the new evidence submitted by the claimant did not demonstrate a change in his condition but simply that the earlier determination was mistaken. If the presumption was not rebutted, the factfinder would weigh all of the evidence on the remaining elements of entitlement to determine whether the claimant was entitled to benefits. The original proposal also provided that the remaining issues of entitlement were subject to *de novo* adjudication unless the parties had stipulated to, or waived their right to contest, those issues in the earlier proceeding. Thus, once the claimant established a change in his condition, no parties to the claim were entitled to rely on findings made in connection with the denial of the prior claim.

The Department substantially revised its proposal in its second notice of proposed rulemaking. 64 FR 54984–85 (Oct. 8, 1999). The Department deleted the rebuttable presumption and substituted a threshold test which allowed the miner to litigate his entitlement to benefits without regard to any previous findings by producing new evidence that established any of the elements of entitlement previously resolved against him. The Department explained that this test effectuated 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), by accepting the correctness of the earlier denial of benefits. In addition, in response to several comments, the Department restored a provision requiring the denial of an additional survivor's claim, but limited the circumstances in which such a denial was appropriate. The Department proposed the automatic denial of an additional survivor's claim in cases in which the denial of the previous claim was based solely on a finding or findings that were not subject to change. For example, if the earlier claim was denied solely because the miner did not die due to pneumoconiosis, the regulation would require the denial of any additional claim as well. The Department responded to other comments, rejecting the suggestion that the revised regulation was inconsistent with § 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 922, as incorporated by 30 U.S.C. 932(a), and § 413(d) of the Black Lung Benefits Act, 30 U.S.C. 923(d). Finally, the Department discussed why findings favorable to the claimant that were made in the previous denial of benefits should not be given preclusive effect, and clarified the date from which benefits were payable in the event an additional claim was awarded.

(b) Two comments object to the Department's rule allowing subsequent claims on the basis that the record lacks adequate justification of the latency and progressivity of pneumoconiosis. In its first notice of proposed rulemaking, the Department proposed revising the definition of the term ''pneumoconiosis'' in § 718.201 to, among other things, explicitly recognize that it referred to a progressive disease. 62 FR 3343–44 (Jan. 22, 1997). Several commenters argued that the Department's proposed definition was scientifically unsound, and presented testimony from a panel of physicians with expertise in pulmonary medicine at the Department's July 22, 1997 hearing in Washington, D.C. The Department also received comments and testimony in support of its proposal.

The commenters opposed to the Department's proposal also objected to the Department's failure to consult the National Institute of Occupational Safety and Health (NIOSH). Although NIOSH had commented favorably on the Department's proposal, and specifically on the provision recognizing the progressive nature of pneumoconiosis, the Department decided, in light of the divergent comments it had received from medical professionals, to seek additional guidance from NIOSH. The Department transmitted a copy of all of the testimony and commentary it had received to Dr. Linda Rosenstock, the Director of NIOSH, and asked NIOSH to determine, in light of the then existing record, whether NIOSH continued to support the Department's proposal. NIOSH responded, in a December 7, 1998 letter from Dr. Paul Schulte, the Director of NIOSH's Education and Information Division, that ''[t]he unfavorable comments received by DOL do not alter our previous position: NIOSH scientific analysis supports the proposed definitional changes.'' Dr. Schulte provided additional medical references to support NIOSH's conclusion. The Department notified parties of this additional evidence in its second notice of proposed rulemaking. *See* 64 FR 54978–79 (Oct. 8, 1999).

One commenter accuses the Department of obtaining assistance from NIOSH's information officer rather than its scientific staff. The Department does not agree that the identity or title of the agency official through whom NIOSH chose to communicate its response to the Department's inquiry renders that response invalid. The Department's request was sent to the Director of NIOSH, and observed that the resolution of the issues related to the definition of the term ''pneumoconiosis'' required scientific and medical expertise. Dr. Schulte's letter, transmitted on behalf of NIOSH in response to the Department's request, specifically refers to ''NIOSH scientific analysis.'' Accordingly, the Department rejects the commenter's inferences that its consultation with NIOSH was less than complete, and that the Department sought to exclude the agency's scientific staff. To the extent that the statute imposes an obligation to consult with NIOSH on the definition of ''pneumoconiosis,'' the Department has fully complied with that obligation.

The commenters opposed to the Department's proposal also attack the scientific basis of the conclusion that the Department and NIOSH have drawn from the evidence of record. In the following discussion, where a scientific article or treatise is cited, the Department has also cited to a Rulemaking Record Exhibit or, when appropriate, the **Federal Register**, where that source appears. This second citation is not an exhaustive list; thus, each source may appear at additional points in the Rulemaking Record. In support of their attack, the commenters have submitted an analysis of the available medical literature from Dr. Gregory Fino, a Board-certified physician in Internal Medicine and Pulmonary Disease, and Dr. Barbara Bahl, who has a doctorate in nursing and biostatistics. Drs. Fino and Bahl analyze nine articles and textbooks dealing with latency, which they define parenthetically as ''0/0 or 0/1 to 1/0+.'' The analysis thus focuses on evidence that would show that a miner whose chest X-rays are classified by a radiologist as ''negative'' (0/0 or 0/1 under the ILO–UC classification scheme, *see* 20 CFR 718.102(b)), after he leaves the mine can develop a disease that will result in chest X-rays that are classified as ''positive.'' Under the ILO–UC scheme, an X-ray classified as category 1, 2, or 3, ranging from 1/0 to 3/3, is considered positive for simple pneumoconiosis. An X-ray classified as A, B, or C is considered positive for complicated pneumoconiosis, also known as progressive massive fibrosis or massive pulmonary fibrosis. 20 CFR 718.102(b), 718.304(a) (1999). They conclude that ''the medical literature provides no evidence that coal workers' pneumoconiosis or silicosis in coalminers is a latent disease. There is also no evidence to show that the development of pulmonary impairment is latent.'' Rulemaking Record, Exhibit, 89–37, Appendix C at 29.

Drs. Fino and Bahl also analyzed five articles dealing with progression, which they define parenthetically as ''1/0 to 1/0.+'' Their analysis of progression thus focuses on whether individuals whose chest X-rays are initially read as 1/0, the lowest positive classification in the ILO–UC scheme, may have later chest X-rays classified greater than 1/0. They observe that ''there are authors who have identified progression of pneumoconiosis in coal miners,'' but that other authors have reached the contrary conclusion. They conclude as follows:

> Why do some miners progress within the ILO scale of simple pneumoconiosis and others do not? The answer lies in the proper definition of pneumoconiosis. Careful attention must be made to differentiate simple coal workers' pneumoconiosis and silicosis. The miners who have been described to progress over time after exposure ceases are miners who have likely contracted silicosis, not simple coal workers' pneumoconiosis. * * *
>
> Silicosis may be a progressive disease in a small percentage of miners after coal mine dust exposure ends. The literature does not support the statement that coal workers' pneumoconiosis is progressive absent further dust exposure. There are no studies that show progressive impairment in miners who have left the mines. The studies do not show any progression in industrial bronchitis after a miner leaves the mines. In fact, the studies do suggest that the minor reduction in the FEV1 [Forced Expiratory Volume in one second] as a result of industrial bronchitis occurs in the first few years of mining and then the effect over the remaining years in the mines is negligible and may even recover.

Rulemaking Record, Exhibit 89–37, Appendix C at 30–31. In evaluating the medical evidence contained in the rulemaking record, the Department is mindful that Congress provided an exceptionally broad definition of the term ''pneumoconiosis:'' ''a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.'' 30 U.S.C. 902(b). The regulatory definitions promulgated by the Department over the last 25 years have reflected the scope of this provision.

In 1978, the Department promulgated its interim criteria, 20 CFR Part 727. Those criteria included a definition of ''pneumoconiosis'' at 20 CFR 727.202. After repeating the statutory definition, the regulation further provided that ''[t]his definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis[,]anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis[,] silicosis, or silicotuberculosis arising out of coal mine employment.'' 43 FR 36825 (Aug. 18, 1978). The Department promulgated its permanent criteria, 20 CFR Part 718, in 1980. Section 718.201, entitled ''Definition of pneumoconiosis,'' contained a definition that was identical to that of § 727.202. 45 FR 13685 (Feb. 29, 1980). The federal courts of appeals have long recognized that the Act compensates not merely coal workers' pneumoconiosis, as that term is used by the medical community, but ''legal'' pneumoconiosis. *See, e.g., Peabody Coal Co.* v. *Lowis,* 708 F.2d 266, 268 n.4 (7th Cir. 1983) (''the 'legal' definition of pneumoconiosis contained in the above-quoted regulation [§ 727.202] includes not only 'true or clinical' pneumoconiosis but also other respiratory or pulmonary diseases arising from dust exposure in coal mine employment''); *Gulf & Western Industries* v. *Ling,* 176 F.3d 226, 231 (4th Cir. 1999) (''[the regulations detail the breadth of what is frequently called

'legal' pneumoconiosis * * *''); *see also* the Department's preamble to § 718.201.

The Department has reviewed all of the medical literature referenced in the record, and does not agree that it lacks support for the proposition that pneumoconiosis is a latent, progressive disease. Contrary to Dr. Fino's conclusions, a number of medical references document the latent, progressive nature of the disease. For example, Seaton, in ''Coal Workers' Pneumoconiosis,'' in Morgan, WKC and Seaton A, eds., *Occupational Lung Diseases* (WB Saunders Co., 3d ed. 1995) 389, *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 34, 42, contains the observation that ''PMF [Progressive massive fibrosis] may occur after dust exposure has ceased, even when the miner has left the industry with no apparent simple pneumoconiosis, although this will only occur if the worker has had substantial dust exposure''). Similarly, National Institute for Occupational Safety and Health, *Criteria for a Recommended Standard: Occupational Exposure to Respirable Coal Mine Dust,* § 4.2.1.3.1, Rulemaking Record, Exhibit 2–1 at 48, summarized an article (Maclaren WM, Soutar CA, ''Progressive massive fibrosis and simple pneumoconiosis in ex-miners,'' Br. J. Ind. Med. 42:734–740 (1985)) as follows: ''Among 1,902 ex-miners who had not developed PMF within 4 years of leaving mining, 172 (9%) developed PMF after leaving mining. Of those 172 miners with PMF, 32% had no evidence of simple CWP (category 0) when they left mining.'' In that article, in fact, Maclaren and Soutar reported both small opacities (evidence of simple pneumoconiosis) and large opacities (evidence of complicated pneumoconiosis) in ex-miners who did not show evidence of coal workers' pneumoconiosis after the miners left the industry.

Moreover, contrary to the conclusion of Dr. Fino and Dr. Bahl, the study conducted by Donnan *et al.* did find significant evidence of latency. Donnan PT, Miller BG, Scarisbrick DA, Seaton A, Wightman AJA, Soutar CA, ''Progression of simple pneumoconiosis in ex-coalminers after cessation of exposure to coalmine dust,'' IOM report TM/97/07 (Institute of Occupational Medicine, December 1997) 1–67, see also Rulemaking Record, Exhibit 89–37, Appendix C at 26, 29. Dr. Fino and Dr. Bahl write that ''only one out of 200 miners [in the study] was found to progress from a negative to a positive film.'' That conclusion, however, was not the conclusion of the study's authors. Their tables 3.4a (Median profusion score for 14 CWP progressors and 19 PMF progressors) and 3.4b (Median profusion score for 161 CWP non-progressors) compare X-rays taken within two years of the dates on which the 200 miners left the coal mining industry with X-rays taken 10 years later. They demonstrate that of 138 ex-miners whose early X-rays were read as 0/0 or 0/1, 11 had later X-rays read as positive for either simple or complicated pneumoconiosis. This proportion, 7.97%, has epidemiologic significance, and supports the authors' conclusion that ''[t]he results have demonstrated that progression does occur after cessation of exposure.'' Donnan *et al.* at 23.

In light of this evidence, the Department is not persuaded by the reliance Dr. Fino and Dr. Bahl place on the conclusion of Drs. Merchant, Taylor and Hodous in ''Occupational Respiratory Diseases'' (National Institute for Occupational Safety and Health, 1986), *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 26. Dr. Fino and Dr. Bahl quote the textbook's statement that ''the chance of radiological progression over ten years at a mean dust concentration of 2 milligrams per cubic meter is essentially zero for a miner with x-ray category 0/0.'' This textbook was published by the Division of Respiratory Disease Studies of the Appalachian Laboratory for Occupational Safety and Health, a component of the National Institute of Occupational Safety and Health, more than 10 years prior to the Donnan study. In light of NIOSH's conclusion that scientific analysis supports the Department's regulations, the Department does not agree that the statement by Merchant *et al.* requires the Department to revise its regulatory approach.

Similarly, the Department is not persuaded by Dr. Fino and Dr. Bahl's attempt to dismiss the effect of silica on coal miners, and therefore to discount the applicability of studies demonstrating the latency and progressivity of silicosis. It remains the Department's position that pneumoconiosis, as defined in the statute, 30 U.S.C. 902(b), is both latent and progressive. The statutory definition includes both simple coal workers' pneumoconiosis and silicosis. Although they acknowledge studies showing that silicosis is a latent, progressive disease, Dr. Fino and Dr. Bahl argue that coal workers' pneumoconiosis must be distinguished from silicosis. The Black Lung Benefits Act, however, does not permit such a distinction. As discussed above, the regulatory definition of the term ''pneumoconiosis,'' implementing the broad statutory definition, includes silicosis within the list of conditions that must be considered pneumoconiosis. In addition, inclusion of silicosis in the definition of pneumoconiosis is based on practical as well as legal considerations. It is difficult to separate the effects of coal and silica in the occupational setting. Coal contains a number of non-organic materials, including quartz, and the percentage of quartz is greater in high rank coals. Seaton, ''Coal Workers' Pneumoconiosis,'' in Morgan, WKC and Seaton A, eds., *Occupational Lung Diseases* (WB Saunders Co., 3d ed. 1995) 389, *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 34, 42. Seaton and colleagues reported a cohort of miners who had a rapid progression of radiologic findings resembling silicosis, despite a relatively low total coal dust exposure. Seaton A, Dick JA, Dodgson J, Jacobsen M., ''Quartz and pneumoconiosis in coal miners,'' Lancet 2:1272 (1981), *see also* Rulemaking Record, Exhibit 2–1 at 50. Analysis revealed that the percentage of quartz in the mixed coal mine dust was significantly higher in these affected miners than in matched controls. They concluded that quartz exposure was an important factor contributing to pneumoconiosis in some miners and that disease in such miners was more aggressive. Moreover, miners who drill into hard rock, such as those who bore shafts or work as roof bolters, are exposed to higher concentrations of quartz and are known to be at higher risk for developing silicosis. Seaton, ''Coal Workers' Pneumoconiosis,'' in Morgan, WKC and Seaton A, eds., *Occupational Lung Diseases* (WB Saunders Co., 3d ed. 1995) 389, *see also* Rulemaking Record, Exhibit 89–37, Appendix C at 34, 42. Based on these observations, it is reasonable to conclude that there is a clear risk of developing pneumoconiosis with characteristics of silicosis in coal miners exposed to dusts with high quartz content. Accordingly, the Department believes that it may properly rely on studies of silicosis in promulgating regulations governing the compensability of pneumoconiosis as that term has been defined by Congress. *See also* Beckett WS, ''Occupational Respiratory Diseases,'' The New England Journal of Medicine, 342:406–13 (Feb. 12, 2000) (citing a study of silicosis to support the conclusion that ''[w]ith many substances (including coal and silica dust), the disease may progress for decades after the exposure has ceased.''). (Dr. Beckett's review article did not appear until after the

rulemaking record had closed; it is cited only as additional evidence confirming the Department's previous use of studies involving silicosis).

Finally, there is also evidence that lung function can continue to deteriorate after a miner leaves the coal mining industry. The authors of Dimich-Ward H and Bates DV, ''Reanalysis of a longitudinal study of pulmonary function in coal miners in Lorraine, France,'' Am J Ind Med, 25:613–623 (1994), *see also* 62 FR 3344 (Jan. 22, 1997), demonstrated a decline of pulmonary function in both smoking and non-smoking coal miners that continues over time even after retirement from mining. Given this evidence of progression, it is clear that a miner who may be asymptomatic and without significant impairment at retirement can develop a significant pulmonary impairment after a latent period. Because the legal definition of ''pneumoconiosis'' includes impairments that arise from coal mine employment, regardless of whether a miner shows X-ray evidence of pneumoconiosis, this evidence of deterioration of lung function among miners, including miners who did not smoke, is particularly significant.

The commenters also cite the 1985 report of the Surgeon General, U.S. Department of Health and Human Services, *The Health Consequences of Smoking: Cancer and Chronic Lung Disease in the Workplace* (1985), *see also* Rulemaking Record, Exhibit 89–21, Appendix 11, in support of their argument. Of the seven items listed in the ''Summary and Conclusions'' section of Chapter Seven, ''Respiratory Disease in Coal Miners,'' none addresses the latency or progressivity of pneumoconiosis. In addition, the Surgeon General's report, which focused on the health consequences of smoking, did not review many of the articles on which the Department's conclusion is based. Because the overwhelming majority of the references cited by the Department in its first and second notices of proposed rulemaking, *see* 62 FR 3343–44 (Jan. 22, 1997); 64 FR 54978–79 (Oct. 8, 1999), as well as the references discussed above, were prepared after 1985, this is not surprising. Accordingly, the Department does not believe that anything in the Surgeon General's report requires the Department to ignore the conclusions that it has drawn from the studies and articles in the rulemaking record.

Contrary to the commenters' argument, then, the record does contain abundant evidence demonstrating that pneumoconiosis is a latent, progressive disease. That evidence is certainly sufficient to justify the Department's regulation governing subsequent claims. Moreover, neither the regulation permitting subsequent claims nor the Department's explicit recognition of the progressive nature of the disease represents a departure from the Department's prior positions. The Department's original promulgation of a regulation governing subsequent claims in 1978 was based on the progressive nature of the disease. 43 FR 36785 (Aug. 18, 1978). The federal courts of appeals have also recognized that pneumoconiosis is a progressive disease. *Plesh* v. *Director, OWCP,* 71 F.3d 103, 108 (3d Cir. 1995) (''pneumoconiosis is progressive and incurable''); *Labelle Processing Co.* v. *Swarrow,* 72 F.3d 308, 314–315 (3d Cir. 1995) (''Congress, in enacting the BLBA, recognized the perniciously progressive nature of the disease * * *. Moreover, courts have long acknowledged that pneumoconiosis is a progressive and irreversible disease.''); *Kowalchick* v. *Director, OWCP,* 893 F.2d 615, 621 (3d Cir. 1990) (''That the three earliest x-rays of record * * * were read negative is not inconsistent with the progressive nature of pneumoconiosis.''); *Shendock* v. *Director, OWCP,* 893 F.2d 1458, 1467 n.10 (3d Cir. 1990) (''it is well recognized that pneumoconiosis is a progressive disease whose symptoms increase in severity over time''); *Bethenergy Mines Inc.* v. *Director, OWCP,* 854 F.2d 632, 636 (3d Cir. 1988) (''Due to the progressive nature of pneumoconiosis, a coal mine operator is less likely to know the details underlying a particular claim than an employer is in the typical case arising under the LHWCA.''); *Zielinski* v. *Califano,* 580 F.2d 103, 107 (3d Cir. 1978) (''pneumoconiosis and related lung diseases progress slowly''); *Eastern Associated Coal Corp.* v. *Director, OWCP,* ____ F.3d ____, No. 99–1312, slip op. at pp. 11–12 (4th Cir. July 12, 2000) (observing ''the assumption of progressivity that underlies much of the statutory regime''); *Lane Hollow Coal Co.* v. *Lockhart,* 137 F.3d 799, 803 (4th Cir. 1998) (''pneumoconiosis is progressive and irreversible''); *Adkins* v. *Director, OWCP,* 958 F.2d 49, 51 (4th Cir. 1992) (''pneumoconiosis is a progressive disease''); *Greer* v. *Director, OWCP,* 940 F.2d 88, 90 (4th Cir. 1991) (pneumoconiosis is ''a slowly-progressing condition''); *Hamrick* v. *Schweiker,* 679 F.2d 1078, 1081 (4th Cir. 1982) (''pneumoconiosis is a progressive disease''); Prater v. Harris, 620 F.2d 1074, 1082 (4th Cir. 1980) (''pneumoconiosis is a progressive disease''); *Barnes* v. *Mathews,* 562 F.2d 278, 279 (4th Cir. 1977) (''pneumoconiosis is a slow, progressive disease often difficult to diagnose at early stages''); *Crace* v. *Kentland-Elkhorn Coal Corp.,* 109 F.3d 1163, 1167 (6th Cir. 1997) (''because of the progressive nature of pneumoconiosis, more recent evidence is often accorded more weight''); *Consolidation Coal Co.* v. *McMahon,* 77 F.3d 898, 906 (6th Cir. 1996) (recognizing ''the progressive nature of pneumoconiosis''); *Sharondale Corp.* v. *Ross,* 42 F.3d 993, 997 (6th Cir. 1994) (''the material change provision [provides] relief from the principles of finality for those miners whose conditions have deteriorated due to the progressive nature of black lung disease''); *Johnson* v. *Peabody Coal Co.,* 26 F.3d 618, 620 (6th Cir. 1994) (''Pneumoconiosis is a progressive debilitating disease.''); *Woodward* v. *Director, OWCP,* 991 F.2d 314, 320 (6th Cir. 1993) (''Pneumoconiosis is a progressive and degenerative disease.''); *Campbell* v. *Consolidation Coal Co.,* 811 F.2d 302, 303 (6th Cir. 1987) (recognizing ''the progressive nature of pneumoconiosis''); *Back* v. *Director, OWCP,* 796 F.2d 169, 172 (6th Cir. 1986) (''Because of the progressive nature of pneumoconiosis, earlier negative and later positive X-rays of the same individual are not necessarily in conflict.''); *Orange* v. *Island Creek Coal Co.,* 786 F.2d 724, 727 (6th Cir. 1986) (''pneumoconiosis * * * is a progressive disease''); *Director, OWCP* v. *Bivens,* 757 F.2d 781, 788 (6th Cir. 1985) (''the Black Lung Benefits Act provides compensation for disability based on an invisible and progressive disease''); *Collins* v. *Sec'y of HHS,* 734 F.2d 1177, 1180 (6th Cir. 1984) (''Medically we note that pneumoconiosis is a slow, progressive disease. Its characteristics and symptoms often do not manifest themselves in a way that promote [sic] immediate detection. In some cases the disease may take years before it is readily detectable.''); *Smith* v. *Califano,* 682 F.2d 583, 587 (6th Cir. 1982) (''coal workers'' pneumoconiosis * * * is a progressive disease''); *Hill* v. *Califano,* 592 F.2d 341, 345 (6th Cir. 1979) (''pneumoconiosis is a slowly progressive disease''); *Morris* v. *Mathews,* 557 F.2d 563, 568 (6th Cir. 1977) (recognizing Congressional finding that ''pneumoconiosis [is] a progressive chronic dust disease of the lung''); *Begley* v. *Mathews,* 544 F.2d 1345, 1354 (6th Cir. 1976) (describing pneumoconiosis as ''a disease known to be of a slowly progressive character''); *Amax Coal Co.* v. *Franklin,* 957 F.2d 355, 359 (7th Cir. 1992) (''Black lung

disease, at least when broadly defined, is a progressive disease * * *.''); *Dotson* v. *Peabody Coal Co.,* 846 F.2d 1134, 1139 (7th Cir. 1988) (''Pneumoconiosis is a progressive disease* * *''.); *Russell* v. *Director, OWCP,* 829 F.2d 615, 616 (7th Cir. 1987) (''Coal miners'' pneumoconiosis (black lung) is a progressive, debilitating disease.''); *Amax Coal Co.* v. *Director, OWCP,* 801 F.2d 958, 964 (7th Cir. 1986) (recognizing ''the difficulty of clinically diagnosing the progressive disease''); *Consolidation Coal Co.* v. *Chubb,* 741 F.2d 968, 973 (7th Cir. 1984) (''In light of the progressive nature of pneumoconiosis, [the ALJ's] according greater weight to the recent x-ray was not irrational.''); *Lovilia Coal Co.* v. *Harvey,* 109 F.3d 445, 450 (8th Cir. 1997) (recognizing progressive nature of pneumoconiosis); *Robinson* v. *Missouri Mining Co.,* 955 F.2d 1181, 1184 (8th Cir. 1992) (''pneumoconiosis is a progressive disease''); *Campbell* v. *Director, OWCP,* 846 F.2d 502, 509 (8th Cir. 1988) (''pneumoconiosis is a progressive disease''); *Newman* v. *Director, OWCP,* 745 F.2d 1162, 1165 (8th Cir. 1984) (''pneumoconiosis is a progressive disease''); *Padavich* v. *Mathews,* 561 F.2d 142, 146 (8th Cir. 1977) (''Pneumoconiosis is a progressive illness* * *.''); *Humphreville* v. *Mathews,* 560 F.2d 347, 349 (8th Cir. 1977) (''pneumoconiosis is a progressive disease''); *Wyoming Fuel Co.* v. *Director, OWCP,* 90 F.3d 1502, 1507 (10th Cir. 1996) (recognizing ''the nature of pneumoconiosis as a disease that develops progressively and is difficult to diagnose''); *Lukman* v. *Director, OWCP,* 896 F.2d 1248, 1253 (10th Cir. 1990) (recognizing real purpose of duplicate claims regulation is to provide ''miners with progressively worsening health full and equal access to black lung benefits.''); *Ohler* v. *Sec'y of HEW,* 583 F.2d 501, 506 (10th Cir. 1978) (''pneumoconiosis is a progressive disease, as is emphysema''); *Paluso* v. *Mathews,* 573 F.2d 4, 10 (10th Cir. 1978) (''It is well-established medically that pneumoconiosis is a progressive disease which frequently defies diagnosis.''); *Alabama Dry Dock and Shipbuilding Corp.* v. *Sowell,* 933 F.2d 1561, 1566 (11th Cir. 1991) (black lung ''can lie essentially dormant in the body for many years after an employee has left his employment before progressing to the point where [it] is disabling''); *Curse* v. *Director, OWCP,* 843 F.2d 456, 457 (11th Cir. 1988) (recognizing black lung disease develops slowly and progressively); *Doss* v. *Califano,* 598 F.2d 419, 421 (11th Cir. 1979) (''pneumoconiosis is a progressive disease''); *but see Zeigler Coal Co.* v. *Lemon,* 23 F.3d 1235, 1238 (7th Cir. 1994) (chastising an administrative law judge for assuming that pneumoconiosis is progressive without any evidence in the record to support the assumption).

Although one commenter asserts that the regulation creates an irrebuttable presumption that each miner's condition is progressive, it actually does no such thing. As revised, § 725.309 simply effectuates the current one-element test adopted by a substantial number of federal appellate courts and most recently the Benefits Review Board, *Allen* v. *Mead Corp.,* ____ Black Lung Rep. (MB) ____, BRB No. 99–0474 BLA (May 31, 2000). The one-element test allows a miner who demonstrates a material change in one of the conditions of entitlement previously decided against him to avoid an automatic bar on establishing his current entitlement to benefits. To the extent that the commenter would require each miner to submit scientific evidence establishing that the change in his specific condition represents latent, progressive pneumoconiosis, the Department disagrees and has therefore not imposed such an evidentiary burden on claimants. Rather, the miner continues to bear the burden of establishing all of the statutory elements of entitlement, except to the extent that he is aided by two statutory presumptions, 30 U.S.C. 921(c)(1) and (c)(3). The revised regulation continues to afford coal mine operators an opportunity to introduce contrary evidence weighing against entitlement.

(c) One comment submitted in connection with the first notice of proposed rulemaking, and cited by another comment submitted in connection with the second notice of proposed rulemaking, suggests that the Department's proposed revision would compensate the 15 to 20 percent of cigarette smokers who develop chronic airway obstruction if they spent 10 years or more in the coal mining industry. The Department does not agree that the possibility that miners will suffer reduced pulmonary function as a result of cigarette smoking justifies the automatic denial of additional claims by miners under § 725.309. In addition, the previously cited study by Dimich-Ward and Bates documented the progressive decrement in lung function among both miners who smoked and those who did not. Dimich-Ward H, Bates DV, ''Reanalysis of a longitudinal study of pulmonary function in coal miners in Lorraine, France,'' Am J Ind Med, 25:613–623 (1994), see also 62 FR 3344 (Jan. 22, 1997). The Department accordingly believes that a miner who files his first claim before he is truly totally disabled, but later becomes totally disabled, must be afforded an opportunity to establish that his condition is related to his coal mine employment. Under § 718.204, the miner continues to bear the burden of proving this element of his entitlement. To the extent that a coal mine operator produces medical evidence demonstrating that the miner's total disability is due solely to cigarette smoking, that evidence would also be relevant to the inquiry under § 718.204.

(d) A number of comments argue that § 725.309 violates accepted principles of claim preclusion and issue preclusion, particularly with respect to the treatment of additional claims filed by miners' survivors. The Department disagrees. In its initial proposal, the Department explained that its additional filing rules gave full effect to the principles of claim preclusion but that the applicability of these principles was limited in two important respects: (1) The liberal reopening provision created by Congress under § 22 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 922, incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a); and (2) the recognition that an individual's eligibility for workers' compensation benefits is not fixed at a single time, but, especially with respect to occupational diseases, may be subject to relitigation even if the worker's first claim is denied. 62 FR 3352 (Jan. 22, 1997). Under these principles, and subject to the limitation that the party must have a full and fair opportunity to litigate its position, *Kremer* v. *Chemical Constr. Corp.,* 456 U.S. 461, 481 n. 22 (1982), a final adjudication of the merits of a cause of action will preclude the parties from relitigating issues that were or could have been raised in the first proceeding. *Rivet* v. *Regions Bank of Louisiana,* 522 U.S. 470, 476 (1998), citing *Federated Department Stores, Inc.* v. *Moitie,* 452 U.S. 394, 398 (1981).

Section 725.309 applies these principles to the adjudication of black lung benefits claims. For example, if the sole basis for denying a miner's claim is a finding on an issue that is not subject to change, and that the miner had an opportunity to fully and fairly litigate, a subsequent claim by the miner must also be denied. Thus, where the first claim was denied solely on the grounds that the applicant did not work as a miner, and he does not allege that he engaged in any additional coal mine employment since he filed that application, his second claim must be denied as well. Where the issue is subject to change, however, neither claim preclusion principles nor

§ 725.309 bars the litigation of the miner's additional claim. For example, where the original denial was based on the miner's failure to establish that his respiratory impairment was totally disabling, and new evidence establishes that that condition has worsened, the miner should not be barred from prosecuting a second application for benefits.

The regulation gives similar treatment to cases involving miners' survivors. Where a previous survivor's claim was denied solely on the basis that the survivor did not prove that the miner died due to pneumoconiosis, an element not subject to change, the survivor may be barred from litigating another claim filed more than one year after the denial of the first one. The Department does not agree, however, with the commenters' suggestion that none of the elements of a survivor's claim is subject to change. In the case of a miner's survivor, for example, the Secretary's regulations recognize, consistent with Departmental practice, court of appeals precedent, and applicable Social Security law, that although a miner's survivor who remarries is not then eligible for benefits, she may become re-entitled to benefits if that marriage ends. *See* preamble to § 725.213. Section 725.309 recognizes this possibility by allowing a miner's survivor to litigate a second claim where one of the grounds on which the first claim was denied, *e.g.,* that the survivor was married, is subject to change.

Moreover, § 725.309 incorporates two other limitations which are accepted components of traditional claim preclusion. First, where none of the elements is subject to change, and denial by virtue of claim preclusion is appropriate under § 725.309, the regulation requires the party defending the claim to specifically plead that doctrine. The Supreme Court has observed that ''[c]laim preclusion (res judicata), as Rule 8(c) of the Federal Rules of Civil Procedure makes clear, is an affirmative defense.'' *Rivet,* 522 U.S. at 476. Section 725.309 similarly requires an operator seeking the denial of an additional survivor's claim by virtue of preclusion to raise that issue at the appropriate time. Like traditional claim preclusion, § 725.309 offers the party defending the cause of action an affirmative defense that is subject to waiver if not properly and timely raised. *See, e.g., Garry* v. *Geils,* 82 F.3d 1362, 1367 n. 8 (7th Cir.1996).

Second, claim preclusion is inappropriate even in traditional civil litigation where the party against whom the defense is invoked was not able to fully litigate those issues which the defendant now seeks to bar. *Kremer,* 456 U.S. at 481 n. 22. For example, this issue would arise if the administrative law judge adjudicating the survivor's first claim found that the survivor's remarriage barred her entitlement, and alternatively concluded that the miner did not die due to pneumoconiosis. In that case, the survivor could not have overturned the adverse finding on the cause of the miner's death because she would not have been able to avoid the prohibition on the eligibility of remarried widows. Accordingly, she could not be said to have had a full and fair opportunity to litigate the issue of the cause of the miner's death. In these circumstances, neither ordinary principles of claims preclusion nor § 725.309 would preclude her from litigating her entitlement to benefits in a subsequent claim.

Similarly, the Department's application of claim preclusion to additional claims contains an exception based on the absence of an opportunity to fully and fairly litigate the issues in a previous proceeding. As the Department explained in its second notice of proposed rulemaking, where one of the applicable conditions of entitlement has changed, *e.g.,* where the miner has become totally disabled or a survivor has ended her second marriage, neither the party defending against the claim—the coal mine operator or the Trust Fund—nor the claimant is entitled to rely on findings made in connection with the denial of an earlier claim for benefits. 64 FR 54985 (Oct. 8, 1999). One commenter's suggestion that an administrative law judge's determination in the original proceeding that an X-ray is not worthy of credit precludes any further litigation of that issue in a subsequent proceeding simply reflects a misunderstanding of the tenets of issue preclusion. Where that finding was not essential to the original denial of benefits, because the ALJ ultimately denied benefits on another basis, or used alternative bases, issue preclusion would not prevent a second factfinder from making a different finding, based on his independent weighing of the evidence, in connection with an additional claim.

(e) One comment opposes the revised version of § 725.309, suggesting it represents a revised application of the common law concept of claim preclusion to adjudications under the Act. In fact, however, with one exception in the case of survivors' entitlement, the revised version of section 725.309 functions no differently than the former regulation with respect to this common law doctrine. As the Department observed in its initial proposal, its ''one-element'' rule, allowing a miner to avoid claim preclusion by establishing one of the conditions of entitlement decided against him in the previous adjudication, derives from a series of appellate decisions adopting the Department's interpretation of the former regulation. *See* 62 FR 3351 (Jan. 22, 1997); *see also* 64 FR 54984 (Oct. 8, 1999). The provision requiring the denial of survivors' claims is also substantially the same as the former rule. Like the revised version, the former rule was subject to waiver just as any other affirmative defense would be under common law. *See Clark* v. *Director, OWCP,* 838 F.2d 197, 200 (6th Cir. 1988) (permitting the Director to waive reliance on section 725.309). The provision governing additional survivors' claims has been altered only in order to accommodate revisions to section 725.213, which will explicitly permit a remarried survivor to establish her entitlement to benefits upon ending her marriage. Accordingly, the Department does not agree that it has substantially revised the applicability of the common law doctrine of claim preclusion under the Black Lung Benefits Act.

(f) One comment argues that the one-element test codified by the revised regulation violates the principles of issue preclusion. The commenter suggests that an X-ray that is found not to be credible in an earlier adjudication may not be credited in a subsequent adjudication. Common law principles of issue preclusion, however, do not require such a result. Instead, once a claimant has submitted new evidence in order to establish one of the elements of entitlement previously resolved against him, an administrative law judge must conduct a *de novo* weighing of the evidence relevant to the remaining elements, regardless of whether any of that evidence is newly submitted. The Court of Appeals for the Seventh Circuit discussed this issue at length in *Peabody Coal Co.* v. *Spese,* 117 F.3d 1001 (7th Cir. 1997) (en banc). It held as follows:

> The law of preclusion also bars relitigation of issues between the same parties when those issues were actually litigated and necessary to the decision of the earlier tribunal. *See Astoria Fed. Sav. & Loan Ass'n* v. *Solimino,* 501 U.S. 104, 107, 111 S.Ct. 2166, 2169, 115 L.Ed.2d 96 (1991) (preclusion applies to administrative agency acting in judicial capacity to resolve fact issues properly before it); *United States* v. *Wyatt,* 102 F.3d 241, 245 n. 5 (7th Cir. 1996), cert. denied, __ U.S. __, 117 S.Ct. 1325, 137 L.Ed.2d 486 (1997); *Waid* v. *Merrill Area*

Public Schools, 91 F.3d 857, 866 (7th Cir. 1996) (state agency hearing). * * *

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[The Fourth Circuit, in *Lisa Lee Mines* v. *Director, OWCP,* 86 F.3d 1358 (4th Cir. 1996) (en banc), *cert. denied,* 519 U.S. 1090 (1997)] pointed out, correctly, that a claimant who loses on three possible alternate grounds has no incentive to take an appeal to ''correct'' the agency on grounds 2 and 3, even if he thinks there was error, if ground 1 is unassailable. Assuming that the passage of time has led to a material change in ground 1 and he can demonstrate this to the Director, the question is whether he should be barred from proceeding on a new claim just because he has not also developed new evidence to negate grounds 2 and 3. Under the Director's ''one-element'' approach, as endorsed by the Fourth Circuit and others, * * * the answer is no. This answer is consistent with general principles of issue preclusion, under which holdings in the alternative, either of which would independently be sufficient to support a result, are not conclusive in subsequent litigation with respect to either issue standing alone. *See Lisa Lee Mines,* 86 F.3d at 1363, citing Restatement (Second) of Judgments § 27, comment i (1982); *Comair Rotron, Inc.* v. *Nippon Densan Corp.,* 49 F.3d 1535, 1538 (Fed. Cir. 1995) (issue on which preclusion is sought must have clearly been necessary to judgment); *Baker Elec. Co-op., Inc.* v. *Chaske,* 28 F.3d 1466, 1475 (8th Cir. 1994); *Gelb* v. *Royal Globe Insur. Co.,* 798 F.2d 38, 45 n. 6 (2d Cir. 1986).
117 F.3d at 1008.

The commenter's example, an X-ray that is found not to be credible in the previous adjudication, illustrates the operation of the regulation. If the prior claim was denied solely on the basis that the miner failed to establish the existence of pneumoconiosis, the commenter's concern about a re-weighing of the X-ray evidence submitted in the prior adjudication is simply unfounded. Because this was the only issue resolved against the claimant, he must introduce new evidence that demonstrates the existence of the disease if he is to avoid an automatic denial of an additional claim. Consequently, the factfinder may not award benefits simply by redetermining the credibility of the earlier evidence. In most cases, however, the denial of the prior claim will rest on multiple findings. For example, an administrative law judge may conclude that the claimant has not established either that he suffers from pneumoconiosis or that he suffers from a totally disabling respiratory impairment. In such a case, the Department's regulation, consistent with the principles of issue preclusion set forth in *Spese,* requires that the claimant submit new evidence relevant only to one of the issues. If he submits new evidence that establishes his total disability, the factfinder must weigh the X-ray evidence *de novo.* Far from contravening accepted principles of issue preclusion, the Department's regulation gives those principles full force and effect. The commenter's suggestion, that a party must be bound by a credibility determination that it was unable to overturn on appeal, turns those principles on their head.

(g) One comment suggests that the Department would breach its fiduciary duty to the Black Lung Disability Trust Fund in any case in which it affirmatively waived its right to rely on the automatic denial of an additional survivor's claim. The Department's obligation to the Trust Fund is to ensure that the Fund not be required to pay non-meritorious claims, *i.e.,* that the Trust Fund does not pay benefits to individuals who do not meet the statutory eligibility criteria. Where appropriate, the Department will invoke the automatic denial provision in order to reduce the transaction costs that the Fund would incur in defending a non-meritorious survivor's claim. The Department does not believe, however, that it is obligated to invoke claim preclusion in order to bar a claim in which a surviving spouse meets all of the conditions of entitlement and simply erred in filing a first application while remarried.

(h) One comment suggests that the Department should penalize individuals who file an additional claim without a change in condition. The Department disagrees. In its second notice of proposed rulemaking, the Department announced its desire to reduce the costs associated with non-meritorious claims by providing applicants with a more realistic view of their possible entitlement based on better pulmonary evaluations and better reasoned explanations of the denials of their claims. 64 FR 54968, 54984 (Oct. 8, 1999). The Department also explained, however, that it did not believe that it was appropriate to penalize an applicant simply because he had filed a previous claim for benefits prematurely. *Id.* The complete pulmonary evaluation provided by the Department includes difficult tests, and the Department does not believe that a miner would deliberately subject himself to that testing if he did not truly believe that he met the Act's eligibility criteria. Moreover, preventing a miner from filing an additional claim merely on the grounds that a previous additional claim was denied may result in the denial of benefits to individuals who meet the Act's eligibility requirements. Even requiring miners to wait an additional period of time between additional claims would involve similar risks. The average applicant for benefits is over 60 years old, and any delay in the receipt of benefits may effectively deny them the right to receive benefits and appropriate medical treatment. Accordingly, the Department does not intend to ''penalize'' individuals who file unsuccessful subsequent claims.

(i) A number of comments object that the revisions encourage the repeated relitigation of cases without Congressional authority. The Department has previously explained that section 725.309 does not allow the relitigation of denied claims. 64 FR 54968, 54984–85 (Oct. 8, 1999). Once a claim has been denied, and the one-year time period for modification has passed, a claimant cannot thereafter seek to have that claim reopened. Even if he prevails on a subsequent claim, the miner will be unable to obtain benefits for any period prior to the date on which the earlier denial became final. Thus, rather than encouraging repeated relitigation, the Department is simply effectuating Congressional intent that miners who are totally disabled due to pneumoconiosis receive compensation for their injury. Additional or subsequent claims must be allowed in light of the latent, progressive nature of pneumoconiosis. Thus, the additional claim is a different case, with different facts (if the claimant is correct that his condition has progressed). There is no indication that Congress intended to deny a miner benefits, or otherwise penalize him, for erroneously filing an application before his disease had progressed to the point of total disability.

Moreover, as the Department explained in its second notice of proposed rulemaking, the revised version of § 725.309 does not have a reopening effect equivalent to that of H.R. 2108. 64 FR 54972 (Oct. 8, 1999). The House of Representatives passed H.R. 2108 in 1994, but the Senate adjourned without taking action on the legislation. If enacted, the bill would have required the *de novo* consideration of any claim filed on or after January 1, 1982, without regard to any earlier denials. The Department's regulation does not have that effect. It simply codifies the Department's former rule, as interpreted by the appellate courts, and provides procedures to be followed upon the filing of an additional claim covering later periods of alleged benefit entitlement. Accordingly, the Department is not authorizing the reopening or relitigation of claims in excess of Congressional authority. In addition, as the Department has previously explained, Congress' failure to enact legislation governing additional claims does not prevent the Department

from promulgating regulations on that subject as long as the regulations are issued pursuant to an appropriate grant of statutory authority. *Ibid*.

(j) One comment suggests that the Black Lung Disability Trust Fund should be liable for the payment of any subsequent claims that are approved. The commenter states that imposing the liability for these claims on the insurance industry is fundamentally unfair. The Department disagrees. As revised, section 725.309 does not alter the adjudication of additional claims in any substantive manner. Since 1978, section 725.309 has recognized the need for allowing additional claims and provided the conditions under which such claims could be approved. As the Department has repeatedly emphasized, the revised regulation simply effectuates the gloss given this regulation by the federal courts of appeals. The Department recognizes that additional claims filed after the effective date of these regulatory revisions will be adjudicated under new procedural rules, and under regulations that clarify the entitlement criteria in Part 718 in a manner consistent with appellate interpretations of the existing criteria. The insurance policies purchased by coal mine operators to secure their liability under the Black Lung Benefits Act require the insurer to assume the risk of adverse appellate court interpretations of the statute and regulations as well as the possibility of revision of the statutory criteria. *See* 20 CFR 726.203(b) (1999) (insurance endorsement). Accordingly, the Department does not agree that the insurance industry is entitled to relief from the effect of revising § 725.309.

(k) A number of comments voice their approval of the changes in the Department's second notice of proposed rulemaking. No other comments have been received concerning this section and no other changes have been made to it.

20 CFR 725.310

(a) In its first notice of proposed rulemaking, the Department proposed amending subsection (b) to limit the documentary medical evidence that parties are entitled to submit in connection with a request for modification. 62 FR 3353 (Jan. 22, 1997). The Department amended subsection (c) to reconcile a number of appellate decisions concerning the district director's ability to conduct modification proceedings under the Black Lung Benefits Act and to ensure that any party requesting modification receives a *de novo* adjudication of the existing evidence of record. The Department also revised subsection (d) with the stated purpose of prohibiting the recovery, by either the Trust Fund or a responsible operator, of benefits paid pursuant to a final award of benefits that is later modified. In its second notice of proposed rulemaking, the Department added two provisions to subsection (d). The first would allow the recovery of any benefits that were paid when the claimant was at fault in creating the overpayment. The second provision implemented the Department's intention to bar recovery of overpayments arising from modification of awards where the award was final before initiation of the modification proceedings. 64 FR 54985–86 (Oct. 8, 1999). In addition, the Department proposed revising the evidentiary limitation in subsection (b) to correspond to similar changes in § 725.414. Finally, the Department responded to comments addressing the responsibility of factfinders to reweigh the evidence of record on modification, and the district director's authority to initiate modification in responsible operator cases.

(b) One comment argues that the Department's proposed regulation destroys the effect of claim preclusion and issue preclusion, while another comment suggests that the revised regulation would allow an adjudicator simply to reweigh the evidence of record and reach a conclusion different from the one reached before. Both observations are correct, and both outcomes are mandated by the statutory language that the regulation implements, 33 U.S.C. 922, incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a). In *Banks* v. *Chicago Grain Trimmers Association*, 390 U.S. 459 (1968), the Supreme Court reversed an appellate court's holding that a claimant's modification request was barred by *res judicata*, or claim preclusion. Instead, the Court held that the statute clearly authorized reopening compensation awards in order to correct factual errors. In *O'Keeffe* v. *Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 255 (1972), the Court held that a factfinder was authorized to grant modification under section 22 ''merely on further reflection on the evidence initially submitted.'' *See also Betty B Coal Co.* v. *Director, OWCP (Stanley)*, 194 F.3d 491, 497 (4th Cir. 1999) (modification procedure is extraordinarily broad, especially insofar as it permits the correction of mistaken factual findings); *The Youghiogheny & Ohio Coal Co.* v. *Milliken*, 200 F.3d 942, 954 (6th Cir. 1999) (ALJ has the authority on modification simply to rethink his conclusions). One commenter also objects that the regulation would prohibit an administrative law judge from simply denying a modification request based on the claimant's failure to present additional evidence. In its second notice of proposed rulemaking, the Department observed that the Supreme Court's *O'Keeffe* decision requires this result. 64 FR 54986 (Oct. 8, 1999). Accordingly, the commenters' observations do not provide a basis for altering the Department's proposal.

(c) Two comments renew the argument that the Department should not be able to initiate modification in responsible operator cases. The Department responded to a similar comment in its second notice of proposed rulemaking by citing the clear statutory language providing the district director with the independent authority to initiate modification. (''Upon his own initiative, * * *, on the ground of a change in conditions or because of a mistake in a determination of fact * * * the deputy commissioner may * * * issue a new compensation order. * * * 33 U.S.C. 922(a), as incorporated by 30 U.S.C. 932(a)). The Department also observed that there were awarded cases 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. In such cases, the Department noted the district director's need to exercise his modification authority. 64 FR 54986 (Oct. 8, 1999). In response, one commenter requests that the Department limit its authority to initiate modification to those specific cases involving operator bankruptcy. The Department declines to do so. The district director's initiation of modification in any case, whether the defendant is a responsible operator or the Trust Fund, is consistent with Congress's intent. Congress has included in the Black Lung Benefits Act section 22 of the Longshore and Harbor Workers' Compensation Act, a workers' compensation program in which the overwhelming majority of cases represent disputes between an employee and his private employer. Thus, Congress clearly contemplated that the district director would exercise his modification authority in cases involving private employers. The examples provided by the Department in its second notice of proposed rulemaking were not intended to be an exclusive listing of the circumstances in which a district director would be justified in initiating modification in a responsible operator case. Because the

Department does not believe it can readily identify all of the circumstances in which district director-initiated modification would be appropriate, it does not intend to limit the district director's discretion in the initiation of modification proceedings.

(d) One comment argues that an operator seeking to modify a benefits award should not be able to obtain new pulmonary testing, but should instead be limited to the report of one consultant. The commenter also argues, however, that miners should be able to submit the results of additional testing in support of a modification petition seeking to change a denial of benefits to an award. The Department does not agree that opposing parties should be governed by different evidentiary rules. One of the Department's goals in proposing a limitation on the submission of documentary medical evidence, as reflected in § 725.414 and § 725.310, is to ensure that claimant and the responsible operator have an equal opportunity to present the highest quality evidence to the factfinder. That goal would not be served by creating an evidentiary advantage for a claimant who requests modification of a denial of benefits. In such cases, both the claimant and the responsible operator, or Trust Fund in appropriate cases, will be entitled to submit one medical report, and associated testing, as well as appropriate rebuttal evidence, as outlined in the Department's second notice of proposed rulemaking.

(e) One comment argues that in light of the evidentiary limitations imposed by section 725.310 and 725.408, an operator will be deprived of its ability to seek modification of an erroneous responsible operator determination that is discovered after the hearing. The Department disagrees that the regulations will always prevent an operator from seeking modification of a responsible operator determination based on newly discovered evidence. It is true, however, that the regulations limit the types of additional evidence that may be submitted on modification and, as a result, an operator will not always be able to submit new evidence to demonstrate that it is not a potentially liable operator.

The Department explained in its previous notices of proposed rulemaking that the evidentiary limitations of §§ 725.408 and 725.414 are designed to provide the district director with all of the documentary evidence relevant to the determination of the responsible operator liable for the payment of benefits. The regulations recognize, and accord different treatment to, two types of evidence: (1) Documentary evidence relevant to an operator's identification as a potentially liable operator, governed by § 725.408; and (2) documentary evidence relevant to the identity of the responsible operator, governed by § 725.414 and 725.456(b)(1). Under section 725.408, a coal mine operator that has been identified as a potentially liable operator by the district director with respect to a particular claim for benefits must contest that identification within 30 days of the date on which it receives that notification, and must submit certain evidence within 90 days of receipt of notification. § 725.408(a), (b). The specific issues on which the operator must submit all of its documentary evidence within this 90-day period include whether the operator was an operator after June 30, 1973; whether it employed the miner for a cumulative period of not less than one year; whether the miner was exposed to coal mine dust while working for the operator; whether the operator employed the miner for at least one day after December 31, 1969; and whether the operator is financially capable of assuming liability for the payment of benefits. The time period for submitting this evidence may be extended for good cause, § 725.423, but the operator may not thereafter submit any further documentary evidence on these issues. § 725.408(b)(2).

Sections 725.414 and 725.456(b)(1) govern the remaining documentary evidence relevant to the liability issue, *i.e.,* evidence relevant to which of the miner's former employers is the responsible operator according to the criteria set forth in § 725.495. Under § 725.414, an operator may submit documentary evidence to prove that a company that more recently employed the miner should be the responsible operator. This evidence must be submitted to the district director in accordance with a schedule to be established by the district director. § 725.410. Additional documentary evidence may be submitted only upon a showing of extraordinary circumstances. § 725.456(b)(1).

The operator's ability to seek modification based on additional documentary evidence will thus depend on the type of evidence that it seeks to submit. Where the evidence is relevant to the designation of the responsible operator, it may be submitted in a modification proceeding if extraordinary circumstances exist that prevented the operator from submitting the evidence earlier. For example, assume that the miner's most recent employer conceals evidence that establishes that it employed the miner for over a year, and that as a result an earlier employer is designated the responsible operator. If that earlier employer discovers the evidence after the award becomes final, it would be able to demonstrate that extraordinary circumstances justify the admission of the evidence in a modification proceeding.

That same showing, however, will not justify the admission of evidence relevant to the employer's own employment of the claimant. Under § 725.408, all documentary evidence pertaining to the employer's employment of the claimant and its status as a financially capable operator must be submitted to the district director. The comment appears to suggest that there will be cases in which an operator discovers evidence bearing on its own employment of the miner after the period for submitting evidence has closed. The Department does not believe that there are extraordinary circumstances sufficient to justify the admission of this evidence in any further proceedings. The evidence in question is within the control of the operator notified by the district director or, where an insurance company is the real party-in-interest, in the control of a party with whom that insurer has contracted to provide necessary coverage. The time period set forth in section 725.408 is adequate to permit a full investigation and development of this evidence. If the operator or insurer is unable to locate the evidence within that period, it should seek an extension of time from the district director.

A party's ability to seek reconsideration under § 22 of the Longshore and Harbor Workers' Compensation Act is subject to the limitation that reconsideration must "'render justice under the Act.'" *McCord* v. *Cephas,* 532 F.2d 1377, 1380–81 (D.C. Cir. 1976). In *McCord,* an employer declined to supply evidence and participate in the initial adjudication of the claimant's application for benefits under the Longshore and Harbor Workers' Compensation Act. After the award became final, the employer sought reconsideration. The D.C. Circuit held that although the adjudication officer had jurisdiction to consider the employer's request, his consideration should take the interests of justice into account. *See also General Dynamics Corp.* v. *Director, OWCP,* 673 F.2d 23, 25 (1st Cir. 1982). In order to properly administer the Black Lung Benefits Act in accordance with this expression of Congressional intent, S.Rep. No. 588, 73d Cong., 2d Sess., 3–4 (1934); H.R.Rep. No. 1244, 73d Cong., 2d Sess.,

4 (1934), the Department has balanced the desire of operators to request modification against the Department's interest in ensuring that potentially liable operators submit all of the evidence relevant to their employment of the miner while the claim is first pending before the district director. The Department believes that it is appropriate to prohibit an operator's ability to introduce, in a modification proceeding, ''new'' evidence relevant to the operator's employment of the miner or the operator's status as a financially capable operator.

(f) One comment argues that the Department has not taken sufficient steps to prevent the misuse of modification by claimants who file repeated modification petitions. The commenter has supplied no information that suggests there is a widespread problem involving the filing of non-meritorious modification petitions by claimants. Like operators, claimants may only obtain such reconsideration as will render justice under the Act, and operators remain free to assert, on a case-by-case basis, that the application of this standard requires a denial of a claimant's request for modification. The Department does not believe, however, that it should establish numerical or temporal limitations (*e.g.,* limiting claimants to a maximum number of modification requests, or no more than a certain number in a given time period) on a claimant's right to seek modification. Congress's overriding concern in enacting the Black Lung Benefits Act was to ensure that miners who are totally disabled due to pneumoconiosis arising out of coal mine employment, and the survivors of miners who die due to pneumoconiosis, receive compensation. Because any limitation on the right to file modification petitions could deny, or delay, the payment of compensation to eligible claimants, the Department does not believe that such limitations are appropriate.

(g) One comment suggests that the proposal authorizes claimants to petition for modification in order to avoid the repayment of an overpayment. The Department does not believe that the regulation addresses this situation. The Department's current practice, in cases in which payments from the Black Lung Disability Trust Fund have been made based on the district director's initial determination, and benefits have subsequently been denied by a higher tribunal, has been to suspend the collection of any potential overpayment if that denial has been appealed further. The Department currently permits its district directors to exercise discretion as to whether to suspend collection where the original denial has become final and the claimant has filed a request for modification. For example, in cases where the request is based solely on a change in the miner's condition, a district director could reasonably conclude that the overpayment of benefits for a period prior to that change should not be suspended. In both former § 725.547(c) and new § 725.549(a), district directors are permitted to ''issue appropriate orders to protect the rights of the parties.'' The Department anticipates that any disputes over the collection of overpayments will be resolved under that provision. Accordingly, there is no need to address the collection of overpayments in the regulation governing modification.

(h) No other comments have been received concerning this section, and no other changes have been made to it.

20 CFR 725.311

(a) The Department proposed revising § 725.311 in its first notice of proposed rulemaking in order to remove the rule allowing parties an additional 7 days within which to respond to a document that is sent by mail, and to add the birthday of Martin Luther King, Jr., to the list of legal holidays contained in the regulation. 62 FR 3354 (Jan. 22, 1997). The Department also sought to resolve a split between the Courts of Appeals for the Fourth and Tenth Circuits governing the time period for responding to a document which was supposed to be served by certified mail but was not. *Compare Dominion Coal Corp.* v. *Honaker*, 33 F.3d 401, 404 (4th Cir. 1994) with *Big Horn Coal Co.* v. *Director, OWCP*, 55 F.3d 545, 550 (10th Cir. 1995). In a case in which the party actually received the document, notwithstanding improper service, the rule would commence the time period for response upon a party's actual receipt of the document. The Department did not address this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment objects to deletion of the seven-day grace period, formerly applicable to all documents sent by mail, arguing that the Department has no good reason to eliminate it. The commenter also suggests that, if the grace period is not replaced with something else, the regulation will cause unnecessary litigation over deadlines and the unnecessary deprivation of the parties' rights.

When the Department first proposed section 725.311, *see* 43 FR 17743–44 (April 25, 1978), the regulation contained a three-day mailing rule which paralleled the rule in the Federal Rules of Civil Procedure. *Compare* Fed. R. Civ. P. 6(e). In the final rule, the Department changed the time period to seven days ''[i]n view of the difficulties encountered in mail deliveries in many rural coal mining areas.'' 43 FR 36786 (Aug. 18, 1978). The Department's experience in administering the black lung benefits program, however, has suggested that the grace period contained in the former regulation was a source of confusion for the parties as well as for the district directors. For example, it could be argued that the former regulation added an additional seven days to the one-year time limit for filing a modification petition, or the 30-day time limit for filing a response to a proposed decision and order. The federal rule has engendered similar litigation. *See, e.g., FHC Equities* v. *MBL Life Assurance Corp.*, 188 F.3d 678, 681–82 (6th Cir. 1997) (rule does not apply to time periods that begin with entry of an order or judgment).

Accordingly, the Department has eliminated the seven-day grace period insofar as it formerly applied to all documents served by mail. The Department believes that, rather than increasing litigation, the revised regulation will provide the parties with more exact notice of when pleadings are due, and thus will reduce litigation over issues raised by the seven-day grace period. As a general rule, the analogy between the Department's black lung regulations and the federal rules is inexact. The federal rules govern the filing of a variety of pleadings, including responses to complex motions. Rule 6(e) attempts to ensure that a party receives the full amount of time—usually thirty days—allotted by the drafters of the rules for preparing a response. In contrast, the documents whose filing is governed by Part 725 are relatively straightforward and simple. They include responses to a schedule for the submission of evidence issued under § 725.410, which will contain the district director's designation of the responsible operator, and a proposed decision and order issued under § 725.418. The regulations require that a party do no more within the initial 30-day period following the issuance of these documents than indicate its agreement or disagreement with the assertions or findings contained in the document. The Department believes that this 30-day time period, commencing with the date the document is sent, provides ample time for the parties' responses. Deleting the grace period

ensures that all parties to a claim, including claimants who are not represented by an attorney, are able to ascertain their response time from the date of a document.

The Department recognizes that one of the filings governed by Part 725 is more complex. Section 725.408 requires that an operator that has been identified by the district director of its status as a potentially liable operator must accept or contest that identification within 30 days of the date on which it receives notification from the district director. That response requires the operator to address five specific assertions: that the operator was an operator after June 30, 1973; that the operator employed the miner for a cumulative period of not less than one year; that the miner was exposed to coal mine dust while working for the operator; that the miner's employment with the operator included at least one working day after December 31, 1969; and that the operator is capable of assuming liability for the payment of benefits. That response requires more investigation than the others in Part 725. In addition, unlike the other response times governed by Part 725, the operator's response does not begin to run on the date that the notification is mailed, but on the date that it is received. In order to ensure that operators have the full 30 days in which to file their responses, and to allow the Department to assess the timeliness of that response, the Department has added a sentence to subsection (d). This provision will allow the district director to presume, in the absence of evidence to the contrary, that the notice was received seven days after it was mailed.

(c) One comment urges enlarging the number of communications which must be sent by certified mail to include several types of decisional documents issued by the district director. Specifically, the commenter suggests use of certified mail to serve the following documents: initial determination; proposed decision and order; decision on modification; denial by reason of abandonment; notice of conference; and memorandum of conference. The Department's revised regulations ensure that all important documents are served by certified mail. See proposed § 725.407(b) notification of potentially liable operator, § 725.409(b) (denial by reason of abandonment); § 725.410(c) (evidentiary submission schedule); § 725.418(b) (proposed decision and order). The revised regulations eliminate the district director's initial finding and memorandum of conference. The ''initial determination'' is a document, served on all the parties after the issuance of a proposed decision and order, requesting that the designated responsible operator commence the payment of benefits. It does not require a written response. 20 CFR 725.420 (1999). With respect to a case in which a petition for modification is being adjudicated, the district director may issue either a proposed decision and order or a denial by reason of abandonment at the conclusion of the proceedings; both of these documents must be served by certified mail. The Department believes the current requirements provide adequate protection for the parties, and therefore declines to add the notice of conference to the list of documents which must be served by certified mail. Section 724.416, governing the conduct of informal conferences, permits the imposition of sanctions only for a party's unexcused failure to attend. In the case of a claimant, the district director must offer the claimant an opportunity to explain why he did not appear at the conference. *See* § 725.409(b). The Department believes that failure to receive the notice of conference would constitute an adequate explanation for a claimant's failure to appear. Similarly, any employer against whom the district director has imposed sanctions for an unexcused failure to appear at an informal conference may request reconsideration based on its failure to receive the required notice. Obviously, district directors may obviate the need for disputes over whether a party received the notice by sending it via certified mail.

(d) Two comments urge the Department to afford a party either a rebuttable presumption or a conclusive finding of non-receipt of a document if it must be sent by certified mail, the party alleges a failure to receive it, and the Department cannot produce a signed return receipt. The recommended presumption is not necessary. In the foregoing circumstances, an allegation of non-receipt and absence of the signed return receipt is sufficient to impose on the Department the burden to prove by some other evidence that the individual received the document. The lack of the signed receipt itself, however, should not be conclusive if other circumstances demonstrate the individual actually received the document. The Department therefore declines to amend the proposal.

(e) One comment argues that subsection (d) is inconsistent with existing law. The commenter believes subsection (d) requires the response time to commence upon *service* of the document rather than the *date of actual receipt* when a document is served in violation of the certified mail requirement. Subsection (d), however, states that the response time ''shall commence on the date the document was received.'' The provision is therefore clear that only actual receipt of a document served in violation of a certified mail requirement commences the recipient's time for response.

(f) No other comments concerning this section were received, and no changes have been made in it.

Subpart D

20 CFR 725.351

The Department made only technical changes to section 725.351 in its initial notice of proposed rulemaking, and the rule was not open for comment. *See* 62 FR 3340–41 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department proposed deleting the requirement in subsection (a)(3) that a district director must seek the approval of the Director, OWCP, before issuing a subpoena to compel the production of documents. 64 FR 54986–87 (Oct. 8, 1999). No comments were received concerning this section, and no changes have been made in it.

20 CFR 725.362

In its initial notice of proposed rulemaking, the Department proposed revising section 725.362 in order to conform the regulation to the requirements of 5 U.S.C. 500(b), which allows an attorney to enter an appearance without submitting an authorization signed by the party he represents. The Department also proposed adding a requirement that a notice of appearance, whether by an attorney or by a lay representative, include the OWCP number of the claim. 62 FR 3354 (Jan. 22, 1997). The Department did not discuss the rule in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). No comments were received concerning this section, and no changes have been made in it.

20 CFR 725.365

The Department received one comment relevant to § 725.365. This section was not open for comment; it was repromulgated without alteration for the convenience of the reader. *See* 62 FR 3341 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). Therefore no changes are being made in it.

20 CFR 725.366

The Department has received one comment relevant to § 725.366. This

section had only technical revisions made to it and was not open for comment, *see* 62 FR 3341 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). Therefore no changes are being made in it.

20 CFR 725.367

(a) In its initial notice of proposed rulemaking, the Department proposed a number of revisions to clarify the application of section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 928, as incorporated by 30 U.S.C. 932(a), and made relevant to adjudications under the Black Lung Benefits Act. 62 FR 3354 (Jan. 22, 1997). The regulation provided a non-exclusive list of instances in which an operator could be held liable for the payment of a claimant's attorney's fee, and recognized the Trust Fund's liability for fees by making it coextensive with that of a responsible operator. The Department proposed a substantial revision of this regulation in its second notice of proposed rulemaking. 64 FR 54987–88 (Oct. 8, 1999). Because the evidentiary limitations proposed by the Department make legal representation for claimants advisable at the earliest possible stage of claims adjudication, the Department revised the regulation to require operators or the Trust Fund to pay a reasonable fee for any necessary work done even if the work was performed prior to the date on which the operator controverted the claimant's entitlement to benefits. Thus, although the creation of an adversarial relationship and the ultimately successful prosecution of a claim were still necessary to trigger employer or fund liability for attorneys' fees, the date on which the adversarial relationship commenced no longer served as the starting point for such liability. The Department rejected comments suggesting that lay representatives should be entitled to collect fees from responsible coal mine operators or the fund. The Department also discussed the several appellate court decisions and their impact on responsible operator and fund liability for attorneys' fees.

(b) The Department has revised the first sentence of subsection (a)(1) and the first sentence of subsection (a)(2) in order to reflect changes to §§ 725.410 and 725.412. In place of the former initial finding, the district director will issue a schedule for the submission of additional evidence under § 725.410. This schedule will include the district director's preliminary analysis of the medical evidence of record, and his designation of the responsible operator liable for the payment of benefits. Section 725.412 provides that, following receipt of the schedule, the designated responsible operator may file a statement accepting the claimant's entitlement to benefits. The operator may avoid any liability for attorneys' fees by filing this statement within 30 days of the issuance of the schedule. If it fails to do so, the responsible operator will be considered to have created an adversarial relationship between the operator and the claimant. If the district director exercises his authority under § 725.415 or § 725.417 to issue another schedule for the submission of additional evidence in order to designate a different operator as the responsible operator, and that operator is ultimately determined to be liable for the payment of benefits, that operator will be liable for the payment of attorneys' fees only if it fails to accept the claimant's entitlement within 30 days of the date upon which it is notified of its designation. In cases where there is no operator liable for the payment of benefits, the district director's issuance of a schedule for the submission of additional evidence will create the adversarial relationship between the Black Lung Disability Trust Fund and the claimant, such that the Trust Fund will be liable for attorneys' fees if the claim is successfully prosecuted. Similarly, in subsection (a)(4) the Department has deleted the reference to an operator's ''notice of controversion'' contesting a claimant's request for an increase in the amount of benefits payable. As revised, the regulations do not require a specific notice of controversion to create the adversarial relationship between a claimant and an employer.

The Department has also substituted the phrase ''reasonable fees for necessary services'' for the phrase ''fees for reasonable and necessary services'' in subsection (a), and has substituted the phrase word ''necessary'' for the word ''reasonable'' in subsections (a)(1)–(5). The changes make the regulation consistent with § 725.366(a). The previous wording was not intended to create a different test for gauging the need for an attorney's services, and the revision will eliminate any potential confusion.

(c) Two comments argue that the Department's proposal violates the plain language of the incorporated provision of the Longshore and Harbor Workers' Compensation Act governing the payment of attorneys' fees. Specifically, they argue that section 28 permits employer liability for a claimant's attorney's fees only for services rendered after the employer controverts the applicant's eligibility for benefits. One of the commenters also cites the expectation, created by the statute, that a claimant is responsible for a portion of the fees owed to his attorney and specifically the fee for any service provided before the employer controverts the applicant's entitlement. The commenter suggests that, by removing that responsibility from the claimant, the Department has not properly implemented the statute.

The Department does not agree that the revised regulation violates the plain language of the statute. The only court to have considered this issue is the Court of Appeals for the Fourth Circuit. In *Kemp* v. *Newport News Shipbuilding and Dry Dock Co.,* 805 F.2d 1152 (4th Cir. 1986), the court held that the LHWCA is ambiguous on the issue of whether an employer may be liable for attorneys' fees incurred by a claimant before the employer has controverted the claimant's entitlement. 805 F.2d at 1153. Instead, the statute provides only that an employer will be liable for attorneys' fees after it contests the applicant's entitlement, leaving unresolved the starting point of such liability. The court recently reiterated its interpretation of LHWCA § 28 in *Clinchfield Coal Co.* v. *Harris,* 149 F.3d 307, 310–11 (4th Cir. 1998). In resolving statutory ambiguity through the regulatory process, the Department is entitled to select any reasonable interpretation that is consistent with Congressional intent. *Chevron U.S.A., Inc.* v. *Natural Resources Defense Council,* 467 U.S. 837, 842–3 (1984).

The Department is fundamentally altering the obligations of the parties at the district director level in a manner that will encourage claimants to consult with attorneys much earlier in the process. Among other things, the Department is limiting the quantity of medical evidence that all parties are entitled to submit. In addition, at the claimant's request, the Department will provide his treating physician with the test results obtained during the complete pulmonary evaluation authorized by section 413(b) of the Act, 30 U.S.C. 923(b). Because these revisions will require claimants to make critical decisions at the earliest stage of adjudication, the regulations must also encourage attorneys to represent claimants as early as possible. The Department hopes that claimants will receive advice when that advice is most helpful. Insurance carriers, who are primarily liable in cases in which they provide insurance to the responsible operator, as well as self-insured operators, most commonly have the assistance of experienced attorneys and claims processing agents in the early

stages of claim development, and the Department believes that claimants should have comparable aid. Accordingly, the Department believes that it is justified in adopting a new interpretation as to the starting point of the employer's or the fund's liability for attorneys' fees.

In addition, contrary to the suggestion of the commenter, the Department's proposal does not eliminate all instances in which a claimant may be responsible for his attorney's fees. Section 28(c), 33 U.S.C. 928(c), states that ''[a]n approved attorney's fee, in cases in which the obligation to pay the fee is upon the claimant, may be made a lien upon the compensation due under an award.'' The commenter argues that a claimant will never be liable for attorneys' fees under the Department's proposal, and that the proposal thus contravenes the statutory language. The Department does have the authority to vary incorporated provisions of the Longshore Act for purposes of administering the Black Lung Benefits Act, *see* 30 U.S.C. 932(a). It has not done so in this case, however. Instead, the Department's regulation does contemplate that a claimant may be liable for an attorney's fee. 20 CFR 725.365. For example, in any case in which the liable party, either the Trust Fund or the operator, accepts the claimant's entitlement prior to the expiration of the 30-day period in § 725.412(b) but the claimant has nevertheless retained counsel who has performed services in connection with the claim, the prerequisite for shifting fee liability—the controversion of entitlement—has not been met. A similar case may arise where the operator initially designated the responsible operator by the district director fails to accept the claimant's eligibility, but the finally designated responsible operator does accept the claimant's eligibility. In such a case, the responsible operator would not be liable for the payment of the claimant's attorney's fee. Because the overwhelming majority of coal mine operators contest claimant eligibility at this stage, the Department does not expect this kind of case to arise often. In either case, however, the claimant remains responsible for any reasonable fees approved by the district director for necessary work performed in obtaining the award. Accordingly, the Department's revised attorney fee regulation does not violate any statutory command.

(c) One comment observes that the Department's revisions would expand the availability and award of attorneys' fees, while another argues that the Department's provision may not be applied retroactively. It has consistently been the Department's position that before liability for a claimant's attorney's fee may shift to a responsible operator or the fund, there must be a controversion of entitlement sufficient to create an adversarial relationship followed by the successful prosecution of a claim. Nothing in this regulation alters that requirement. The Department does agree, however, that once these prerequisites are met, the revised regulation could result in the award of higher attorneys' fees. The Department believes that an increase in attorneys' fees is necessary in order to encourage earlier attorney involvement in the adjudicatory process, and that such involvement will be helpful to claimants in light of the evidentiary restrictions imposed by these regulations. The Department also hopes to encourage a larger number of attorneys to represent claimants by allowing the award of higher fees. During the rulemaking hearings, witnesses repeatedly brought to the Department's attention that few attorneys are willing to represent claimants, in part because of the many restrictions on the award of attorneys' fees. Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations,* (June 19, 1997), p. 22 (testimony of Cecil Roberts); p. 168 (testimony of John Cline); pp. 238–239, 246 (testimony of Grant Crandall). The Department also agrees that the rule should not be applied retroactively, and has changed § 725.2 accordingly.

(d) Several comments agree with the Department's revisions, but two urge the Department to take further steps to increase the participation of attorneys in black lung benefits adjudications by providing additional attorney funding from the Black Lung Disability Trust Fund. Specifically, the commenters urge the Department to make funds available to pay black lung associations and other non-profit groups assisting claimants or to advance fees awarded to claimant attorneys litigating against responsible operators before the award of benefits becomes final. The commenters also urge the Department to repeal the prohibition on receiving fees for time spent preparing a fee petition, and to clarify the right of attorneys to obtain fees for time spent litigating their right to fees.

The Department cannot agree that amounts from the Trust Fund should be made available to pay additional attorneys' fees. In its initial proposal, the Department observed that one of its goals in revising the regulation of attorneys' fees was to ensure that the liability of the Trust Fund for such fees was coextensive with that of a liable coal mine operator. 62 FR 3354 (Jan. 22, 1997). This liability derives from a series of appellate court opinions holding that the Trust Fund must stand in the shoes of a coal mine operator in any case in which no operator may be held liable for the payment of benefits. 62 FR 3354 (Jan. 22, 1997). Those opinions rejected the Department's argument that the Trust Fund could not be held liable for any attorneys' fees. Although the Department's regulations have been revised to acknowledge the Trust Fund's liability under these circumstances, the Department does not believe that the statute can be read in the manner suggested by these commenters to authorize the expenditure of additional amounts of Trust Fund moneys to increase counsel availability for black lung claimants.

With respect to time spent preparing a fee petition and litigating the issue of attorneys' fees, two comments seek the revision of material in § 725.366. Because § 725.366 was not listed among the regulations open for comment, no changes are being made in it. 62 FR 3341 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). Moreover, the regulation's current language does not prohibit an attorney from receiving a fee for time spent litigating the amount of his attorney's fees, and the Department does not believe that more explicit language is necessary. The Benefits Review Board has held that time spent by an attorney defending a fee represents ''necessary work done,'' so as to entitle the attorney to an additional fee under 20 CFR 802.203(c) (1999), *see Workman* v. *Director, OWCP,* 6 Black Lung Rep. (MB) 1–1281, 1–1283 (Ben Rev. Bd. 1984), and the Department believes that §§ 725.366 and 725.367 require the same result. The prohibition in § 725.366 on fees for time spent filling out a fee application presents an entirely different question from whether it is reasonable to require an employer who unsuccessfully challenges that application to pay a fee for the necessary additional time that the attorney was required to spend defending his fee request. Because the Department believes that the current regulations permit an award of attorneys' fees in the latter case, it is not necessary to change the regulation.

(e) No other comments were received concerning this section, and no changes have been made in it.

Subpart E

20 CFR 725.403

The Department made only technical revisions to § 725.403 in its first notice of proposed rulemaking, and the regulation was not open for comment. 62 FR 3341 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department proposed deleting § 725.403. 64 FR 54988 (Oct. 8, 1999). Section 725.403 implemented the requirement in 30 U.S.C. 923(c) that claimants who filed applications under the Black Lung Benefits Act between July 1 and December 31, 1973, 30 U.S.C. 925, must file a claim under the workers' compensation law of their state unless such filing would be futile. Because the time period for filing such claims expired over 25 years ago, the Department proposed removing § 725.403, and specifically invited comment on its removal. The Department did not receive any comments on the proposed removal of § 725.403 and therefore has removed it from further publications of the Code of Federal Regulations. The Department has not altered the rules applicable to any claim filed between July 1 and December 31, 1973, however. Parties interested in reviewing § 725.403 may consult 20 CFR 725.403 (1999).

20 CFR 725.404

The Department received one comment relevant to § 725.404. The Department made only technical revisions to this section, and the regulation was not open for comment; *see* 62 FR 3340–41 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). Therefore no changes are being made in it.

20 CFR 725.405

(a) In its first notice of proposed rulemaking, the Department proposed revising subsection (b) to recognize its practice of refusing to provide a complete pulmonary evaluation to claimants who never worked as a miner. 62 FR 3354 (Jan. 22, 1997). The Department did not discuss § 725.405 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Two comments argue the regulation is too limited because it does not address the district director's obligation to develop evidence other than medical evidence. The Department disagrees. The specific purpose of this regulation is stated in its title: ''Development of medical evidence; scheduling of medical examinations and tests.'' The development of evidence in general is addressed at § 725.404. In any event, subsection (d) of § 725.405 authorizes the district director to collect ''other evidence'' concerning the miner's employment and ''[a]ll other matters relevant to the determination of the claim.'' This language is sufficiently broad to acknowledge the district director's obligations concerning evidentiary development of a claim as well as the authority to discharge those obligations. No useful purpose would be served by a more specific enumeration of particular areas of inquiry in this provision.

The type of inquiry urged by these commenters is covered in more detail elsewhere in the Secretary's regulations. Section 725.495(b) imposes on the Director, OWCP, the burden of proving that the responsible operator designated liable for the payment of benefits is a potentially liable operator. In addition, § 725.495(d) requires that if the responsible operator designated for the payment of benefits is not the operator that most recently employed the miner, the district director must explain the reasons for his designation. These provisions make necessary the district director's gathering of a miner's employment history, including, in most instances, his Social Security earnings record. Indeed, § 725.404(a) requires each claimant to furnish the district director with a complete and detailed history of coal mine employment and, upon request, supporting documentation. The district director must send to each operator notified of its potential liability for a claim copies of the claimant's application and all evidence obtained by the district director relevant to the miner's employment. § 725.407(b), (c). If the district director concludes that the miner's most recent employer cannot be designated the responsible operator because it is not financially capable of assuming liability for the payment of benefits, the district director must explain his conclusion based on a search of the records maintained by the OWCP. § 725.495(d). Only if the OWCP has no record of insurance or authorization to self-insure for that last employer, and the record so states, may OWCP name an employer other than the miner's most recent as the responsible operator for the claim. Thus, the district director's obligation to develop the evidence of record, other than medical, is set forth elsewhere in the regulations where relevant.

(c) One comment recommends changing the regulatory reference to ''miner'' in paragraph (a) from § 725.202 to § 725.101(a)(19). This recommendation is rejected. While both sections define ''miner,'' § 725.202 provides the more detailed definition as well as the criteria and presumptions which apply to determining whether a particular individual satisfies the definition.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.406

(a) In its first notice of proposed rulemaking, the Department proposed revising § 725.406 to address the relationship between the evidentiary limitations contained in § 725.414 and the complete pulmonary evaluation provided by the Department under 30 U.S.C. 923(b). 62 FR 3354–55 (Jan. 22, 1997). As initially proposed, § 725.406 retained the Department's practice of allowing a claimant to select the physician to perform the complete pulmonary evaluation at the Department's expense. In those cases, however, the report generated by the evaluation would have counted as one of the two reports that the claimant was entitled to submit into evidence. If, on the other hand, the claimant went to a physician selected by the Department, the evaluation would not count against the limitations imposed on the claimant. Instead, in cases in which the Black Lung Disability Trust Fund would bear liability for benefits, such a report would count as one of the two reports that could be offered by the Director. In cases in which a responsible operator was potentially liable for benefits, the complete pulmonary evaluation provided by a doctor of the Department's choosing would not have counted against the evidentiary limit imposed on either the responsible operator or the claimant. The Department also discussed its responsibilities for ensuring that the report, and each component of the evaluation, substantially complied with the Department's quality standards. Finally, the Department clarified the mechanism by which it might seek reimbursement of the cost of the evaluation from an operator that had been finally determined to be liable for the payment of claimant's benefits.

The Department proposed major revisions to § 725.406 in its second notice of proposed rulemaking. 64 FR 54988–990 (Oct. 8, 1999). The Department agreed with commenters who suggested that it placed an unnecessary burden on a claimant to choose whether or not to select a physician to perform his complete pulmonary evaluation. In most cases, such a choice would be made before a claimant obtained representation, and could result in a claimant being limited

thereafter to the submission of only one additional medical report. Accordingly, the Department proposed the creation of a list of physicians, authorized by the Department to perform complete pulmonary evaluations. Miners who applied for benefits would be required to select a physician from that list, but could choose any listed doctor either in their state of residence or from a contiguous state. The resulting evaluation would not be considered one of the two medical reports that a claimant was entitled to submit in support of his claim for benefits.

The Department further stated its intent to develop more rigorous standards for selecting physicians authorized to perform a complete pulmonary evaluation. The Department's suggested standards included: (1) Qualification in internal or pulmonary medicine; (2) ability to perform each of the necessary tests; (3) ability to schedule the claimant for an evaluation promptly; (4) ability to produce a timely, comprehensive report; and (5) willingness to answer follow-up questions and defend his conclusions under cross-examination. The Department specifically sought comment on these and other standards for selecting physicians to be included on its list, 64 FR 54989 (Oct. 8, 1999). In addition, the Department stated its intention to survey clinics and physicians on the fees they charged for these services, with the goal of attracting highly qualified doctors to perform the testing and evaluation required by the Department for the complete pulmonary evaluation. The Department also added subsection (d) to the proposed regulation in order to allow a claimant to have the Department send the objective test results obtained in connection with the complete pulmonary evaluation to his treating physician. The Department noted its intent to make available to each claimant at least one set of legally sufficient objective test results so that no claimant would be hindered by a lack of financial resources in pursuing his application for benefits. 64 FR 54989 (Oct. 8, 1999).

The Department rejected comments suggesting the deletion of subsection (e), permitting the district director to clarify ''unresolved medical issues.'' The Department also discussed comments concerning the district director's ability to determine whether all parts of the complete pulmonary evaluation were in substantial compliance with the Department's quality standards. The Department revised subsection (c) to provide a claimant whose initial tests do not comply with the quality standards due to a lack of effort with one additional opportunity to take those tests. Finally, the Department discussed its treatment of subsequent claims, in which the Department provides a new complete pulmonary evaluation, and modification requests, in which it does not. 64 FR 54989–90 (Oct. 8, 1999).

(b) Several comments continue to oppose subsection (e), observing that if the Department develops a list of highly qualified physicians to perform the complete pulmonary evaluation, it should have no need to seek the opinion of yet another physician at this stage of the adjudication. Another comment objects to the proposed substitution of evidence under subsection (e), calling it the destruction of relevant evidence. In response to the initial proposal, the same commenter objected to subsection (e) because the district director's authority to have the miner retested and reexamined invited piecemeal and protracted evidentiary development. The Department has reconsidered the authority granted by subsection (e), and agrees that the provision should be deleted. The Department has relabeled subsection (f) as subsection (e) to accommodate this revision. The deletion of subsection (e) does not affect the district director's authority under subsection (c) to determine whether the individual components of the complete pulmonary evaluation have been administered and reported in compliance with the Department's quality standards. The Department agrees, however, that the district director should have no need to send the claimant for additional examination and testing after completion of a complete pulmonary evaluation, the components of which are in substantial compliance with the applicable quality standards, § 725.406(a)–(c). Under revised § 725.406, the initial evaluation will be performed by a highly qualified physician who may be asked to clarify and/or supplement an initial report if unresolved medical issues remain.

(c) Two comments state that a miner should be entitled to choose an authorized physician anywhere in the country to perform his complete pulmonary evaluation rather than being limited to one from his state of residence or a contiguous state. The commenters state that claimants would be willing to pay the additional costs incurred as a result of such travel. Although the commenters suggest that there will not be a sufficient supply of physicians in some areas, such as Wyoming and Alabama, the Department has no evidence that would support that contention. Moreover, even if the Department is unable to obtain a sufficient pool of physicians in certain states (a pool that includes physicians in all contiguous states), the Department will simply adjust the procedural rules applicable to claimants who reside in those states. The absence of a sufficient pool of physicians in some limited number of states would not justify a national exception to the policy of requiring claimants to submit to a complete pulmonary evaluation in their own region. In addition, claimants remain free to go to any physician of their choosing for the development of evidence in support of their claims.

(d) One comment argues that claimants should be randomly assigned to physicians on the Department's list rather than allowing claimants their own choice. The Department disagrees. The list that the Department ultimately compiles will contain physicians who are well-qualified to perform complete pulmonary evaluations, and whose opinions the Department is willing to accept in the initial stages of adjudication of the claimant's eligibility. Claimants may already be acquainted with one or more physicians on the list, and requiring that claimant submit to an examination by a different physician, perhaps in a neighboring state, would be inefficient. Accordingly, the Department has not changed the regulation.

The commenter also argues that the mere fact that a physician is included on the Department's approved list by meeting the Department's standards does not guarantee that the physician will provide an impartial opinion, particularly when a claimant has a role in selecting the physician who will perform the complete pulmonary evaluation. The Department does not believe that it is required to provide an absolute guarantee of the impartiality of physicians selected for inclusion on the list. By establishing high standards for the performance of these evaluations, and by ensuring that only highly qualified physicians are included on the approved list, the Department will be taking appropriate steps to ensure impartial opinions. In addition, the Department has revised subsection (c) to limit a miner's choice of the examining physician in two respects. First, the miner may not select a close relative of himself or his spouse. The regulation uses the term ''fourth degree of consanguinity'' to exclude, among others, parents, children, grandchildren, brothers, sisters, nephews, nieces, aunts, uncles, and first cousins from those individuals otherwise qualified to perform a complete pulmonary evaluation. Second, the miner may not select any physician who has examined him or treated him in the year preceding

his application for benefits. The Department believes that it would be inappropriate to allow a miner to select a physician with whom he has an ongoing treatment relationship to perform the complete pulmonary evaluation paid for by the Department. Although the Department does not mean to suggest that a physician would be unable to provide an impartial assessment of the miner's respiratory condition in such a case, his opinion could present at least the appearance of a conflict of interest. In order to ensure the credibility of the Department's pulmonary evaluation, the Department has adopted a bright-line test, in the form of a one-year cutoff, that will be easily understood by miners and their physicians. The Department believes that a physician's examination or treatment of the miner prior to the one-year period preceding the miner's application should not disqualify that physician from performing the complete pulmonary evaluation. The Department reserves the right to delete a physician from the list if he is unable to provide an impartial opinion.

(e) Several comments argue that the Department needs to make public the criteria it will use to select physicians for inclusion on the list. In its second notice of proposed rulemaking, the Department notified interested parties that these criteria will be published in the Department's Black Lung Program Manual which will be available to the public. 64 FR 54989 (Oct. 8, 1999). Interested parties will thus be able to monitor the Department's standards and use of these standards in selecting physicians for inclusion on the list.

In addition, a number of commenters responded to the Department's request for comments on the standards that the Department proposed to use to select physicians. Two commenters emphasized the importance of requiring that the evaluations be performed by a physician board-certified in internal medicine or a physician board-eligible in pulmonary medicine or one with extensive knowledge of pulmonary disease. The Department will make every effort to ensure that its list includes highly qualified physicians. Optimally, the Department will be able to enlist the services of Board-certified internists who have a subspecialty in pulmonary medicine, who are Board-eligible in pulmonary medicine, or who can demonstrate extensive experience in the diagnosis and treatment of pneumoconiosis to perform complete pulmonary evaluations. There may be circumstances, however, in which there will not be a sufficient supply of such highly qualified physicians willing to perform the evaluation. In such areas, the criteria will need to afford the Department enough flexibility to ensure an adequate supply of physicians who meet certain minimum qualifications, such as affiliation with a black lung clinic funded in part by the Department of Health and Human Services.

Two comments urge the Department to rule out physicians who have demonstrated that they do not accept one or more of the basic premises of the Black Lung Benefits Act. These commenters urge the Department to review the opinions and depositions of each physician who seeks to be included on the list, eliminating those with opinions which make it impossible to provide a sound evidentiary basis for the district director's initial decision. Another comment urges the Department to accept any physician who applies for inclusion on the list provided that the physician possesses the necessary professional qualifications. As an initial matter, the Department does not intend to screen physicians who apply for inclusion on the list beyond satisfying itself that the basic requirements for inclusion are met. The Department simply does not have the resources to conduct an intensive review of the medical reports and/or deposition testimony submitted by each physician in previous black lung cases. The Department reserves the right, however, to exclude from its list of approved physicians those who prove unable to provide opinions that are consistent with the premises underlying the statute and the Secretary's regulations. The federal courts of appeals have held that a denial of benefits may not be based on a medical opinion that is fundamentally at odds with the premises of the Black Lung Benefits Act. *See, e.g., Lane Hollow Coal Co.* v. *Director, OWCP,* 137 F.3d 799, 804–5 (4th Cir. 1998); *Penn Allegheny Coal Co.* v. *Mercatell,* 878 F.2d 106, 109–110 (3rd Cir. 1989); *Robbins* v. *Jim Walter Resources, Inc.,* 898 F.2d 1478, 1482 (11th Cir. 1990); *Wetherill* v. *Director, OWCP,* 812 F.2d 376, 382 (7th Cir. 1987); *Kaiser Steel Corp.* v. *Director, OWCP,* 757 F.2d 1078, 1083 (10th Cir. 1985). The Department reserves the right to determine appropriate exclusions from the list on a case-by-case basis.

(f) One comment states that the regulation should require the district director to explain to a claimant the possible consequences of having his test results provided to his treating physician. The Department intends to provide such information to claimants, *see also* 64 FR 54989 (Oct. 8, 1999), but does not believe that the regulation must reflect this intention. The regulation itself does state that a report from the claimant's treating physician, based on the Department's clinical testing, will count as one of the two reports the claimant is entitled to submit into evidence under § 725.414, § 725.406(d).

(g) One comment states that the Department's requirements prevent physicians from exercising their professional judgment by dictating the tests that they are required to perform and by emphasizing promptness and timeliness over completeness and thoroughness. The Department disagrees. The Act authorizes the Department to set minimal quality standards for medical evidence. Reports of physical examination must substantially comply with the applicable quality standards, § 718.104. That regulation requires that a report of physical examination be based on, among other things, a chest X-ray, a pulmonary function test, and a blood gas study, unless medically contraindicated. Because these tests are necessary for a complete pulmonary evaluation, the Department has authorized their performance under § 413(b) of the Act, 30 U.S.C. 923(b), for the last two decades. The Department expects that each physician included on the list will not only be able to administer these tests, but will commit to doing so in substantial compliance with the Department's quality standards, §§ 718.102–.106. The Department does not believe that its requirements prevent a physician from preparing a thorough and complete medical report. In order to process claims expeditiously, however, the Department must also ensure that the examination is scheduled promptly, and the resulting report is prepared in a timely manner. The Department recognizes that, in some cases, the claimant's choice of a physician may result in a slight delay if the physician he has selected is busy. The delay in such a case, however, is solely within the control of the claimant. If he is willing to accept the delay, he may wait for that physician. If not, he may choose another from the Department's approved list.

(h) Several comments approved of the revisions affording the claimant the right to select a doctor to perform the complete pulmonary evaluation from an approved list.

(i) No other comments were received concerning this regulation.

20 CFR 725.407

(a) In its first notice of proposed rulemaking, the Department proposed moving subsections (a) and (c) of 20

CFR 725.407 (1999) to § 725.406 and eliminating subsection (b). *See* preamble to §§ 725.407 and 725.408, 62 FR 3355 (Jan. 22, 1997). In their place, the Department proposed a new regulation governing the identification and notification of ''potentially liable operators,'' a subset of the miner's former employers that might be liable for a given claim. Depending on the complexity of the miner's employment history, section 725.407 would permit the district director initially to notify one or more potentially liable operators, and their insurers, of the existence of a claim and would also allow the notification of additional potentially liable operators at any time prior to referral of the case to the Office of Administrative Law Judges. The proposal placed no time limit on the notification of an operator if that operator fraudulently concealed its identity as an employer of the miner.

In its second notice of proposed rulemaking, the Department proposed revising subsection (d) to permit the district director to notify additional potentially liable operators after an administrative law judge reversed a district director's denial by reason of abandonment pursuant to § 725.409 and remanded the case for further proceedings. 64 FR 54990 (Oct. 8, 1999). The Department observed that without this provision, subsection (d) could have been read to prohibit the notification of additional operators, notwithstanding the fact that the district director had not been able to complete his administrative processing of the claim before its referral to the Office of Administrative Law Judges. In addition, the Department rejected a suggestion that it provide guidelines for district directors to use in determining the cases in which it would be appropriate to name more than one potentially liable operator.

(b) The Department has made two changes to § 725.407 to conform to changes to other regulations in this subpart. The Department has deleted the reference to a district director's initial finding in subsection (a) because the district director will no longer issue initial findings. The Department has replaced the reference to § 725.413 in the first sentence of subsection (d) with a reference to § 725.410(a)(3). This change reflects a move to § 725.410 of the district director's authority to dismiss potentially liable operators that the district director has previously notified.

(c) One comment objects that the Secretary's regulations preclude the dismissal of potentially liable operators who can prove that they were not properly named. This comment is more appropriately addressed under § 725.465, the regulation governing the dismissal of claims and parties.

(d) One comment argues that the revised regulation will raise the litigation costs of responsible operators. The commenter observes that the Department does not dispute the allegation, made in response to the Department's first notice of proposed rulemaking, that the Department's changes will generally increase litigation costs by $6,000 per claim. The commenter states that the revisions in the Department's second notice of proposed rulemaking will result in an additional $6,000 in costs per claim. With regard to the first figure, the commenter appears to have mischaracterized its prior comment. An economic analysis conducted by Milliman & Robertson, Inc., and submitted to the Department in response to the first notice, was based in part on an assumption that ''the average defense costs of $6,000 per claim currently expended by the responsible operators/insurers primarily on claims that are initially awarded or denied and appealed by the claimant (presently, approximately 30% of all claims filed), will be expended on all claims at the earliest stage of adjudication.'' Rulemaking Record, Exhibit 5–174, Appendix 5 at 4. This economic analysis did not assert that costs would rise in all cases, but that operators and insurers would be required to incur the cost of fully developing evidence in cases (70 percent of the claims filed) in which they formerly did not have to do so. The analysis did not assert that the Department's proposal would raise litigation costs in the remaining 30 percent of cases. The Department has no basis on which to dispute the industry's statement that its average defense costs, in cases that proceed beyond an initial denial of benefits by the district director, are $6,000. In fact, the economic analysis prepared for the Department in connection with the Regulatory Flexibility Act adopted the figures provided by the Milliman & Robertson economic analysis with respect to the costs of litigating claims at various levels of adjudication. Rulemaking Record, Exhibit 80 at 42.

The Department's second notice of proposed rulemaking, however, undermined the assumption that all of an employer's defense costs would be expended at the earliest stage of adjudication. Under the Department's first proposal, an employer would have been required to develop all of its evidence regarding both its liability as an operator and the claimant's eligibility while the case was pending before the district director. The Department's second notice of proposed rulemaking, however, proposed a substantial alteration in procedure that would permit parties to maintain their current practice of deferring the development of medical evidence until after a case has been referred to the Office of Administrative Law Judges. 64 FR 54993 (Oct. 8, 1999). The Department has adopted this second proposal in these final regulations. Consequently, while potentially liable operators will be required to develop evidence relevant to their liability while claims are pending before the district directors, they will no longer need to expend money on the development of medical evidence in those cases (70% of cases, according to industry estimates) that do not proceed beyond the district director level. In addition, the Department has further revised its regulations to require that all but one potentially liable operator, the one finally designated as responsible operator, be dismissed as parties to the case upon issuance of the district director's proposed decision and order. *See* § 725.418(d) and explanation accompanying § 725.414. Thus, only one potentially liable operator will incur costs in the adjudication of each claim for benefits beyond the district director level.

Under the revised regulations, potentially liable operators will be required to submit evidence to the district director in each case regarding their employment of the miner. *See* § 725.408. In addition, in the small number of cases in which the Department does not name the miner's most recent employer as the responsible operator, the earlier employer that has been designated the responsible operator may incur additional costs in attempting to establish that a more recent employer should be held liable for the payment of benefits. In comparison to the costs of developing medical evidence, however, the Department believes that the additional costs imposed by the regulations will not be significant.

The industry submitted an additional analysis by Milliman and Robertson to the Department in response to the second notice of proposed rulemaking. Rulemaking Record, Exhibit 89–37, Appendix A. That analysis abandons the assumption that the Department's regulations will cause the expenditure of $6,000 in defense costs in every case, rather than only those that proceed beyond the district director level, and replaces it with an assumption that claims defense costs will rise from their

current level of $6,314 to $12,000 under the new regulations. Rulemaking Record, Exhibit 89–37, Appendix A at 16. It is this analysis, apparently, that gives rise to the statement that the second notice of proposed rulemaking will result in an additional $6,000 in costs per claim. The economic analysis contains no explanation for its assumption that defense costs will double under the new regulations. Because the Department's regulations will actually reduce the quantity of medical evidence a party may submit from former levels, eliminate the need to expend money on developing medical evidence in the majority of cases, and eliminate potentially liable operators other than the designated responsible operator as parties to each case beyond the district director level, the Department believes that the assumption is incorrect.

(e) No other comments have been received concerning this regulation.

20 CFR 725.408

(a) The Department proposed eliminating 20 CFR § 725.408 (1999) in its first notice of proposed rulemaking, and replacing it with a regulation designed to elicit necessary information from a miner's former employers. 62 FR 3355–56 (Jan. 22, 1997). As proposed, § 725.408 required any operator notified of its liability under § 725.407 to file a response within 30 days of its receipt of that notification, indicating its intent to accept or contest its identification as a potentially liable operator. Specifically, an operator that contests its liability was required to admit or deny five assertions relevant to that liability: (1) That it operated a coal mine after June 30, 1973; (2) that it employed the miner for a cumulative period of not less than one year; (3) that the miner was exposed to coal mine dust while employed by the operator; (4) that the miner's employment with the operator included at least one working day after December 31, 1969; and (5) that the operator is financially capable of assuming its liability for the payment of benefits. The regulation required the operator to submit all documentary evidence relevant to these issues while the case was pending before the district director, within 60 days from the date on which the operator received notification.

In its second notice of proposed rulemaking, the Department responded to comments that the 60-day time period was too short by enlarging it to 90 days. 64 FR 54990–91 (Oct. 8, 1999). In addition, the Department observed, the period could be extended by the district director for good cause shown pursuant to § 725.423. The Department also acknowledged that, as proposed, the regulation required potentially liable operators to develop and submit evidence in cases that ultimately did not proceed beyond the earliest stage of adjudication. The Department stated that the district director's receipt of this information was necessary, however, in order to ensure that the correct parties were named in those cases that did proceed to the Office of Administrative Law Judges. The Department stated that it did not believe that the cost of developing this evidence would be significant. Finally, the Department rejected the suggestion that it bifurcate the administrative law judge's resolution of entitlement and liability issues.

(b) The Department has modified subsection (a)(1), and has added the phrase ''any of'' to subsection (a)(3), to clarify the meanings of those sentences.

(c) One comment argues that the Department's revision of this regulation injects additional complexity, adds unnecessary burdens and expense in cases involving multiple operators, and sets traps for unwary litigants. The commenter also argues that the Department's revision is based on the erroneous premise that operators are always better informed as to their employment of the miner. The Department agrees that the revised regulations place additional burdens on coal mine operators who have, in the past, routinely filed form controversions of their liability for benefits and waited until the case was referred to the Office of Administrative Law Judges to develop their defenses. In its first notice of proposed rulemaking, the Department explained its intention to change this practice in order to provide the district director with sufficient information to allow him to identify the proper responsible operator. Requiring the submission to the district director of all evidence relevant to the liability issue has become even more important in the final revision of the Department's rules. As revised, the regulations will permit the district director to refer a case to the Office of Administrative Law Judges with no more than one operator as a party to the claim, the responsible operator as finally designated by the district director. See § 725.418(d) and explanation accompanying § 725.414. The regulations prohibit the remand of cases for the identification of additional potentially liable operators, or to allow the district director to designate a new responsible operator, thereby reducing delay in the adjudication of the merits of a claimant's entitlement. This change also places the risk that the district director has not named the proper operator on the Black Lung Disability Trust Fund, however. 62 FR 3355–56 (Jan. 22, 1997). The Department believes that the additional demands placed upon potentially liable operators are not unreasonable. In addition, the Department does not accept the criticism that the regulation sets traps for unwary litigants. The nature of the evidence required by the Department, and the time limits for submitting that evidence, are clearly set forth in the regulations, and will be communicated to potentially liable operators who are notified of a claim by the district director.

The commenter also argues that the Department's revision is based on the erroneous premise that operators are better able to obtain information about their employment of the miner than is the government. The commenter states that the situation is made more difficult where the employment relationship was remote in time or if the miner worked for many different companies. The Department agrees that, in some cases, it may be more difficult for employers, and particularly for insurers, to readily ascertain the facts of the miner's employment. Clearly, however, operators and insurers are in a better position to ascertain these facts than is the Department of Labor. To the extent that an employer or insurer has difficulty in obtaining evidence in a specific case, it may ask that the time period for developing this evidence be extended. The Department will provide the operators notified of a claim the information that it has, including a copy of the miner's application and all evidence relating to his coal mine employment, § 725.407(c).

(d) One comment argues that the 90-day time limitation for an operator to submit documentary evidence in support of its position as to liability remains inadequate, and that, in any event, it should not commence until the operator receives the claimant's employment history, the Itemized Statement of Earnings obtained from the Social Security Administration, and, where applicable, the policy number of the insurance policy that the Department believes provides appropriate coverage. The Department intends to make every effort to supply a potentially liable operator notified of a claim with all of the information pertinent to that notification. As noted above, this information will include a copy of the employment history provided by the claimant. The Department will also provide the applicable insurance policy number if it has it. Similarly, if the Department has received the Itemized Statement of

Earnings, it will provide a copy to the potentially liable operator. The Department's receipt of that record, however, depends on the speed with which the Department's request is processed by the Social Security Administration. It will not be possible in all cases to supply that record to potentially liable operators at the time they receive notification. The initial information supplied to the operator should nevertheless be sufficient to allow it to accept or reject its notification as a potentially liable operator. If the operator needs additional time to respond to that initial notification, it may request an extension of time for good cause shown pursuant to § 725.423. Operators are not limited to a single extension of time in which to obtain this evidence, although a district director may reasonably expect the operator to demonstrate its diligence prior to requesting an additional extension.

(e) Several comments have misconstrued the requirements of § 725.408. Two comments argue that the proposal would shift the burden to the named responsible operator to investigate the proper responsible operator within 90 days and that the 90-day time period is unrealistic for that purpose. One comment argues that the revised regulations are objectionable because they make a responsible operator responsible not only for its own defense but also for the defense of other potentially liable operators. This statement has never been true with respect to liability determinations, and, under the Department's final regulations, is no longer true of entitlement determinations. Another comment argues that DOL's rationale for imposing this time limit on operators—*i.e.,* that operators have better access to the claimant's entire work record—is flawed. Section 725.408, however, does not govern the introduction of evidence relevant to the liability of other operators that employed the miner. Instead, the evidence required by § 725.408 is limited to evidence relevant to the notified operator's own employment of the miner and that operator's financial status. Documentary evidence relevant to another operator's liability is required later pursuant to the schedule established pursuant to § 725.410(b), and in accordance with the limitations set forth in § 725.414(b). Accordingly, the Department will discuss these comments under §§ 725.410 and 725.414.

(f) One comment argues that by creating adversity among the miner's former employers, the Department's revised regulations will create ethical problems for the limited pool of attorneys who currently represent employers in black lung benefits cases, and will therefore deprive employers of their right to the counsel of their choice. The Department acknowledges that the revised regulations increase the adversity among a miner's former employers in any case in which the district director has designated as the responsible operator an operator other than the operator that most recently employed the miner. In such a case, where the designated responsible operator may seek to develop evidence to show that a more recent employer should be designated the responsible operator, an attorney clearly could not represent both employers. Moreover, to the extent that the attorney has previously represented one of the operators, the applicable ethical rules of the attorney's state bar may prevent the attorney from accepting representation of the other operator. In most cases, however, this problem will be more illusory than real. Most of the cases in which the Department will name more than one potentially liable operator will be cases in which the miner's most recent employer is out of business, and had no insurance, or cannot be located. As a general rule, these employers typically have not participated in the adjudication of earlier black lung benefits claims. Accordingly, there will be few, if any, attorneys who will be unable to represent the designated responsible operator. Moreover, in cases in which the interests of potentially liable operators are not directly adverse, state rules typically permit an attorney to represent a client, even if the attorney has represented another party to the case previously, if the attorney obtains the consent of the previous client.

The Department recognizes that there may be a small minority of cases in which a true conflict is unavoidable. For example, if the miner's most recent employer, ABC Coal Co., denies that it employed the claimant as a miner, the Department may also name the miner's next most recent employer, XYZ Coal Co., as a potentially liable operator. An attorney who represented ABC in previous litigation could not now represent XYZ, whose interests are directly adverse. The possibility of such a conflict, however, is not a limitation on the Department's efforts to revise the regulations implementing the Black Lung Benefits Act. The Administrative Procedure Act does guarantee a party the right to be represented by counsel during an administrative adjudication. 5 U.S.C. 555(b). Contrary to the commenter's suggestion, however, nothing in that Act requires an administrative agency to structure its rules in order to preserve the ability of a limited number of attorneys to represent coal mine operators. Where the state ethics rules require an attorney to decline representation of a client, that client is entitled to seek other counsel. The Department does not believe that coal mine operators will be unable to find competent counsel to represent their interests. In fact, the Department has included two or more coal companies as parties in cases under the former regulations, *see, e.g., Martinez* v. *Clayton Coal Co. et al.,* 10 Black Lung Rep. (MB) 1–24 (Ben. Rev. Bd. 1987) (involving three coal mine operators), and did not receive any reports that the operators encountered problems in obtaining representation.

(g) One comment states that the regulation denies mine operators a reasonable opportunity to develop a record. In its second notice of proposed rulemaking, the Department explained its belief that the 90-day time period, which may be extended for good cause, affords sufficient time for operators to submit evidence relevant to their employment of the miner. 64 FR 54990 (Oct. 8, 1999). It cannot be emphasized too often that the period provided by § 725.408 does not require the development of evidence relevant to the designation of other potentially liable operators as the responsible operator. That evidence will be submitted later, in accordance with the schedule established by the district director pursuant to § 725.410.

(h) One comment argues that the regulation creates an impermissible presumption and thus violates the Supreme Court's decision in *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994). Section 725.408 does not create any presumptions. To the extent that the commenter objects to any other presumption used to establish the identity of the responsible operator liable for the payment of benefits, the Department discussed similar objections in its second notice of proposed rulemaking, *see* 64 FR 54972–74 (Oct. 8, 1999), and its response to comments under § 725.495 of Subpart G of this part.

(i) One comment states the response time given potentially liable operators under § 725.408 should mirror the time period given claimants to submit information in § 725.404. The Department disagrees. Section 725.404 provides that claimants must provide the district director with a complete and detailed employment history as well as proof of age, marriage, death, family relationship, dependency, or other

matters of public record. If the information submitted by the claimant is insufficient, the district director must give the claimant a specified reasonable period of time within which to provide the information. Claimants applying for benefits have a positive incentive to supply this information; without it, the district director is unable to complete processing of the case, and any award of benefits will necessarily be delayed. In contrast, § 725.408 seeks information from the claimant's former employers, who have no similar incentive to provide information to the Department. The regulation thus establishes a presumptively reasonable period of time within which an employer must provide that information, and allows the employer to seek an extension of that period for good cause. Because §§ 725.404 and 725.408 affect different parties with different incentives, and serve different purposes, the Department does not believe that the time periods need be made identical.

(j) One comment urges that operators be given the 60 days originally proposed by the Department to respond to notification of potential liability rather than 90. The Department has retained the 90-day time period, which may be extended for good cause, to accommodate the operator community's general objection to the 60-day period and to provide additional time, as a matter of right, in that small percentage of cases in which the miner's employment history is complex or in the distant past.

(k) No other comments were received concerning this regulation, and no other changes have been made in it.

20 CFR 725.409

(a) The Department proposed revising § 725.409 in its first notice of proposed rulemaking to make explicit one basis for denying a claim by reason of abandonment. The Department observed that the Court of Appeals for the Fourth Circuit had confirmed the Department's use of the authority in subsection (a)(3) to dismiss a claim by reason of abandonment based on a claimant's failure to appear at an informal conference. *Wellmore Coal Co.* v. *Stiltner,* 81 F.3d 490, 497 (4th Cir. 1996). The Department proposed to add subsection (a)(4) to the regulation to clarify that authority. In addition, the Department proposed to clarify the procedures for denying claims by reason of abandonment. 62 FR 3356 (Jan. 22, 1997). In the second notice of proposed rulemaking, the Department explained that, because of the severe effect of a dismissal, it had proposed revising § 725.416, the regulation governing informal conferences, to ensure that the parties to a claim are provided with the district director's reasons for holding an informal conference. Thus, under revised § 725.416, the district director is required to explain why he believes an informal conference will assist in the voluntary resolution of the issues in the case. The Department also rejected a suggestion that an administrative law judge should be permitted to hear the merits of claimant's entitlement in a case in which the claimant has requested a hearing as to the district director's dismissal of the claim, and the ALJ finds error in the district director's denial of the claim by reason of abandonment. In response to this comment, the Department added a sentence to subsection (c) of the regulation, to clarify its intent that an administrative law judge must remand a case for further administrative processing if he finds the district director erred in denying the claim. Finally, the Department rejected a comment that the proposal would increase the number of additional claims filed.

(b) Two comments continue to object to the Department's unwillingness to allow an administrative law judge to consider the merits of a claimant's entitlement to benefits if he finds that the district director improperly denied the claim by reason of abandonment. In its second notice of proposed rulemaking, the Department explained that a denial by reason of abandonment may take place before the administrative processing of the claim has been completed, such as when a claimant unjustifiably refuses to attend a required medical examination. § 725.409(a)(1); 64 FR 54991 (Oct. 8, 1999). The Department has reconsidered its complete prohibition on allowing an administrative law judge to resolve the merits of a claim, however. Where the parties have completed their submission of evidence to the district director, and the district director has completed his analysis of the evidence relevant to the liability of all potentially liable operators, and has made a final designation of the responsible operator liable for the payment of benefits, the Department agrees that it would make no sense to require remand to the district director in the event the administrative law judge overturns his denial by reason of abandonment. Accordingly, the Department has revised subsection (c) to permit the Director, through the Office of the Solicitor, to make a case-by-base determination as to whether remand for further administrative processing is necessary. If further remand would be pointless, the Director's consent, which must be made in writing, would allow the case to proceed on the merits of the claimant's entitlement to benefits. The Department has also added a new sentence to subsection (c) to clarify the effect of a denial of a claim by reason of abandonment on a subsequent claim filed by the same individual.

(c) Several comments state that the Department should refer a claim for a hearing on the merits even if the claim has been denied by reason of abandonment. The Department disagrees. A claimant whose claim has been denied by reason of abandonment has suggested, by his actions, that he no longer wishes to pursue his claim for benefits. Referring all of these cases to an administrative law judge for hearing would be pointless and inefficient. It is true that in some cases, the claimant may have decided that he still desires benefits, but believes that the action required of him by the district director is unreasonable. Requiring these claimants to request an administrative law judge to resolve their dispute does not impose an unreasonable burden. Accordingly, the Department has not altered this requirement in the regulation.

(d) Several comments request that the Department reconsider denying a claim by reason of abandonment as an appropriate sanction. Another comment supports the denial. The Department explained its reason for using a denial by reason of abandonment where a claimant fails to attend an informal conference in its second notice of proposed rulemaking. 64 FR 54991–92 (Oct. 8, 1999). The Department continues to believe that, although a denial is a harsh sanction, it is the only valid sanction that may be imposed for a claimant's failure to participate in the adjudication process. A claimant whose failure to participate is the result of simple negligence may avoid that sanction by indicating his willingness to comply with the district director's initial instructions.

(e) Several comments request that the Department reconsider its use of informal conferences. These comments are more appropriately addressed under § 725.416.

(f) No other comments were received concerning this section.

20 CFR 725.410–725.413

(a) In its first notice of proposed rulemaking, the Department proposed new §§ 725.410–725.413 in order to streamline the investigation and initial adjudication of claims for black lung benefits. 62 FR 3356 (Jan. 22, 1997). The

proposed regulations provided for concurrent investigations into the medical issues surrounding the claimant's eligibility and the identity of the operator liable for the payment of any benefits. Under the proposed regulations, those investigations would have culminated in an initial finding containing the district director's preliminary resolution of both issues. If any party indicated dissatisfaction with the initial finding, the district director would have proceeded to an initial adjudication of the claim and would have established a schedule for the submission of evidence. The proposed regulations included a number of significant changes. For example, the Department stated that it would not honor hearing requests made before the conclusion of administrative proceedings. In addition, the Department provided claimants with up to one year to respond to an initial finding.

In its second notice of proposed rulemaking, the Department did not discuss §§ 725.410, 725.412, or 725.413. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department did discuss § 725.411, although it did not propose any additional changes to that regulation. Instead, the Department advised all interested parties that it intended to substantially revise the documents used in connection with the issuance of an initial finding under § 725.411. The Department noted its commitment to improve the quality of the information provided to parties to the adjudication of black lung claims. The Department hoped that improved communication would make district office claims processing easier to understand and would also give claimants a clearer picture of the medical evidence developed in connection with their claims. It was hoped that with better information, claimants would be able to make more informed decisions as to how to proceed. In response to a number of comments, the Department stated that a hearing request filed within one year of the initial finding would constitute a request for further adjudication of the claim. The Department also discussed its decision not to honor premature hearing requests, *i.e.*, requests for hearing made before the district director issued a proposed decision and order. Additionally, the Department rejected the suggestion that the one-year response time to an initial finding impermissibly extended a claimant's modification rights. Finally, the Department explained its decision not to permit an extension under § 725.423 of the one-year time period.

(b) A number of comments continue to object to the Department's proposal with respect to the initial adjudication of claimant eligibility and operator liability. Among other things, these commenters criticize the increased formality and complexity of the proposed procedure; the burdensome requirement that operators must respond to initial findings in all cases; and the Department's failure to honor premature hearing requests. In response to these comments, the Department has reconsidered the procedural rules governing district director claims processing, and has altered the proposal in a number of significant respects.

(i) The Department will no longer issue an initial finding of claimant eligibility and operator liability. Instead, following the development of certain medical evidence under § 725.405, including the complete pulmonary evaluation authorized by § 725.406, and the submission of evidence relevant to the employment of the miner by potentially liable operators notified pursuant to § 725.407, the district director will issue a schedule for the submission of additional evidence. § 725.410. This schedule will notify the parties of the district director's preliminary evaluation of the evidence regarding the miner's eligibility, but will not require a formal response as to eligibility from any party. In the event that the district director concludes that the evidence supports an award of benefits, and there is no operator that may be held liable for the payment of benefits, § 725.411 requires the district director to issue immediately a proposed decision and order awarding benefits payable by the Black Lung Disability Trust Fund. In such a case, the district director will not issue a schedule for the submission of additional evidence because no further evidentiary development is needed. In the event the district director's preliminary evaluation of the medical evidence in a Trust Fund case weighs against a benefits award, the district director will issue a schedule allowing the submission of additional medical evidence, but the claimant need not respond. Instead, the claimant may wait until the issuance of the proposed decision and order, which will provide him 30 days within which to request a hearing. Similarly, an operator need not respond to a district director's schedule for the submission of evidence. Silence on an operator's part as to the claimant's entitlement to benefits after issuance of the district director's schedule will be deemed a contest of that entitlement. The revised regulations thus eliminate certain responses that previously would have been required following issuance of the proposed initial findings. In addition, they eliminate the one-year period of time that the proposal would have provided a claimant to respond to the initial finding. Two commenters continued to object to that time period. Instead, all parties will have the statutory period, one year, to file a request for modification after the district director's proposed decision and order becomes effective. The proposed decision and order becomes effective 30 days after issuance, *see* § 725.419.

By replacing the notice of initial finding with a less formal schedule for the submission of additional evidence, the Department hopes to further its goal of providing more easily understood documents. The schedule will summarize the medical evidence developed by the Department, and provide a clear explanation of why that evidence may fail to establish a claimant's entitlement to benefits. In addition, the schedule will provide a clear explanation of the steps remaining in the district director's claim processing. A number of commenters had objected to the complexity of the Department's proposed procedures, and the Department believes that this simplified, revised process will eliminate confusion.

(ii) The schedule will also contain the Department's preliminary designation of the responsible operator liable for the payment of claimant's benefits. Along with the schedule, the district director will supply all potentially liable operators with a copy of the evidence needed to meet the Director's initial burden of proof under § 725.495, if such a showing is necessary. Within 30 days of the date on which the schedule is issued, the designated responsible operator must either agree or disagree with the district director's designation. If it disagrees, it must submit any evidence regarding the liability of other operators in accordance with the district director's schedule. The schedule must provide a minimum of 60 days to submit evidence pertaining to both responsible operator liability and the claimant's entitlement, and an additional 30 days to respond to other parties' evidence. These periods may be extended pursuant to § 725.423 for good cause shown. In addition, the designated responsible operator may, but does not have to, agree that the claimant is entitled to benefits. Silence on this issue for 30 days after the district director issues a schedule will be deemed a decision to contest the claimant's benefit entitlement sufficient

to make the responsible operator liable for a reasonable attorney's fee if the claimant successfully prosecutes his claim.

(iii) The Department has also deleted the language in proposed § 725.411 which would have rendered invalid premature hearing requests. Accordingly, the Department will continue its current practice of following the decision in *Plesh* v. *Director, OWCP*, 71 F.3d 103, 111 (3d Cir. 1995). Under that decision, the Department may complete its administrative processing of the claim, but must forward a claim for a hearing at the conclusion of that processing if the claimant has previously filed a request for a hearing and that request has not been withdrawn. The Department has revised § 725.418 to accomplish this result and to extend similar treatment to operators. *See* response to comments under § 725.418.

(c) Two comments submitted in connection with the Department's first notice of proposed rulemaking, and renewed in connection with the Department's second notice of proposed rulemaking, argue that the Department's proposed § 725.413 improperly transfers adjudication powers from the administrative law judge to the district director in violation of the Administrative Procedure Act. The Department disagrees. The regulations currently permit the district director to issue a proposed decision and order. Any party aggrieved by the proposed decision and order may request a formal hearing before the Office of Administrative Law Judges, making the district director's factual findings irrelevant. If no party objects to the proposed decision and order, however, it becomes final. 20 CFR 725.419 (1999). The revised regulations continue that procedure. They do not deny any party the right to an adjudication of contested issues by an administrative law judge, as provided by both the Administrative Procedure Act, 5 U.S.C. 556, and section 19 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 919, as incorporated by 30 U.S.C. 932(a).

(d) Several comments submitted in connection with the Department's first notice of proposed rulemaking state that the time frames for developing and submitting evidence to the district director are too short. These time frames, which have been moved from proposed § 725.413(c)(2) to § 725.410(b), set only the minimum periods for evidentiary submissions. Section 725.423 allows any party to request additional time within which to take a required action if good cause is shown. In addition, the Department has relaxed the requirements for the development of documentary medical evidence in §§ 725.414 and 725.456, and has increased the opportunities for submitting such evidence outside the periods established by § 725.410. The Department has not modified, however, the requirement contained in the original proposal, that all documentary evidence pertaining to operator liability must be submitted to the district director in the absence of extraordinary circumstances. In a small number of claims, the responsible operator designated by the district director may wish to submit documentary evidence to meet its burden of establishing that another employer of the miner should be the responsible operator. The Department estimates that these cases will represent less than 10 percent of all responsible operator claims. The Department recognizes that, in some of these cases, the initial 60-day period may be insufficient to allow the designated responsible operator to complete its development of the necessary evidence. In such a case, however, the operator may request that the district director grant it additional time. In addition, if the district director finds the evidence submitted by the designated responsible operator persuasive, he may designate a different operator as the responsible operator only after he provides that operator, pursuant to § 725.410, with at least 60 additional days to develop its own evidence relevant to both the liability and eligibility issues. Finally, in a case in which the operator encounters particular difficulty in obtaining the necessary evidence, it may be able to establish the existence of ''extraordinary circumstances'' permitting the introduction of such evidence after the case is referred to the Office of Administrative Law Judges. No changes are necessary in response to these comments.

(e) One comment submitted in connection with the Department's first notice of proposed rulemaking objects to the district director's authority to reinstate an operator which has been dismissed. This authority is necessary to correct erroneous dismissals, especially since an operator can not be named a party to a claim once a case is referred to the Office of Administrative Law Judges for a hearing on the merits, § 725.407(d). The remainder of the commenter's objections pertain more properly to § 725.414, and are addressed under that regulation.

(f) In light of the extensive changes to §§ 725.410–.413, none of the other comments received concerning the proposed revisions to these regulations remain relevant.

20 CFR 725.414

(a) In its first notice of proposed rulemaking, the Department proposed to limit the quantity of documentary medical evidence that parties to a claim would be able to submit. Specifically, the Department's initial proposal would have permitted the claimant and the party opposing the claimant's entitlement each to submit the results of no more than two complete pulmonary examinations or consultative reports, and one review of each of its opponent's diagnostic studies and examinations. Parties could submit additional documentary medical evidence only by demonstrating extraordinary circumstances. In proposing this limitation, the Department acknowledged the concerns of the Court of Appeals for the Sixth Circuit in *Woodward* v. *Director, OWCP,* 991 F.2d 314, 321 (6th Cir. 1993). In that decision, the court noted the superior financial resources of some parties allowed the development of a greater quantity of evidence with the result that the ''truth-seeking function of the administrative process is skewed and directly undermined.'' 991 F.2d at 321. 62 FR 3356–61 (Jan. 22, 1997). In cases in which the Department named more than one potentially liable operator as a party to the claim, the proposal delegated responsibility for the development of documentary medical evidence to the responsible operator designated by the district director. Other operators would be permitted to submit documentary medical evidence, up to the limit of two medical evaluations per side, only by showing that the designated responsible operator had not undertaken a full development of the evidence and that, without it, the potentially liable operator was unable to secure a full and fair litigation of the claimant's eligibility.

The Department also proposed to require that all documentary evidence—evidence relevant to operator liability as well as medical evidence relevant to a claimant's eligibility—be submitted while the case was pending before the district director. Like the limitation on the quantity of medical evidence, the required submission of evidence to the district director was made subject to an extraordinary circumstances exception. The Department observed that this proposal would end parties' current practice of delaying the development of evidence on both issues until a claim was referred to the Office of Administrative Law Judges. It would also provide district directors with a

better evidentiary record on which to adjudicate a claim. The proposal would have required parties to identify all of their witnesses while a case was pending before the district director. Finally, the Department explained that both proposed revisions were permissible exercises of the broad regulatory authority granted the Department under the Black Lung Benefits Act.

The Department proposed several significant revisions in its second notice of proposed rulemaking. 64 FR 54992–96 (Oct. 8, 1999). Responding to numerous comments, the Department withdrew its proposed requirement that all documentary medical evidence be submitted to the district director. Instead, the Department proposed to retain the current procedures, allowing parties to submit documentary medical evidence to the Office of Administrative Law Judges up to 20 days prior to the formal hearing. *See* preamble to § 725.456. The Department did not revise its proposal with respect to documentary evidence relevant to the issue of operator liability, however. Any such evidence that was not submitted to the district director could be submitted to the administrative law judge only upon a showing of extraordinary circumstances. The Department observed that this proposal represented a weighing of the claimant's interest in the prompt adjudication of his entitlement against the interest of the Department in protecting the Black Lung Disability Trust Fund from unwarranted liability. Under the Department's proposal, the Director, OWCP, would be unable to have a case remanded to the district director for the development of additional evidence as to operator liability once a case was referred to the Office of Administrative Law Judges for an adjudication of the merits. This provision helped to ensure the prompt adjudication of the claimant's entitlement. The procedure also subjected the Trust Fund to the risk, however, that a district director would not name the correct operator as a party to the claim before the case was referred to OALJ. Such a risk could be justified only if the district director was able to examine all of the documentary evidence relevant to the issue of operator liability.

Although numerous comments had objected to the Department's limitation on the quantity of medical evidence, the Department did not propose to alter that limitation. In order to accommodate the differing circumstances of individual cases, however, and to ensure that all parties were given due process, the Department proposed revising the standard that would allow a party to exceed that limitation. Accordingly, the Department replaced the ''extraordinary circumstances'' exception with a ''good cause'' standard that would be easier to meet in appropriate cases. The Department also clarified the types of documentary medical evidence that parties would be entitled to submit, in order to resolve some of the ambiguities presented by its original proposal. Specifically, the Department proposed that a party's affirmative case be limited to two chest X-ray interpretations, the results of two pulmonary function studies, two arterial blood gas studies, and two medical reports. In rebuttal, each party would be able to submit one piece of evidence analyzing each piece of evidence submitted by the opposing side. For example, an operator could have each of the claimant's chest X-rays reread once, and could submit one report challenging the validity of each pulmonary function test submitted by the claimant. The Department also provided the parties with an opportunity to rehabilitate the evidence they had submitted in connection with their affirmative case that had been the subject of rebuttal. The second proposal justified the medical evidentiary limitations as applied to multiple potentially liable operators named as parties to the same claim. Finally, the Department clarified the provision in subsection (a)(4) as allowing the submission of hospital records and any other treatment records relating to the mine's respiratory or pulmonary condition without regard to the evidentiary limitations elsewhere in the regulation.

(b) A number of comments continue to object to the proposed requirement that more than one potentially liable operator might be retained as a party to a claim and might have to participate in a joint defense of the claimant's eligibility for benefits subject to the same medical evidentiary limitations as would be present in a case involving only one operator. The Department proposed this requirement in order to ensure that a claimant in a multiple operator case—a case in which the identity of the responsible operator was in doubt—would not have to face more documentary medical evidence than a claimant whose eligibility was opposed by only one potentially liable operator. On further reflection, however, the Department has decided not to retain more than one potentially liable operator as a party to each case after the case is referred to the Office of Administrative Law Judges. The final revisions to the regulations attempt to simplify and streamline the processing of claims at the district director level. For example, the final rules eliminate certain party responses formerly required to be filed with the district director, and thus reduce the parties' transaction costs. Similarly, in these final rules, the Department has simplified the adjudication of claims beyond the district director level by permitting the district director to refer a case to the Office of Administrative Law Judges with only one designated responsible operator as a party to the claim. *See* explanation accompanying §§ 725.415, 725.416, 725.417, 725.418, and 725.421.

The Department recognizes that this solution may slightly increase the Black Lung Disability Trust Fund's liability. In the event the responsible operator designated by the district director is adjudicated not liable for a claim, the Black Lung Disability Trust Fund will pay any benefit award. The Department's proposals, on the other hand, would have subjected the Trust Fund to liability only where the miner was not employed by any operator that met the criteria for a potentially liable operator, or where the district director had not named as a party to the claim the operator ultimately held to be the responsible operator. The Department's final regulations create Trust Fund liability in different circumstances: where the district director's designation of the responsible operator proves to be incorrect. For example, if the miner's most recent employer, ABC Trucking Co., argues that it did not employ the claimant as a miner, the proposal would have permitted the district director to retain, as parties to the claim, the miner's prior employers as fallback potentially liable operators. Under the final regulation, however, if the district director designates ABC as the responsible operator, and the ALJ awards benefits but finds that the miner's next most recent employer, XYZ Coal Co., should have been the responsible operator, benefits will be payable by the Trust Fund. The Department intends that, once a claim is referred to the Office of Administrative Law Judges, the Department shall not be able to impose liability for that claim on any operator other than the one finally designated as responsible operator by the district director, whether through remand by the administrative law judge or through modification of a finally awarded claim. This limitation will eliminate a major source of delays in the adjudication of claims, and prevent a claimant from having to relitigate his entitlement to benefits. To the extent

that a denied claimant files a subsequent claim pursuant to § 725.309, of course, the Department's ability to identify another operator would be limited only by the principles of issue preclusion. For example, where the operator designated as the responsible operator by the district director in a prior claim is no longer financially capable of paying benefits, the district director may designate a different responsible operator. In such a case, where the claimant will have to relitigate his entitlement anyway, the district director should be permitted to reconsider his designation of the responsible operator liable for the payment of the claimant's benefits.

The Department does not believe that the risk of increased Trust Fund liability is significant. Serious disputes about the identity of the responsible operator arise in less than 10 percent of claims. In addition, the regulations still require that all of the documentary evidence relevant to the issue of operator liability be submitted to the district director, and that all of the potential witnesses as to this issue be identified. In fact, the Department's willingness to accept the risk that the district director's designation will be incorrect reinforces the need for both of those requirements. Thus, the district director will be able to make a determination as to the identity of the responsible operator based on the same information that will be available to the administrative law judge. In such circumstances, the Department believes that any additional risk of liability imposed on the Trust Fund is acceptable.

The Department has made extensive revisions to § 725.414 to implement this change. Subsection (a)(3)(iv) and the introductory paragraph of subsection (a)(3) have been deleted, and references to potentially liable operators other than the designated responsible operator have been removed from subsections (a)(2)(ii), (a)(3)(i), (a)(3)(ii), and (c). The Department has revised subsection (a)(3)(iii) to reflect the Trust Fund's right to develop evidence in a case in which the district director has notified one or more potentially liable operators of their liability pursuant to § 725.407, but has subsequently dismissed all of the operators. The revised regulation also recognizes the Trust Fund's right to develop and submit evidence relevant to the compensability of a claimant's medical benefits. The Department has also revised subsections (b)(1) and (b)(2) to clarify the meaning of the regulation.

In addition, the Department has deleted subsection (a)(6). As proposed, subsection (a)(6) would have required the district director to admit into the record all of the evidence submitted while the case was pending before him. As revised, however, the regulation may require the exclusion of some evidence submitted to the district director. In the more than 90 percent of operator cases in which there is no substantial dispute over the identity of the responsible operator, most of the evidence available to the district director will be the medical and liability evidence submitted pursuant to the schedule for the submission of additional evidence, § 725.410. In the remaining cases, however, the district director may alter his designation of the responsible operator after reviewing the liability evidence submitted by the previously designated responsible operator. For example, he may decide that the evidence submitted by ABC Trucking Co. establishes that the claimant did not work as a miner for that company, and may designate the claimant's next most recent employer, XYZ Coal Co., as the responsible operator. In such a case, the regulations require that the district director issue another schedule for the submission of additional evidence in order to give XYZ Coal the opportunity to submit additional evidence bearing on its liability for benefits. If the district director ultimately concludes that XYZ should be designated the responsible operator, the regulation requires him to exclude the medical evidence previously developed by ABC, unless XYZ adopts that evidence as its own, § 725.415(b). The Department has revised § 725.415(b) to defer the development of any additional medical evidence in such a case until after the district director has completed his analysis of all evidence pertaining to operator liability and has made a final responsible operator determination. At that point, the responsible operator will have an opportunity, if it was not the initially designated responsible operator, to develop its own medical evidence or adopt medical evidence submitted by the initially designated responsible operator. Because the district director will not be able to determine which medical evidence belongs in the record until after this period has expired, the Department has revised §§ 725.415(b) and 725.421(b)(4) to ensure that the claimant and the party opposing entitlement are bound by the same evidentiary limitations. Accordingly, the Department has deleted the requirement in § 725.414(a)(6) that the district director admit into the record all of the medical evidence that the parties submit.

The Department does not expect the deletion to have a significant practical effect. Because the Department withdrew its first proposal requiring that all medical evidence be submitted to the district director, *see* paragraph (a), above, the Department expects that parties generally will not undertake the development of medical evidence until the case is pending before the administrative law judge. Certainly, if the designated responsible operator believes itself not to be liable for a given claim, it might defer the development of medical evidence while developing evidence relevant to liability. Accordingly, in the overwhelming majority of cases, there will be no evidence that the district director will be required to exclude from the record. The Department recognizes, however, the theoretical possibility that a claimant may have to undergo additional physical examination and testing. In the example discussed above, if ABC Trucking had submitted the result of its examination and pulmonary testing, XYZ could, if it chose not to use ABC's evidence, require the claimant to submit to an additional examination. The Department does not believe that this is a likely scenario, however, even in cases in which the district director changes his designation of the responsible operator.

(c) Two comments dispute the Department's observation, in its second notice of proposed rulemaking, 64 FR 54996 (Oct. 8, 1999), that autopsy and biopsy reports are generally not developed in connection with a claim, and that those reports need not be addressed in the Department's evidentiary limitations. The Department has reconsidered its earlier proposal allowing the admission of these reports without regard to number, and agrees that the evidentiary limitations of § 725.414 should be revised. Accordingly, the regulation now permits each side to submit, as part of its affirmative case, one report of an autopsy and one report of each biopsy. Subsections (a)(2)(i) and (a)(3)(i) have been revised accordingly. In addition, the Department has revised subsections (a)(2)(ii) and (a)(3)(ii) to allow each side to submit one report in rebuttal of an autopsy report and one report in rebuttal of each biopsy report offered by the opposing side. The Department has also deleted the reference to autopsy and biopsy reports in subsection (a)(4), the catch-all provision permitting the introduction of evidence that is not addressed elsewhere in § 725.414.

(d) Several comments object to the Department's proposed addition of subsection (e). This provision, which tracks the current regulation at 20 CFR 725.414(e)(1) (1999), would have

prohibited the introduction of evidence before an administrative law judge which was obtained by a party while the claim was pending before a district director but which was withheld from the district director or any other party. Another comment states that the subsection is meaningless since it suggests that withheld evidence must be admitted upon the request of a party, even absent a showing of extraordinary circumstances. The Department agrees that this provision should be deleted. *See* preamble to § 725.456, paragraph (b). Accordingly, subsection (e) has been deleted. A corresponding change has been made to § 725.456.

(e) A number of comments argue that the Department should limit the claimant and the party opposing entitlement to one examination and one set of pulmonary testing. Thus, instead of being able to submit the results two pulmonary function studies and two arterial blood gas studies, each party would be entitled to submit only one set of test results. One commenter states that this revision would simply maintain the status quo with respect to testing. The Department disagrees. The former regulations do not limit the number of test results a party may submit, and evidentiary records often contain a substantial number of such tests. The Department recognizes that the testing may be difficult for some claimants. In the absence of good cause, the Department's regulations limit the maximum total number of tests to five in the vast majority of cases involving a designated responsible operator (four in a case in which the Black Lung Disability Trust Fund will be liable for the payment of any benefits), and spread these tests out over time. The first such test will be performed in connection with the complete pulmonary evaluation shortly after the claimant files his application, § 725.406. The last test will most likely be performed shortly before the formal hearing, as parties seek to complete the development of their evidence before the twentieth day prior to the hearing, as required by § 725.456(b)(2). It would not be appropriate to further limit the testing that a claimant must undergo. An operator who wishes to submit the results of two physical examinations performed in accordance with § 718.104 is entitled to have the physicians who perform those examinations administer appropriate testing, *see* § 718.104(a)(6). Accordingly, the Department has not changed the regulation in this respect.

(f) A number of comments continue to object generally to the Department's proposed limitations on the quantity of medical evidence that parties may submit in the adjudication of a black lung claim. Among other things, they argue that the proposed limitations violate § 413(b) of the Black Lung Benefits Act, 30 U.S.C. 923(b), which requires the consideration of ''all relevant evidence,'' and infringe on the rights of coal mine operators under the due process clause of the Constitution. The Department has previously addressed both arguments. In its first notice of proposed rulemaking, the Department explained that § 413(b), which is contained in Part B of the Black Lung Benefits Act, was incorporated into Part C, governing adjudications by the Department of Labor, ''to the extent appropriate.'' 30 U.S.C. 940. The proposed evidentiary limitations thus represent the extent to which the Department believes that medical evidence should be submitted for consideration by the factfinder. In addition, the Department has noted that § 413(b) does not require the admission of all evidence simply because that evidence could be described as relevant, and that the Department was free to prescribe conditions under which evidence would be admissible in black lung adjudications. 62 FR 3358–59 (Jan. 22, 1997). The Department discussed the requirements of the due process clause in its second notice of proposed rulemaking. The Department observed that a due process analysis involves weighing the potentially disparate interests of a number of parties. 64 FR 54994–95 (Oct. 8, 1999). In the Department's view, the regulation achieves the correct balance, particularly in light of the Department's decision to permit parties to exceed the numerical limitations on documentary medical evidence upon a showing of good cause. To the extent that these commenters objected, on due process grounds, to the requirement that potentially liable operators other than the responsible operator defer to the responsible operator's development of medical evidence, those objections have been rendered moot by the Department's revisions permitting only one designated responsible operator to be included as a party to a case before the Office of Administrative Law Judges.

The Department also cannot accept the assertion, made by several commenters, that the numerical limits are fundamentally unfair, and that they will result in inaccurate and incomplete evaluations of the claimant's pulmonary condition. In cases involving a coal mine operator, the record may contain up to five medical reports—two submitted by the claimant, two by the operator, and the results of the complete pulmonary evaluation. Each of these reports may be based on independent medical testing. Accordingly, the Department does not agree that the evaluation of the claimant's medical status will be less than complete and thorough. Moreover, the Department does not agree that requiring the parties to develop medical evidence meeting certain quality standards, §§ 718.102—718.107, will result in an unfair adjudication of the claimant's entitlement to benefits.

(g) One comment suggests that the Department's rationale for its proposed change is insufficient, and that anecdotal evidence of a few cases in which coal mine operators submitted a large volume of evidence does not demonstrate that the current procedure is unfair. The commenter further argues that the former system, developed under the Administrative Procedure Act, is a fair system. The Department agrees that the APA generally provides a fair basis for the adjudication of parties' interests in the administrative context. In its first notice of proposed rulemaking, however, the Department demonstrated that Congress did not explicitly impose the requirements of the APA on adjudications under the Federal Mine Safety and Health Act. *See* 62 FR 3359 (Jan. 22, 1997). In addition, the Department expressed its preference for a bright-line test that allows adjudication officers to resolve issues of eligibility based on the quality of the medical evidence developed by the parties rather than merely the quantity of evidence that parties with superior financial resources may be able to submit. The Department continues to believe that the adjudications that will take place under these revised regulations will result in fairer, more credible evaluations of black lung claims than the former system permitted.

(h) One comment argues that the ''minimum'' number of examinations that may be submitted by the parties is not equal. The commenter also objects that the claimant is entitled to travel a longer distance to obtain his medical evidence than the employer is authorized to send him to obtain its medical evidence. Specifically, the commenter states that a claimant could travel less than one hundred miles away for the complete pulmonary evaluation provided by the Department under § 725.406, but then travel a longer distance to obtain a subsequent examination at his own expense. Because the limitation on the travel an operator can require is tied to the distance traveled for the § 725.406 evaluation, the commenter argues that

the claimant could in fact travel much farther than the operator is permitted to send him in obtaining its evidence. The commenter's emphasis on a ''minimum'' number of medical reports is puzzling; since parties on both sides remain free not to submit any medical evidence, the Department believes that the commenter refers to the maximum permissible number of reports and tests. That limitation is equally balanced. Unless the administrative law judge finds that good cause justifies the admission of additional evidence, each side may submit up to two medical reports, two chest X-ray interpretations, the results of two pulmonary function studies and arterial blood gas studies, one report of each biopsy, and one autopsy report. The Department believes that the limitation applicable to each type of evidence per side represents an inherently fair way of ensuring that the adjudication officer's focus is on the quality of the evidence submitted rather than on its quantity. To the extent that the comment refers to the claimant's ability to select the physician to perform the complete pulmonary evaluation from among those on the Department's list, the Department has responded to that comment under § 725.406. *See* preamble to § 725.406, paragraph (b).

With respect to the travel requirements, the Department believes that a coal mine operator should not be entitled to wait to develop its medical evidence until after the claimant has finished his evidentiary development in order to learn how far it may ask the claimant to travel. The complete pulmonary evaluation offers the claimant the opportunity to travel anywhere in his state or any contiguous state at Departmental expense. The Department does not believe that a claimant will deliberately select a closer physician for this examination and then pay for his own travel to a more distant location for either of the two medical reports that he is entitled to submit. Accordingly, the Department believes that the distance a claimant travels for the complete pulmonary evaluation, or 100 miles, whichever is greater, represents a proper limitation on a coal mine operator's ability to compel the claimant to travel. Moreover, the regulation's proscription on additional travel is not absolute. Like the former regulation, 20 CFR 725.414(a)(1999), which subsection (a)(3)(i) mirrors, subsection 725.414(a)(3)(i) permits an operator to request the district director to authorize a trip of greater distance. Operators who are unable to find a qualified physician within the 100-mile radius thus may seek permission to send the claimant further.

(i) Three comments suggest that the determination as to whether additional evidence would provide only marginal utility should not be made by regulation of the Department of Labor but by administrative law judges on a case-by-case basis. These commenters contend it is up to administrative law judges to determine when evidence is cumulative and that the Department should not micromanage the adjudicatory process. The Department has previously expressed its preference for a ''bright-line'' limitation over the *ad hoc* determinations of individual adjudication officers. 62 FR 3357 (Jan. 22, 1997). Where the circumstances compel a determination of whether additional medical evidence should be allowed, *i.e.,* upon an allegation of good cause for submitting medical evidence in excess of the evidentiary limitation, that determination will be made by administrative law judges. The need for such a determination in some cases, however, does not obviate the more compelling need for a general rule limiting the amount of medical evidence that parties may submit in black lung benefits claims. The Department believes that it should be incumbent on the party seeking to exceed that limit to demonstrate good cause for submitting additional evidence.

(j) One comment argues that the Department should include the ''good cause'' exception in § 725.414 as well as in § 725.456, and that its failure to do so represents a trap for the unwary. The Department does not agree that the ''good cause'' exception needs to be repeated in § 725.414. As a practical matter, the Department's removal of the requirement that parties submit all of their documentary medical evidence before the district director will generally cause parties to delay the development of their evidence until a case reaches the administrative law judge. Thus, the Department does not anticipate that there will be many occasions on which a party would ask the district director, rather than the administrative law judge, to find ''good cause'' to exceed the numerical limitations of § 725.414. In any event, because any finding on this issue by the district director would be subject to *de novo* review by an administrative law judge, the Department does not believe that the absence of an explicitly stated ''good cause'' exception while a case is pending before the district director will impair the parties' development of evidence.

(k) One comment argues that, contrary to the opinion expressed in the Department's second notice of proposed rulemaking, the progressive nature of pneumoconiosis should not constitute ''good cause'' for the submission of additional evidence because it is scientifically unsupported. In its second notice of proposed rulemaking, the Department had suggested that the progressive nature of the disease might justify an administrative law judge's finding of good cause to admit documentary medical evidence in excess of the § 725.414 limitations when both parties had fully developed their evidence prior to the hearing but the hearing had to be rescheduled due to weather conditions. 64 FR 54994–95 (Oct. 8, 1999). The commenter suggests that a claim of regression should be automatic good cause. The Department has discussed the evidence demonstrating the progressive nature of pneumoconiosis in its response to comments under § 725.309. The Department does not agree that a bare claim of ''regression'' should entitle a coal mine operator to exceed the § 725.414 evidentiary limitations. The example provided by the Department was intended to illustrate one of the circumstances in which the ''good cause'' exception might apply; it was not intended to provide an automatic right to submit documentary medical evidence in excess of the limitations in any particular case.

(l) One comment states that the ''good cause'' exception is unnecessarily complex and leaves many unanswered questions. The commenter poses a hypothetical situation involving a claimant's submission of an additional report of examination, and asks what additional evidence the opposing party may submit in response or in rebuttal. The Department does not believe that the regulation or this preamble can explicitly anticipate every conceivable situation that may arise in the adjudication of claims. Instead, the Department fully expects that administrative law judges will be able to fashion a remedy in all cases that both permits the party opposing entitlement to develop such rebuttal evidence as is necessary to ensure a full and fair adjudication of the claim, and retains the principle inherent in these regulations that the fairest adjudication of a claimant's entitlement will occur when the factfinder's attention is focused on the quality of the medical evidence submitted by the parties rather than on its quantity.

(m) One comment argues that the Department's regulations improperly deny a dismissed operator the right to defend itself, in violation of the Black Lung Benefits Act, the Longshore and

Harbor Workers' Compensation Act, and the Administrative Procedure Act. Under the regulations, if an operator is dismissed by the district director, and is not reinstated before a case is referred to the Office of Administrative Law Judges, it may not be held liable for benefits. Such an operator will therefore not need to defend itself. If the district director dismisses an operator and later realizes that he did so incorrectly, he may reinstate that operator but must provide it with an opportunity, under § 725.410, to develop additional evidence. Consequently, the Department does not agree that the regulations limit the rights of dismissed operators.

(n) One comment states that the requirement that a party identify a testifying witness while a claim is pending before the district director is unreasonable and onerous, and that it diminishes the authority of administrative law judges. This comment is more appropriately addressed under § 725.457, governing the use of witnesses before an administrative law judge. *See* preamble to § 725.457, paragraph (b).

(o) A number of comments generally favor the Department's medical evidentiary limitations.

(p) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 725.415

(a) In its first notice of proposed rulemaking, the Department revised § 725.415 to require the district director to issue a proposed decision and order in each case. Citing the need to strengthen the integrity of the district director's adjudication, the Department proposed removing the district director's authority to refer a claim to the Office of Administrative Law Judges without first issuing a proposed decision and order. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss § 725.415 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has revised subsection (b) in light of its decision not to allow more than one operator to remain a party to a black lung claim after the conclusion of district director processing. As revised, the regulation recognizes the district director's authority to reconsider his initial designation of a responsible operator following the submission of liability evidence by that initially designated operator. Where the district director believes that that evidence establishes that the first operator is not the proper responsible operator, he may issue another schedule for the submission of additional evidence under § 725.410, designating a new responsible operator and providing that operator with time within which to submit its own evidence relevant to the liability issue. If, after reviewing that operator's evidence, the district director decides that his first designation was correct, he may not allow the second designated responsible operator to develop any additional medical evidence. If, however, he decides that his second designation was correct (or proceeds to a third or fourth designation), he must provide the operator that he finally determines to be the responsible operator with the opportunity to submit medical evidence. That operator may develop its own evidence, or may adopt any evidence previously submitted by an operator. In either case, the finally designated responsible operator is subject to the evidentiary limitations set forth in § 725.414.

(c) The Department has replaced the reference to § 725.413(c)(2) with a reference to § 725.410(b) in order to reflect the new provision governing the time period for submitting documentary evidence to the district director. The Department has also deleted the word ''operator's'' from the title of the regulation. As revised, the Department's regulations do not provide a separate period for the development of an operator's evidence.

(d) One comment submitted in connection with the first notice of proposed rulemaking states that this section affords the district director too much authority, but does not identify which specific powers are objectionable. Without more detail, the Department cannot respond meaningfully to the commenter's concerns. Subsection (b) does enumerate the possible actions a district director may take after reviewing all of the evidence developed in conjunction with the claim. The district director may notify additional potentially liable operators, issue another schedule for the submission of additional evidence, schedule a conference, issue a decision, or take any other action appropriate to the circumstances of the claim. The district director must enjoy some degree of flexibility in determining how to proceed once evidentiary development has concluded. For example, the district director may determine, in light of evidence submitted by the designated responsible operator, that one or more additional potentially liable operators must be notified of the claim, or that a previously notified potentially liable operator should be designated the responsible operator. In such cases, the district director must have sufficient authority to permit the parties to submit additional evidence on the liability issue. Accordingly, the Department does not view the authority provided the district director as excessive.

(e) One comment states that eliminating the requirement in § 725.414, as initially proposed, that all documentary medical evidence be submitted to the district director has also eliminated the need to strengthen the integrity of the district director's adjudication. The Department disagrees. In light of the Department's final revisions, the proposed decision and order will be the only decisional document that the district director issues addressing the claimant's eligibility for benefits and the liability of a responsible operator for the payment of those benefits. A substantial number of claimants currently accept the district director's conclusions regarding their eligibility, and do not seek further review of their claims for benefits. The alternative to issuing proposed decisions and orders—referring all cases to the Office of Administrative Law Judges (OALJs) for a formal hearing on the merits—would represent a considerable and unnecessary expenditure of the resources of the OALJs, the Office of Workers' Compensation Programs, and the coal mine operators who must litigate such cases. Accordingly, the Department does not agree that § 725.415 should be revised to retain the current rule under which district directors may simply forward cases to the OALJs. Also, issuance of some document is necessary to establish the date from which the parties' modification rights begin to run. The Department believes that it will be easier for all parties if there is only one such document in each case.

(f) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.416

(a) In its first notice of proposed rulemaking, the Department proposed revising subsection (c) to provide for the imposition of sanctions on any party that failed to appear at a scheduled informal conference and whose absence was not excused. The Department also proposed revising subsection (d) to put parties on notice that those attending the conference would be deemed to have the authority to stipulate to facts or issues or resolve the claim. 62 FR 3361 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department responded to a number of comments from a variety of sources urging the elimination of informal conferences.

Although the Department declined to eliminate conferences, it proposed revising subsection (b) to require the district director to articulate specific reasons for holding one. In the absence of such a statement, the district director would be prohibited from imposing sanctions for a party's failure to appear. In addition, in order to reduce parties' costs, the Department proposed to recognize the current practice of allowing parties to participate in informal conferences by telephone. 64 FR 54996 (Oct. 8, 1999).

(b) A number of comments generally oppose the use of informal conferences, contending they create additional delay and complexity in district director claims processing. As explained in both its first and second notices of proposed rulemaking, the Department believes that informal conferences may serve useful purposes, including, in appropriate cases, narrowing issues, achieving stipulations, and crystallizing positions. 62 FR 3361 (Jan. 22, 1997); 64 FR 54996 (Oct. 8, 1999). The Department agrees, however, that conferences should not unduly delay the further adjudication of a claim. In addition, they should be held only in appropriate circumstances. Accordingly, the Department has made two major changes to § 725.416. In subsection (a), the Department has added the requirement that a district director conduct any conference within 90 days of the date on which the period for submitting evidence under § 725.410(b) closes, unless one of the parties requests a postponement for good cause. The Department has also deleted the reference in subsection (b) to the district director's discretion to reschedule conferences. Subsection (a) permits the district director to reschedule conferences, but only upon the motion of a party. The Department has also replaced the reference to § 725.413(c)(2) in subsection (a) with a reference to § 725.410(b) in order to reflect a change in those regulations. In addition, in order to further limit the delay caused by informal conferences, the Department will continue to require that the district director issue a decision within 20 days of the close of all conference proceedings, including the time permitted for the submission of any additional evidence. *See* § 725.417.

The Department has made a second major change to § 725.416 to remove any appearance of impropriety in the informal conference process. The district director is a subordinate of the Director, Office of Workers' Compensation Programs, a party in each claim for black lung benefits. The district director is also responsible for the development of evidence on behalf of the Black Lung Disability Trust Fund. These dual roles may affect the degree to which the district director is viewed as a neutral arbiter of the issues before him. An appearance of a conflict of interest is particularly troubling in a case in which there is no operator liable for the payment of benefits, and the claimant lacks representation. In order to minimize any appearance of unfairness, the Department believes that conferences should be held only when all parties are capable of making informed judgments to protect their own interests. Accordingly, in addition to explaining why holding a conference in a particular claim would be beneficial, the Department will inform the parties that no conference will be held if all parties do not have representation. In the event that a claimant is not represented, the district director will not hold a conference. An appointed lay representative is sufficient, however, to allow an informal conference to go forward, 20 CFR 725.362, 725.363 (1999). The regulation extends the same protection to operators that are neither insured nor self-insured. Many self-insured coal mine operators and insurers do not obtain formal representation at this stage of adjudication, but have claims processing personnel, either in their offices or in the claims servicing organizations that they use, who are knowledgeable concerning the entitlement and liability criteria of the Black Lung Benefits Act and its implementing regulations. The Department believes that such personnel should be able to enter into binding stipulations on behalf of the self-insured or insured coal mine operator. The Department has replaced the reference to § 725.362 in subsection (d) with a reference to subsection (b) to accomplish this result. Accordingly, the regulation deems that such operators are represented for purposes of scheduling an informal conference. By contrast, the Department intends that operators that are neither insured nor self-insured—operators that are not often called upon to participate in the adjudication of black lung benefits claims—should not be asked to enter into stipulations without the benefit of a formal representative's advice. Because there will no longer be any conferences involving unrepresented claimants, the Department has deleted the last two sentences of subsection (e). The district director may continue to exercise his discretion, however, to determine whether parties understand any stipulations which they are asked to enter. Exercise of this discretion is particularly important where a claimant is represented by a lay representative.

(c) One comment submitted in connection with the first notice of proposed rulemaking and renewed in connection with the second notice of proposed rulemaking objects to the regulation contending it improperly provides for an adjudication of the claim before the district director that is neither on the record nor under oath. The commenter also objects generally to the discretion given the district director to determine the procedures to be used at the conference. The Department recognizes that the informal conference will not be conducted under oath and on the record, but believes that the changes it has made to the informal conference procedures obviate this objection. As revised, an informal conference will only be held if all parties to a claim are represented or are deemed to be represented. This revision removes the danger that the district director will be able to obtain a stipulation from an unsophisticated party. Moreover, following the termination of the informal conference proceedings, the district director will issue a proposed decision and order. The district director's ''adjudication'' of the claim is thus subject to the consent of the parties. A request for a hearing will require the district director to forward the claim to the Office of Administrative Law Judges for *de novo* adjudication. Consequently, the district director's inability to conduct the informal conference under oath, and to have the conference transcribed, will not affect the substantive rights of any party.

(d) No other comments have been received concerning this section.

20 CFR 725.417

(a) In its first notice of proposed rulemaking, the Department proposed revising subsection (b) to incorporate the limitations on documentary evidence contained in § 725.414. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss § 725.417 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has revised subsection (b) to clarify the district director's authority to seek additional information on the issue of responsible operator liability even after he has held a conference. The conference may provide the district director with additional information regarding the claimant's employment history. Accordingly, subsection (b) authorizes the district director to issue another

notification of potential operator liability under § 725.407 and/or another schedule for the submission of additional evidence under § 725.410.

(c) One comment objected to the requirement in proposed subsection (d) that parties respond in writing to the district director's memorandum of conference. The Department agrees that this response is unnecessary, and has further streamlined its informal adjudication of claims by eliminating in its entirety the memorandum of conference and the required response that would have followed. Instead, at the conclusion of informal conference proceedings, including the submission of any additional evidence, the district director will issue a proposed decision and order under § 725.418. The Department has also revised subsection (b) in order to clarify the meaning of the sentence.

(d) One comment urges the Department to create a time limit within which the district director must issue a decision after holding a conference. Subsection (c), 20 CFR 725.417(c) (1999), requires the district director to issue a decision within 20 days of the conclusion of the informal conference proceedings. Consequently, no change in the regulation is required.

(e) One comment submitted in connection with the first notice of proposed rulemaking recommended amending subsection (b) to allow submission of post-conference supplementary reports from any physician who has already prepared a report if clarification of the physician's report is needed. No change in the proposed regulation is necessary. A party may request the opportunity to submit additional evidence post-conference which may further support its position or a physician's views. The only restriction imposed by subsection (b) is that such additional evidentiary development cannot circumvent the numerical limitations in § 725.414. To the extent that the comment implies a ''clarifying'' report should be considered an extension of the initial report, the Department disagrees. Excluding supplementary reports from the § 725.414 limitations would create an exception which eviscerates the limitation. A party could invite comment from the physician on almost any aspect of the medical evidence in the record under the guise of ''clarifying'' the physician's views in light of that evidence. In effect, the supplementary report would constitute another medical report. Moreover, any internal ambiguity or omission in the physician's opinion should be apparent upon receipt and review of the report, and can therefore be corrected before submitting the report into the record. If, however, some aspect of a physician's report has been the subject of rebuttal evidence by an opposing party, § 725.414 does allow the rehabilitation of the original report by the submission of a clarifying report from the original doctor. Such rehabilitative evidence is allowed by the evidentiary limitations in § 725.414.

(f) One comment argues that the regulation is questionable in light of the changes made to § 725.414. In the absence of any further explanation by the commenter, the Department is unable to respond.

(g) The Department received no other comments concerning this section.

20 CFR 725.418

(a) The Department proposed revising subsection (a) in its first notice of proposed rulemaking to identify the proposed decision and order as the step which follows a district director's memorandum of conference or, if no conference was held, the period established by the district director for the submission of evidence. The revision was intended to require the issuance of a proposed decision and order in each case, and to eliminate the district director's option of referring the case for a hearing without issuing a proposed decision and order. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss § 725.418 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has added subsection (d) to provide explicitly that, to the extent he has not done so before, the district director must dismiss, as parties to the claim, all potentially liable operators except one. Moreover, the regulation guarantees that no operator may be the finally designated responsible operator unless it: (1) Was notified of its potential liability pursuant to § 725.407, and thus given the opportunity to submit evidence under § 725.408; and (2) given the opportunity to submit additional evidence relevant to the liability of other potentially liable operators and the claimant's eligibility pursuant to § 725.410.

(c) The Department has deleted the reference in the first sentence of subsection (a) to the parties' responses to the district director's recommendations because a district director will no longer issue a memorandum of conference following the termination of conference proceedings. *See* preamble to § 725.416. In its place, the Department has added a reference to the 20-day time period provided by § 725.417(c) within which the district director must issue a proposed decision and order. In addition, the Department has replaced the reference to § 725.413(c)(2) with a reference to 725.410(b) in order to reflect changes to those regulations. The Department has deleted the words ''to be'' in the first sentence of subsection (a) as unnecessary, and has revised the last sentence of subsection (a) to clarify the meaning of the regulation. The Department has also revised subsection (b) to clarify that the proposed decision and order is the document that must be served on the parties by certified mail.

(d) A number of comments objected to the Department's proposed revision of § 725.411, which would have treated a hearing request filed before the conclusion of district director processing as a request for the further adjudication of the claim. *See* 62 FR 3356 (Jan. 22, 1997). The Department believes that its amended procedures in §§ 725.410 through 725.412, 725.416—725.417, will eliminate much of the confusion that has led parties to file hearing requests before the conclusion of administrative processing. Whereas the Department's original proposal authorized the district director to issue an initial finding, a memorandum of conference, and a proposed decision and order, the revised regulations provide for the issuance of only one decisional document in most cases: A proposed decision and order. The Department does agree, however, that it should honor any hearing request that is filed by a party even if it is filed before the conclusion of a district director's processing. Accordingly, the Department has added subsection (c) to require that the proposed decision and order apprise parties of their right to a hearing. Where a party has previously filed a hearing request, and can reasonably be said to be aggrieved by the proposed decision and order, the district director will inform the party that the case will be referred to the Office of Administrative Law Judges unless the party revokes its previous request. In the case of a claimant who has previously requested a hearing, the district director will forward the case if he has denied benefits. In the case of an operator who has previously requested a hearing on either the claimant's eligibility or its liability for benefits, the district director will forward the case if he has awarded benefits.

(e) One comment submitted in connection with the first notice of proposed rulemaking and renewed in response to the second notice of proposed rulemaking expresses general

dissatisfaction with the issuance of a proposed decision and order calling it an unnecessary procedural step. The issuance of this document, however, is the logical culmination of the claims adjudication process at the district director level. Under the revised procedures adopted by the Department, it will serve as the district director's only attempted resolution of the issues of claimant eligibility and operator liability. The proposed decision and order thus serves either as a final disposition of the claim if the parties accept the decision, or as the conclusion of the initial stage of adjudication if a party aggrieved by the result intends to pursue the case to the hearing stage. The Department therefore rejects the suggestion that a proposed decision and order is unnecessary.

(f) No other comments were received concerning this section.

20 CFR 725.419

The Department received two comments relevant to § 725.419. This section was not open for comment; only technical changes were made to it. *See* 62 FR 3340–41 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). Therefore no changes are being made in it.

20 CFR 725.421

(a) In its first notice of proposed rulemaking, the Department proposed deleting language in subsection (a) to allow district directors to maintain the files of cases which have been referred to the Office of Administrative Law Judges. Formerly, those files had been sent to the national office of OWCP's Division of Coal Mine Workers' Compensation. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss § 725.421 in its second notice of proposed rulemaking. *See* list of Proposed Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has revised subsection (b)(3) to ensure that the record is sufficient to establish that the district director provided the finally designated responsible operator with notification of its status as a potentially liable operator under § 725.407 as well as its designation as the responsible operator pursuant to § 725.410. In addition, the Department has revised subsection (b)(4) to ensure that the record forwarded to the Office of Administrative Law Judges contains only medical evidence submitted by the claimant and the finally designated responsible operator or fund, as appropriate. *See* explanation accompanying §§ 725.414, 725.415. All evidence relevant to the issue of operator liability shall be made a part of the record.

(c) In subsection (a), the Department has added the word ''evidentiary'' and deleted the phrase ''in the claim'' to clarify the meaning of the sentence.

(d) One comment submitted in connection with the Department's first notice of proposed rulemaking objects to subsection (c) because it requires a party to pay for copies of documents which have previously been provided. The commenter argues that claimants in particular are unaware of the importance of keeping all documents associated with their claims. No change is made in response to this comment. Subsection (c) is a rule of general applicability, and affects responsible operators and insurance carriers as well as claimants. The provision states that the district director shall determine the amount of the copying fee. It therefore allows the district director to consider mitigating factors (the individual's financial condition, the cost of the documents being replaced, etc.) as grounds for reducing or waiving the copying fee. No other comments concerning this section were received, and no changes have been made in it.

20 CFR 725.422

The Department received several comments relevant to § 725.422. This section was not open for comment; it was repromulgated without alteration for the convenience of the reader; *see* 62 FR 3341 (Jan. 22, 1997); 64 FR 54971 (Oct. 8, 1999). Therefore, no changes are being made in it.

20 CFR 725.423

(a) In its first notice of proposed rulemaking, the Department proposed the addition of § 725.423 to consolidate all of the provisions governing extensions of time in subpart E of part 725. With the exception of two time periods, one in § 725.411(a)(1)(i) governing a claimant's response to an unfavorable initial finding and the other in § 725.419 governing responses to a district director's proposed decision and order, the proposed regulation would have allowed any time period to be extended for good cause shown provided a request for an extension was filed before the time period expired. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss § 725.423 in its second notice of proposed rulemaking. *See* list of Proposed Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has eliminated the reference in § 725.423 to the time period set forth in § 725.411(a)(1) because that time period has been eliminated from the regulations. *See* preamble to §§ 725.410–.413.

(c) One comment submitted in connection with the first notice of proposed rulemaking objects to a single regulation governing extensions of time. The commenter would prefer individual provisions in each affected regulation to add clarity to the proceedings. The Department disagrees. In terms of an efficient structure for the program regulations, a single provision with application to the entire Subpart E is more logical than a series of repetitive provisions added to each regulation containing a time frame for action.

(d) One comment submitted in connection with the first notice of proposed rulemaking urges explicit recognition that a request for an extension of time may be honored even if submitted after the time period for taking action has expired. This suggestion cannot be adopted. A ''well-settled'' principle of the black lung program requires the parties to ''strictly adhere to the substantive and procedural requirements of the Black Lung Benefits Act and its implementing regulations.'' *Jordan* v. *Director, OWCP,* 892 F.2d 482, 486 (6th Cir. 1989). Strict adherence to clearly delineated time frames for taking action promotes ''a just, efficient and final resolution'' of claims. 892 F.2d at 487. Any party, however, may ask for additional time to act. The Department believes a requirement that the extension be sought before the time for acting elapses is reasonable. *See generally Fetter* v. *Peabody Coal Co.,* 6 Black Lung Rep. 1–1173, 1–1175 (1984). Each party has notice of when some action must be taken during the adjudication process. Even if the party cannot complete the action itself, it may at least complete the request for additional time. Submitting a timely request for an extension is not an onerous burden.

(e) One comment recommends including proposed § 725.411(a)(1)(i) among the time periods which can be extended. As originally proposed, section 725.411(a)(1)(i) would have afforded a claimant who has been denied benefits one year from the district director's initial finding within which to request further adjudication. The revisions made by the Department to §§ 725.410–.413 have eliminated the time period in § 725.411(a)(1)(i). Accordingly, the comment is no longer relevant.

(f) One comment urges the Department to specify that a party cannot seek an extension of its right to file a request for modification under § 725.310 if that request is not filed before the expiration of the one-year

time period. By its terms, section 725.423 governs the extension of time periods in subpart E of part 725. It thus does not govern section 725.310, which is located in subpart C. The Department does not believe that a catchall provision for the entire part 725 is appropriate, and, in the absence of such a provision, believes that § 725.423 should not include a reference to any regulations outside of subpart E.

(g) One comment argues that the Department should not create a non-statutory jurisdictional bar by refusing to permit an extension of time in the case of a proposed decision and order. The commenter argues that the Department's regulation violates the rights of parties under the Administrative Procedure Act and the Black Lung Benefits Act to obtain a hearing. The Department disagrees. The time limit established by § 715.419 for responding to a proposed decision and order is necessary to create finality in those cases where no party contests the district director's initial adjudication of a claim. In the event that the Department issues a proposed decision and order awarding benefits and the designated responsible operator fails to respond in a timely manner, the Department must be able to enforce the award against the operator. Enforcement of an award under § 21(d) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 921(d), as incorporated by 30 U.S.C. 932(a), and the collection of benefits owed the Black Lung Disability Trust Fund under 30 U.S.C. 934, however, require that the decision and order awarding benefits be final. The time limit in the current version of § 725.419, 20 CFR 725.419 (1999), has been interpreted to be jurisdictional, *Freeman United Coal Mining Co* v. *Benefits Review Board*, 942 F.2d 415, 422 (7th Cir. 1991), and § 725.423 simply recognizes that interpretation. Contrary to the commenter's suggestion, assigning finality to a district director's proposed decision and order awarding benefits in the absence of a timely objection by the designated responsible operator violates no provision in the Administrative Procedure Act or the Black Lung Benefits Act. Nothing in either statute requires the Department to give effect to a party's late request for a hearing following the conclusion of the district director's administrative proceedings.

(h) No other comments were received concerning this section.

Subpart F

20 CFR 725.452

(a) The Department proposed adding subsection (d) in its first notice of proposed rulemaking to prohibit the deciding of a case without holding a hearing unless the administrative law judge believes an oral hearing is not necessary, notifies the parties that he intends to decide the case on the record, and the parties do not object. 62 FR 3361 (Jan. 22, 1997). The Department did not discuss this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment objects to the Department's insistence on an in-person hearing. The commenter states that an administrative law judge should be entitled to decide whether a hearing is necessary in the event that the parties disagree. The regulation reflects the Department's consistent position that any party is entitled to a hearing before an administrative law judge in a case that is not appropriate for summary judgment. Section 19(c) of the Longshore and Harbor Workers' Compensation Act requires a hearing ''upon application of any interested party.'' 33 U.S.C. 919(c), as incorporated by 30 U.S.C. 932(a). In its recent decision in *Robbins* v. *Cyprus Cumberland Coal Co.,* 146 F.3d 425, 430 (6th Cir. 1998), the Sixth Circuit recognized the existence of such a right in a modification proceeding. *See also Cunningham* v. *Island Creek Coal Co.,* 144 F.3d 388, 389–90 (6th Cir. 1998); *Pyro Mining Co.* v. *Slaton,* 879 F.2d 187, 190 (6th Cir. 1989). The *Robbins* court explained several reasons for requiring an in-person hearing:

> The mere fact that parties rarely bring a live expert is immaterial. [The claimant] should have had the opportunity to bring a live expert. Additionally, although the ALJ required any documentary evidence to be introduced in advance, the Director correctly points out that [the claimant] could request and receive permission at a hearing to introduce additional documentary evidence.

146 F.3d at 429. The in-person hearing also allows the parties to offer lay testimony on such issues as the miner's employment and medical history. Finally, the Department believes that guaranteeing the ability of all parties to appear before a highly qualified administrative law judge increases the parties' confidence in the fairness and impartiality of the adjudication process. Contrary to the commenter's suggestion, the Department does not insist that an in-person hearing must be held in every case. The parties remain free to move for summary judgment under subsection (c) in those rare cases where there is no genuine dispute as to a material issue of fact. In all other cases, however, the Department's revised regulation gives each party to a claim the right to insist on an in-person hearing. Permitting the cancellation of a hearing over the objection of even one of the parties, in a case involving disputed facts, would contravene the explicit command of 33 U.S.C. 919, as incorporated by 30 U.S.C. 932(a). No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.453

Although the Department received comments under this section, the regulation was not open for comment, *see* 62 Fed. Reg. 3341 (Jan. 22, 1997); 64 Fed. Reg. 54970–71 (Oct. 8, 1999). The regulation was repromulgated only for the convenience of readers. Accordingly, no changes are being made in this section.

20 CFR 725.454

(a) In its first notice of proposed rulemaking, the Department proposed eliminating the provision allowing administrative law judges to reopen the record for the receipt of additional evidence for ''good cause.'' 62 FR 3361 (Jan. 22, 1997). The Department's proposal reflected the evidentiary limitations then imposed by § 725.414. The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Several comments submitted in response to both the Department's 1997 proposal and its 1999 reproposal oppose removal from the current regulation of the administrative law judge's authority to reopen the record to receive additional evidence for good cause shown. The Department responded to those objections when it reproposed § 725.414(c), (d) and § 724.456(b) for additional comment. 64 FR 54994–95 (Oct. 8, 1999). At that time, the Department changed the proposed standard for the admission of documentary medical evidence in excess of the regulations' numerical limitations from one of ''extraordinary circumstances'' to ''good cause,'' while leaving the standard for admission of additional evidence relating to operator liability—evidence that was not submitted to the district director—one of extraordinary circumstances. In any event, the standard to be used to govern the introduction of documentary evidence while a case is pending before the Office of Administrative Law Judges

more properly belongs in § 725.456, and it remains there. In that regulation, medical evidence in excess of the limitations contained in § 725.414 may be admitted into the record upon a showing of good cause. No change has been made in § 725.454 in response to these comments.

(c) One comment recommends clarifying subsection (a) to underscore the claimant's right to request a hearing site somewhere outside the 75-mile radius around his residence for the convenience of his representative. No change is made in response to this comment. Subsection (a) specifically provides that a claimant may request an alternate location, and does not limit the site to a specific area or distance from the claimant's residence. A claimant may therefore request the administrative law judge to move the hearing site beyond the 75-mile boundary. Claimants, however, cannot be accorded an unqualified right to determine where hearings should be convened. All matters relating to the conduct of the hearing are ultimately the responsibility of the administrative law judge. He or she must balance the interests and rights of all the parties against the convenience of a particular site for the claimant. Consideration must also be given to administrative convenience and the efficient allocation of human and financial resources in general. An administrative law judge generally schedules several claims for adjudication in one location.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.456

(a) The Department proposed revising section 725.456 in its first notice of proposed rulemaking in order to reflect its original proposal in § 725.414 requiring parties to submit all of their documentary evidence to the district director. As originally proposed, section 725.456 would have prohibited the introduction of any additional evidence before the administrative law judge in the absence of extraordinary circumstances. 62 FR 3361–62 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department eliminated the requirement in § 725.414 that parties submit all of their documentary medical evidence to the district director in the absence of extraordinary circumstances, although it retained that requirement with respect to documentary evidence relevant to the issue of operator liability. Instead, the Department proposed allowing admission of documentary medical evidence in excess of the § 725.414 numerical limitations upon a showing of good cause. Accordingly, in its second proposal, the Department revised section 725.456, adding subsections from 20 CFR 725.456 (1999) to govern the submission of documentary medical evidence to the administrative law judge. 20 CFR 725.456(b)(1)–(3), (c), (d) (1999). The Department also revised subsection (f), now subsection (e), to reflect changes to § 725.406. 64 FR 54996 (Oct. 8, 1999).

(b) A number of comments object to the Department's addition of proposed subsection (c) to § 725.456, which prohibits parties from introducing documentary evidence at the formal hearing that was in their possession while the case was pending before the district director and was withheld from the district director or any other party. Several of the comments argue under a parallel provision, proposed § 725.414(e), that the provision will most severely affect claimants who are not represented by counsel while the case is pending before the district director, and who may unwittingly fail to provide the district director with evidence that they have developed. Another comment urges the Department to harmonize subsection (c) with section 725.414(e).

Subsection (c) was originally promulgated by the Department in 1978, and was designed to ensure that the district director's initial determination of the claimant's eligibility was based on all of the available evidence regarding the miner's medical condition. The subsection was also designed to ensure that the parties had adequate time to respond to an opponent's evidence. *See* 43 FR 36794, 36798 (Aug. 18, 1978). The revised regulations, however, will significantly alter the adjudication of black lung benefits cases. In particular, the district director will make his initial determination in reliance on a complete pulmonary evaluation performed by a highly qualified physician, and will already have all of the evidence relevant to the identification of the responsible coal mine operator. Moreover, as the commenters point out, an unrepresented claimant who obtains an opinion from his treating physician may inadvertently fail to submit it to the district director, and, under proposed subsection (c), would be prevented from submitting it thereafter to the administrative law judge. In addition, the 20-day requirement in subsection (b)(2) will ensure that parties have an adequate period in which to respond to the opposing party's evidence. Thus, the Department does not believe that subsection (c) remains necessary. Neither of the stated bases for the original adoption of the rule remain. Accordingly, proposed subsection (c) is deleted, and proposed subsections (d), (e), and (f) are redesignated as subsections (c), (d), and (e), respectively. The Department has made a corresponding deletion of proposed section 725.414(e). Since both subsections are now deleted, there is no need to harmonize them.

(c) One comment argues that the Department's revision imposes increased costs on coal mine operators by ''front-loading'' the evidentiary development process in claims where such development is unnecessary or could be delayed. This comment appears to be based on the mistaken belief that the Department's regulations continue to require the parties to submit all of their documentary medical evidence to the district director. The Department revised its proposal in 1999, and § 725.456, as reproposed, will allow both the claimant and the designated responsible operator in a claim to delay their development of documentary medical evidence until shortly before the formal hearing. In the event that a claim does not proceed beyond the district director level, the operator will not have to develop any medical evidence. This is the operators' current practice in many claims.

The Department acknowledges, however, that operators will still be required to submit evidence regarding their potential liability for the claim to the district director while the claim is being adjudicated at this earliest stage. Under the former regulations, an operator did not have to submit any evidence to support its denial of liability until the case was referred to the Office of Administrative Law Judges for a formal hearing. In a number of cases, where no party requested a hearing, the operator did not need to develop or submit this evidence at all. Thus, the commenter's observation that the revised regulations will require the ''up-front'' development of evidence is well-taken with respect to operator liability evidence. In both its initial notice of proposed rulemaking and its second notice of proposed rulemaking, however, the Department explained its intention to require potentially liable operators to submit evidence relevant to their employment of the miner and their financial capability to pay benefits at the earliest possible stage. 62 FR 3355–56 (Jan. 22, 1997); 64 FR 54990–91 (Oct. 8, 1999). In these final regulations, the Department has also required operator development and submission of any evidence relevant to the liability of another party during the district director's claims processing. Evidentiary

development as to other parties will be necessary, however, only in that small percentage of claims in which the identity of the responsible operator is in serious question. *See* § 725.414(b). The Department continues to believe that these requirements are justified by the Department's need to ascertain the positions of potentially liable operators on these issues while the case is pending before the district director, especially given the fact that potentially liable operators other than the designated responsible operator will no longer be parties once a case has been referred to the Office of Administrative Law Judges. In addition, the Department continues to believe that the increased costs that operators will have to bear as a result of this ''front-loading'' will not be significant.

(d) One comment submitted in response to the 1997 proposal and the 1999 reproposal states that the Department's revision eliminates the authority of administrative law judges to perform certain functions. Another comment argues that the revision marginalizes administrative law judges and demeans their powers and duties. Although neither comment offers specific examples of functions, powers, and duties that the Department has eliminated by revising section 725.456, the Department has independently reviewed the provision and does not believe that it eliminates any function currently performed by the administrative law judge, nor any power or duty that administrative law judges currently possess. Under the revised regulations, administrative law judges will retain full authority to decide any issue in respect of a claim, as required by section 19(a) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 919(a), as incorporated by 30 U.S.C. 932(a). Neither the Longshore Act nor the Administrative Procedure Act gives administrative law judges the right to demand that more evidence be made available for their decision-making. To the extent that they are unpersuaded by the evidence of record, the administrative law judge must decide that issue against the party that bears the burden of producing the evidence on that issue.

(e) One comment argues that the revised regulation denies the rights of all parties to fully cross-examine adverse evidence and witnesses. The Department does not agree that section 725.456 affects the rights of any party to cross-examine adverse evidence. In *Richardson* v. *Perales,* 402 U.S. 388, 409 (1971), the Supreme Court emphasized the importance of preserving the parties' ability to cross-examine the authors of written medical reports, the evidentiary basis of Social Security's disability determinations. Similarly, the Department's regulations provide all parties with a full and fair opportunity to conduct cross-examination. If the author of a report testifies at the hearing, the opposing party may clearly avail itself of the opportunity to conduct live cross-examination. In cases where the documentary medical evidence stands on its own, the opposing party may question the author of the report under conditions determined by the administrative law judge. *See* § 725.459. Finally, the administrative law judge has the authority, in appropriate cases, to issue a subpoena to compel the attendance of a witness at the hearing. In addition, in any case involving documentary medical evidence, the opposing party has the right, under section 725.414, to submit documentary rebuttal evidence of its own. Accordingly, the Department does not agree that its revisions to 725.456 in any way limit the right of parties to conduct an effective cross-examination.

(f) One comment argues that a party should not be required to make an independent showing of ''good cause'' in order to put on its case. The Department does not agree that § 725.456 prohibits a party from putting on its affirmative case. In combination with § 725.414, this provision places reasonable limitations on the number of medical reports and tests that a party may submit into evidence. A showing of ''good cause'' is necessary only in the event that a party seeks to convince the administrative law judge that the particular facts of a case justify the submission of additional medical evidence, either in the form of a documentary report or testimony. The Department believes that in the majority of cases, the quantity of medical evidence permitted by the regulations, even in the absence of a good cause showing, will provide a more than adequate evidentiary basis for an administrative law judge to determine the claimant's eligibility for benefits.

(g) Three comments approve of the Department's reinstatement of the 20-day rule governing the introduction of documentary evidence before the administrative law judge.

(h) One comment argues that § 725.457(d) is invalid in that it prohibits a physician from testifying as to medical evidence relevant to the miner's condition that is not contained in the record. This comment is more appropriately addressed under section 725.457.

(i) No other comments were received concerning this section and no other changes have been made in it.

20 CFR 725.457

(a) In its initial notice of proposed rulemaking, the Department proposed revising subsection (c) to conform the regulation to the requirement then in § 725.414 that a party identify all of its potential witnesses while the claim was pending before the district director. The Department also proposed adding a subsection (d) to address the permissible scope of a medical witness's testimony. 62 FR 3362 (Jan. 22, 1997). In light of changes to § 725.414 in the second notice of proposed rulemaking, the Department proposed altering the witness identification requirement so that it applied only to witnesses who were testifying to the liability of a potentially liable operator or the designation of the responsible operator. Thus, under the reproposal, the testimony of witnesses relevant to the liability of a potentially liable operator and/or the identification of the responsible operator was permissible only if the identity of that witness was disclosed to the district director.

In the second proposal, the Department eliminated the requirement that parties identify their medical witnesses while the case was pending before the district director because, as revised, the regulations allowed parties to forego development of medical evidence until a case was referred to the Office of Administrative Law Judges. In the reproposal, the testimony of medical witnesses was limited by only two considerations. First, the total number of medical reports and medical witnesses offered by a party could not exceed the limitations set forth in § 725.414 except upon a showing of good cause. Second, a party had to provide the other parties to a claim with appropriate notice of a witness' testimony: 10 days notice of any expert witness who would testify at the hearing, or 30 days notice of a deposition. The Department also revised subsection (d) to permit physicians to testify with respect to any medical evidence relevant to the miner's physical condition that was admitted into evidence. 64 FR 54996 (Oct. 8, 1999). The Department has added a clause to subsection (a) to clarify its intent that parties provide 10 days notice of any medical witness that they intend to present at the hearing, including witnesses who have prepared a medical report that has already been submitted into evidence.

(b) One comment argues that it is unreasonable to require a party to

identify a testifying witness while the claim is pending before the district director and that the requirement illegally diminishes the authority of the administrative law judge who conducts the hearing. The Department disagrees. This limitation is a reasonable extension of the requirement, set forth in Subpart E, that parties develop all of the evidence relevant to the liability of potentially liable operators while the case is pending before the district director. In both notices of proposed rulemaking, the Department explained that requiring the submission of evidence relevant to liability was intended to offset the risk that the Black Lung Disability Trust Fund would be required to assume liability in the event that none of the potentially liable operators named by the district director was ultimately determined to be the responsible operator. *See* 62 Fed. Reg. 3355–56 (Jan. 22, 1997); 64 Fed. Reg. 54993 (Oct. 8, 1999). A party should not be able to avoid the required evidentiary development before the district director by submitting its evidence to the administrative law judge in the form of witness testimony. Accordingly, the regulations require that parties identify all such witnesses while the case is pending before the district director. The regulations also recognize, however, that a party may submit additional documentary evidence on the liability issue at the hearing upon a showing of extraordinary circumstances, § 725.456(b)(1), and the regulations should provide the same standard for allowing witnesses' testimony. For example, the Department intends that a party will have shown extraordinary circumstances to present the testimony of a previously unidentified witness whose testimony is relevant to the issue of operator liability when the witness originally identified by the party is no longer available to testify. Accordingly, the Department has revised subsection (c)(1) to reflect this exception. The Department has also revised subsection (c)(1) to reflect its decision to permit the district director to refer the case to the Office of Administrative Law Judges with only one potentially liable operator, the designated responsible operator, as a party to the claim. The Department has also added a clause to subsection (c)(2) to clarify its intent that the combination of physician testimony and documentary medical reports may exceed the numerical limitations of § 725.414 only upon a showing of good cause. The Department has also deleted the last clause of this subsection; the introductory sentence of subsection (c) is sufficient to make clear the Department's intent that the limitations in the subsection are intended to govern testimony at a hearing as well as by deposition or interrogatories.

The Department does not agree, however, that revised § 725.457 diminishes the authority of administrative law judges. Under the procedures incorporated into the Black Lung Benefits Act from the Longshore and Harbor Workers' Compensation Act and the Administrative Procedure Act, administrative law judges are neutral arbiters of the issues presented to them for resolution. Based on the evidence submitted by the parties within the confines of the regulations promulgated by the Secretary, ALJs have ''full power and authority to hear and determine all questions in respect of such claim.'' 33 U.S.C. 919(a), as incorporated by 30 U.S.C. 932(a). The requirement that parties identify witnesses relevant to the issues of operator liability while a case is pending before the district director, and the limitation on expert testimony, are legitimate agency procedural rules designed to ensure the timely presentation of the evidence needed to adjudicate black lung benefits claims.

(c) Two comments state that the notice provision in subsection (a) should be harmonized with section 725.414(c). The Department does not believe that these provisions are in conflict. Subsection 725.414(c) requires the designated responsible operator to identify witnesses whose testimony may be introduced, either at the hearing or by deposition, on the issues relevant to operator liability while the claim is pending before the district director in the absence of extraordinary circumstances. The Department anticipates that the vast majority of these witnesses will be ''fact witnesses,'' *i.e.,* witnesses whose testimony will establish certain facts pertaining to the miner's employment. For example, an operator may present testimony to establish that the claimant did not work as a miner while working for the operator, or that the claimant was not exposed to coal mine dust. Because these witnesses are not ''expert witnesses,'' the 10-day notice requirement of section 725.457(a) is inapplicable. In cases where the witness who will appear at the hearing is an expert witness, such as a witness who will testify to the coal industry's use of certain terms in a coal mine lease, the party offering that witness's testimony must also provide 10 days notice to all other parties to the claim. That time allows the other parties sufficient time to prepare to cross-examine the expert witness at the hearing. If the witness testifies by deposition, the 30-day notice required by § 725.458 provides sufficient time for preparation.

(d) One comment argues that the Department's limitation on the testimony of physicians found in § 725.457(d) is more restrictive than that in the Federal Rules of Evidence and inconsistent with section 23 of the Longshore and Harbor Workers Compensation Act, 33 U.S.C. 923, as incorporated by 30 U.S.C. 932(a). The Department's regulation prohibits a physician who offers testimony from relying on materials relevant to the miner's medical condition that are not part of the record. The commenter contrasts the regulation with the Seventh Circuit's recent decision in *Peabody Coal Co.* v. *Director, OWCP,* 165 F.3d 1126 (7th Cir. 1999). In *Peabody Coal,* the Seventh Circuit reversed an award of benefits because the administrative law judge had discredited a medical opinion that was based on an autopsy review not admitted into the record. The court held that under Rule 703 of the Federal Rules of Evidence, an expert witness may base his opinion on materials that ''need not be admissible, let alone admitted, in evidence, provided that they are the sort of thing on which a responsible expert draws in formulating a professional opinion.'' 165 F.3d at 1128. The court further noted that it could not think of any reason why black lung adjudications should be subject to tighter restrictions on expert testimony, and added that ''[n]either Congress nor the Department of Labor thinks so. Nothing in the statute or regulations applicable to such cases supports the decision of the administrative law judge to impose tighter limits on expert witnesses in black lung cases than the Federal Rules of Evidence impose in ordinary civil and criminal trials.'' 165 F.3d at 1129.

The regulations under which *Peabody Coal* was adjudicated, however, did not contain any limitations on the quantity of medical evidence that a party was entitled to submit to the administrative law judge. Because the Department has now limited the amount of documentary medical evidence in the record, it cannot allow parties to avoid that limitation by presenting an expert witness who will be free to examine additional material that may not be admitted into the record. For example, if the party has already submitted a medical report prepared by one physician, and a consultative report prepared by a second physician, it is not entitled to submit the consultative report of a third physician in the absence of good cause. The regulation ensures that the party is not allowed to

avoid that limitation simply by having the second physician testify, not only about his own conclusions, but also about the conclusions reached by a third doctor. The Department believes that the limitation contained in subsection (d) is an appropriate means of ensuring the parties' adherence to the evidentiary limitations imposed by section 725.414. Like section 725.414, the revised version of section 725.457 will apply only to claims filed after the effective date of these regulations.

Contrary to the commenter's objection, then, the Department's revision does not ''violate'' the Seventh Circuit's decision in *Peabody Coal.* The court did not base its decision on an interpretation of unambiguous statutory language, but by using the Federal Rules of Evidence in a case in which the statute and regulations were silent. 165 F.3d at 1129. By promulgating a regulation that will produce a result contrary to the court's decision in the same circumstances, the Department has simply exercised its authority to fill in a gap identified by the court. ''The 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).

Nor does section 725.457 violate section 23 of the Longshore Act. Section 23(a) provides that an administrative law judge ''shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure, except as provided by this chapter.'' 33 U.S.C. 923(a), as incorporated by 30 U.S.C. 932(a). Even if this provision could be read as prohibiting the Department from promulgating any regulations under the Longshore Act that govern hearing procedures and the submission of evidence, the Black Lung Benefits Act explicitly authorizes the Secretary of Labor to promulgate regulations that vary incorporated Longshore Act provisions in order to properly administer the black lung benefits program. 30 U.S.C. 932(a); *Director, OWCP* v. *National Mines Corp.,* 554 F.2d 1267, 1274 (4th Cir. 1977). As discussed above, the limitation on the scope of testimony by physicians set forth in § 725.457 is necessary in order to ensure that parties adhere to the limitations on the quantity of medical evidence permitted each side in the adjudication of a claim for black lung benefits. Accordingly, the Department does not agree that the limitation violates section 23 of the Longshore Act.

(e) One comment approves of the Department's revision of the regulation with respect to the testimony of medical witnesses.

(f) No other comments were received concerning this section.

20 CFR 725.458

(a) In its first notice of proposed rulemaking, the Department proposed revising this regulation to ensure that the limitation on the scope of a physician's testimony set forth in § 725.457 was also applicable to testimony offered by deposition and to responses to interrogatories. 62 FR 3362 (Jan. 22, 1997). The Department did not discuss this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department did revise § 725.457(d), however, in order to allow a physician who testifies at a hearing to address all of the medical evidence of record. By incorporating § 725.457(d), § 725.458 also incorporated this expansion of the permissible scope of a physician's testimony.

(b) The Department received several comments concerning the cross-reference to § 725.457(d). The reference to § 725.457(d) incorporates into the rule governing depositions and interrogatories the limitations on the scope of physician-witnesses' testimony at hearing. For the reasons expressed in connection with the reproposal of § 725.457, the scope of allowable physician testimony has been broadened to allow a physician to address all of the other medical evidence of record. 64 FR 54996 (Oct. 8, 1999). No response is therefore necessary to comments addressing the operation of § 725.458, with one exception. One commenter suggests that § 725.458 will permit a party to introduce the deposition testimony of physicians who have not previously submitted medical reports, thereby circumventing the evidentiary limitations imposed by § 725.414. In the second notice of proposed rulemaking, the regulation governing witness' testimony generally, § 725.457, was amended to make the Department's intent clear. 64 FR 55044 (Oct. 8, 1999). Subsection (c) specifically prohibits a witness' testimony, even if taken by deposition or interrogatory, unless the witness meets the requirements of § 725.414. Thus, in the absence of a finding of good cause pursuant to § 725.456(b)(1), if a party has submitted the maximum number of documentary medical reports permitted under § 725.414, it may not submit the testimony of a physician-witness at a hearing or by deposition or interrogatory who has not submitted a written medical report. A physician who has not submitted a written report may testify only if the party has not yet reached the maximum number of documentary medical reports allowed. In such a case, the physician's testimony would not exceed the § 725.414 limitations.

(c) One comment urged the Department to replace the 30-day notice requirement in the regulation with a requirement that the parties need only give ''reasonable notice'' of the date, time and place of the deposition, and the name and address of each person to be examined, the current requirement under Fed. R. Civ. P. 30(b)(1). The Department has no reason to believe that the 30-day notice requirement has proved to be unworkable or even has resulted in major inconvenience to the parties in black lung benefits adjudications. Parties remain free under the regulation to agree to less than 30 days' notice when they believe it is reasonable to do so. Many parties to black lung claims do not secure representation until shortly before the hearing, however, and the Department believes that the 30-day notice of deposition, if sent to an unrepresented party, provides an appropriate period of time not only to obtain the necessary representation but also to arrange for participation in a deposition.

(d) One comment submitted in connection with the Department's first notice of proposed rulemaking urges the Department to require parties to identify, while the case is pending before the district director, all physicians that will be deposed. The commenter argues that this requirement would expedite the claims process, eliminate surprise, and require the timely development of positions. In its second notice of proposed rulemaking, the Department eliminated the proposal, contained in the first notice of proposed rulemaking, that parties submit all of their documentary medical evidence while a case is pending before the district director. The Department explained that the revision reflected the wishes of numerous commenters, and was particularly necessary in the case of claimants who might be unable to obtain representation until shortly before the hearing. 64 FR 54992–93 (Oct. 8, 1999). In light of this revision, the Department does not believe that it would be appropriate to require parties to identify all medical witnesses while a case is pending before the district director. This requirement would effectively reinstate the original proposal by requiring parties to

undertake the development of their case as to medical eligibility at the earliest stage of adjudication. The Department believes that this suggestion would adversely affect unrepresented claimants. Section 725.458 provides that all parties must give 30 days notice of any deposition, and section 725.457(a) provides that parties must give 10 days notice of expert witnesses who will testify at the hearing. The commenter has not suggested that these time periods, which were contained in the program's former regulations, have proved to be insufficient.

(e) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.459

(a) The Department proposed revising section 725.459 in its first notice of proposed rulemaking in order to require any party who compels a witness to appear at a deposition or hearing or respond to interrogatories for the purpose of cross-examination to pay that witness's costs. The Department also restructured and consolidated the remainder of the regulation. 62 FR 3362 (Jan. 22, 1997). The Department reconsidered how such costs should be assigned in its second notice of proposed rulemaking, and proposed that the party offering the witness's affirmative testimony should also pay any costs associated with his subsequent cross-examination. The sole exception to this rule pertained to indigent claimants and required administrative law judges to apportion the costs of cross-examining a witness offered by such a claimant between the claimant and the party or parties defending the claim. 64 FR 54997 (Oct. 8, 1999). The second proposal also required an administrative law judge to determine the least intrusive and expensive means of cross-examination as appropriate and necessary for a full and true disclosure of the facts. 64 FR 55044 (Oct. 8, 1999).

(b) The Department has substituted the term ''shall'' for the term ''may'' in the fourth and fifth sentences of subsection (b) in order to clarify its intention that the administrative law judge is required, rather than merely permitted, to consider the apportionment of the costs of cross-examination in each case involving a witness offered by an indigent claimant.

(c) Two comments approve of the Department's revision of section 725.459 to impose the costs of producing a witness for cross-examination upon the party relying on the witness's opinion, as well as the provision allowing administrative law judges to apportion costs in cases involving indigent claimants.

(d) One comment argues that the Department's proposal violates section 28 of the Longshore and Harbor Workers' Compensation Act by attempting to shift costs to employers in cases other than those authorized by statute. Section 28(d), 33 U.S.C. 928(d), incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a), requires an employer to pay the costs, fees, and mileage for necessary witnesses attending the hearing at the request of a claimant in any case in which an attorney's fee is awarded against the employer. Section 28(d) also requires that the necessity for the witness and the reasonableness of an expert witness fee be approved by an administrative law judge, Benefits Review Board, or court. Section 28(a) limits an employer's liability for attorneys' fees to cases in which the claimant successfully prosecutes his claim for benefits after the employer or carrier contests the claimant's entitlement. Accordingly, the commenter argues, the Department cannot shift the cost of cross-examination to employers in cases where the claimant is unsuccessful.

The Department does not agree. The Black Lung Benefits Act incorporates a variety of Longshore Act provisions governing the payment of costs and fees to witnesses. As with all such provisions, the Act explicitly authorizes the Department to vary the terms of those incorporated provisions in order to properly administer the black lung benefits program and effectuate Congress's intent in providing black lung benefits. *See* 30 U.S.C. 932(a) (permitting the Secretary to ''otherwise provide[] * * * by regulations * * *''); *Director, OWCP* v. *National Mines Corp.*, 554 F.2d 1267, 1274 (4th Cir. 1977). In addition to section 28 of the Longshore Act, incorporated section 7 of the Longshore Act also governs the payment of costs by an operator. Section 7(e) provides the Secretary with the power to order an examination of an employee ''[i]n the event that medical questions are raised in any case,'' and to authorize an additional review or reexamination upon the request of any party. 33 U.S.C. 907(e), as incorporated by 30 U.S.C. 932(a). This statutory section further provides that the Secretary may ''charge the cost of examination or review under this subsection to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk, in appropriate cases * * *.'' Thus, by its explicit terms, the cost-shifting mechanism of section 7(e) is not dependent on the miner's successful prosecution of his claim. Rather, Congress, in incorporating section 7(e) into the Black Lung Benefits Act, demonstrated its concern that miners not have to bear all the costs incurred in determining their entitlement to benefits, even in the event that they are ultimately unsuccessful.

In drafting a regulation governing the payment of witnesses' fees and costs, the Department was cognizant of its obligation to provide all parties with the right to conduct appropriate cross-examination of the witnesses offered by opposing parties. In *Richardson* v. *Perales*, 402 U.S. 388, 409 (1971), the Supreme Court recognized that the ability to cross-examine the preparer of an *ex parte* medical report served as an important guarantee of the reliability of such a report. Because the overwhelming majority of medical issues in the adjudication of a black lung benefits claim are decided on the basis of *ex parte* medical reports, rather than on testimony offered at the hearing, the Department must ensure that parties are permitted access to their opposing party's witnesses for the purpose of cross-examination.

At the same time, however, the Department must ensure that parties are not able to prevent an opposing party from offering a particular witness' opinion simply by scheduling a deposition of that witness. This is a particular problem where the claimant is indigent. Such a claimant must initially pay a physician to provide him with a medical opinion. If the operator exercises its right to cross-examine that physician, the claimant may not be able to afford the additional fees and costs necessary to pay the physician for the time he spends answering interrogatories or attending a deposition. Absent a mechanism permitting the apportionment of such costs, the claimant may be faced with the administrative law judge's refusal to consider his doctor's opinion because the doctor was not made available for cross-examination. The Department does not believe that Congress intended this result, and does not believe that a party's right to cross-examination should be used to exclude evidence offered by an opposing party that cannot afford the costs of expert testimony.

In those few cases in which there might be tension, section 725.459 strikes an appropriate balance between the twin goals of guaranteeing the right of cross-examination and ensuring a full and fair adjudication of an indigent claimant's eligibility for benefits. Consistent with incorporated Longshore Act provisions, as varied in order to

accommodate the needs of the black lung benefits program, and based on the Department's inherent to authority fill the statutory gaps left by Congress in the Black Lung Benefits Act, the revised regulation governing witness' fees represents a sensible cost-spreading measure in those relatively few cases in which a claimant is indigent.

(e) One comment suggests that the Department's witness fee regulation violates Supreme Court precedent. Although the commenter does not cite any specific decision, the Court's seminal decisions on cost-shifting, *Crawford Fitting Co.* v. *J.T. Gibbons, Inc.*, 482 U.S. 437 (1987), and *West Virginia University Hospitals* v. *Casey*, 499 U.S. 83 (1991), do not prevent the Department from shifting the costs of cross-examination to employers in special circumstances. In *Crawford Fitting*, the Court discussed sections 1920 and 1821 of Title 28 of the United States Code, which authorize shifting witness fees of up to $40 per day. The Court ''held that these provisions define the full extent of a federal court's power to shift litigation costs absent express statutory authority to go further.'' *Casey*, 499 U.S. at 86, explaining the decision in *Crawford Fitting*. As discussed above, the Department believes that the Black Lung Benefits Act, by incorporating various provisions of the Longshore Act and authorizing the Secretary to vary those provisions in order to administer the black lung program, provides ample statutory authority for the Department's cost-shifting regulation. The existence of that authority compels the conclusion that the revised regulation does not violate the Court's decisions in *Crawford Fitting* and *Casey*.

(f) One comment argues that the Administrative Procedure Act does not provide the Department with the authority to limit a party's right to cross-examine an adverse witness. The Department discussed the extent to which the Black Lung Benefits Act incorporates the Administrative Procedure Act and the extent to which the Department may vary that incorporation by regulation in its second notice of proposed rulemaking. 64 FR 54972 (Oct. 8, 1999). In addition, the Administrative Procedure Act requires only that parties be allowed to ''conduct such cross-examination as may be required for a full and true disclosure of the facts.'' 5 U.S.C. 556(d). The Seventh Circuit has recently observed that, under the standard used by the Social Security Administration, a standard identical to the one in the Administrative Procedure Act, '' '[c]ross-examination is * * * not an absolute right in administrative cases.' '' *Butera* v. *Apfel*, 173 F.3d 1049, 1057 (7th Cir. 1999), quoting *Central Freight Lines, Inc.* v. *United States*, 669 F.2d 1063, 1068 (5th Cir. 1982). The Court thus upheld a decision by SSA not to grant a claimant's subpoena to compel the attendance at the hearing by two physicians who had examined the claimant. *See also Copeland* v. *Bowen*, 861 F.2d 536, 539 (9th Cir. 1988) (holding that a disability claimant is ''not entitled to unlimited cross-examination, but is entitled to such cross-examination as may be required for a full and true disclosure of the facts.''); *Yancey* v. *Apfel*, 145 F.3d 106, 113 (6th Cir. 1998) (no absolute right to subpoena reporting physician); *Flatford* v. *Chater*, 93 F.3d 1296, 1305 (6th Cir. 1996) (same). Subsection (b) of the revised regulation meets the APA standard by permitting the ALJ to determine the level of cross-examination that is required for a full and true disclosure of the facts.

(g) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.465

(a) The Department made a technical change to section 725.465 in its first notice of proposed rulemaking, but did not open the rule for comment. 62 FR 3341 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department proposed revising subsection (b) to prohibit administrative law judges from dismissing potentially liable operators previously identified by the district director as parties to the case, except upon the motion or the written agreement of the Director. 64 FR 54997 (Oct. 8, 1999).

(b) One comment argues that the Department's proposed limitation on the ability of administrative law judges to dismiss potentially liable operators as parties to a case impermissibly usurps the authority of administrative law judges and violates the Administrative Procedure Act. The commenter states that the proposal violates the fundamental rights of coal mine operators and forces them to remain in a proceeding after they have been adjudicated not to be a proper party. Finally, the commenter states that the proposal violates section 424(a) of the Act, 30 U.S.C. § 934(a).

The Department does not agree that any party has a fundamental right to be dismissed from a black lung benefits adjudication prior to the final resolution of the issue of operator liability. The Department's final regulations, however, governing the treatment of claims in which more than one company has been named as a potentially liable operator have rendered these objections moot except in one instance. As finally revised, section 725.418 requires the district director to dismiss all but one operator as a party before referring the case to the Office of Administrative Law Judges. The Department has revised § 725.465 accordingly. If the district director erroneously fails to dismiss all operators except the one finally designated responsible pursuant to section 725.418(d), the ALJ may do so at any time. Subsection (b), however, continues to prohibit the ALJ from dismissing the responsible operator designated by the district director except upon the consent of the Director. The Department believes that this regulation remains necessary to prevent the premature dismissal of the designated operator by an administrative law judge. Currently, some administrative law judges resolve the responsible operator issue in a preliminary decision, and may dismiss the responsible operator(s) identified by the district director. In such cases, the Director, as the representative of the Black Lung Disability Trust Fund, must either file an interlocutory appeal with the Benefits Review Board, *cf. Collins* v. *J & L Steel,* 21 Black Lung Rep. (MB) 1–183, 1–1–186 (Ben. Rev. Bd. 1999), and ask that the adjudication of claimant's entitlement be held in abeyance pending the outcome of the appeal, or await the ALJ's resolution of the claimant's entitlement and then file an appeal. Both options are problematic. If the Director files an interlocutory appeal and the Board rejects the Director's arguments and affirms the dismissal, the Director may be unable to seek further review under the stricter standards that the federal appellate courts apply to interlocutory orders. *See, e.g., Redden* v. *Director, OWCP,* 825 F.2d 337, 338 (11th Cir. 1987), citing *Coopers & Lybrand* v. *Livesay,* 437 U.S. 463 (1978). If the Director waits until after the claimant's eligibility is resolved to appeal the responsible operator issue to the Board, the Board may affirm the dismissal solely because the operator did not have an opportunity to participate in the adjudication of the merits of the claim. *Crabtree* v. *Bethlehem Steel Corp.,* 7 Black Lung Rep. (MB) 1–354 (Ben. Rev. Bd. 1984). Neither of these options represents an efficient means of resolving the issue of operator liability in the context of adjudicating a miner's eligibility for benefits.

The revised regulation is intended to eliminate these problems, and ensure that the designated responsible operator and the Director have the opportunity to fully litigate the liability issue at all

levels. Moreover, the regulation does not create any undue hardships. If, after considering all of the evidence relevant to the responsible operator issue, the ALJ finds that the designated responsible operator is not liable for the payment of benefits, but concludes that the claimant is entitled to benefits, the operator merely has to wait until the Director, on behalf of the Trust Fund, files an appeal with the BRB. The operator may then participate in that appeal in defense of the ALJ's liability determination if it wishes. If the Director does not petition for review of the ALJ's liability decision, the operator need not participate in any further adjudication of the case, regardless of whether it is formally included as a party.

Moreover, the revised regulation violates neither section 424 of the Black Lung Benefits Act, 30 U.S.C. 934, nor the Administrative Procedure Act. Section 424 requires coal mine operators who have been determined to be liable for the payment of benefits to a claimant to reimburse the Black Lung Disability Trust Fund for amounts the Trust Fund paid to that claimant on an interim basis. The statute requires, however, that the operator's liability have been ''finally determined'' before the reimbursement obligation may be enforced. 30 U.S.C. 934(b)(4)(B). Under the incorporated provisions of the Longshore and Harbor Workers' Compensation Act, that final determination includes not only an administrative law judge's decision, but also decisions by the Benefits Review Board and the court of appeals. Obviously, an appeal by an aggrieved party, including the Director, OWCP, on an operator liability issue cannot proceed in the absence of all the necessary parties. Thus, it is necessary that the designated responsible operator remain a party to a claim even while it is on appeal. Similarly, nothing in the Administrative Procedure Act gives administrative law judges the authority to issue final decisions on issues. Accordingly, the revised regulation does not violate any statutory provision. As revised, § 725.465 simply ensures that no responsible operator designated by the district director will be dismissed prior to a final determination of claimant eligibility and operator liability except with the approval of the Director.

Finally, the regulation does not preclude the designated responsible operator, in a case in which the district director committed an obvious error, from seeking the written agreement of the Director that it be dismissed as a party. The regulation, rather than giving the Director's representative veto power over an ALJ's decision, as the commenter asserts, simply protects the interests of the Trust Fund, and ensures that the Director, as a party to the litigation, receives a complete adjudication of his interests. The Board has upheld the similar requirement in subsection (d), which prohibits the dismissal of a claim in which the claimant has been paid interim benefits from the Trust Fund, absent the Director's consent. *Boggs* v. *Falcon Coal Co.,* 17 Black Lung Rep. (MB) 1–62, 1–66 (1992).

(c) No other comments have been received concerning this regulation and no changes have been made in it.

20 CFR 725.478

(a) The Department proposed revising this regulation in its initial notice of proposed rulemaking in order to recognize the opinions of three appellate courts and the Benefits Review Board that had rejected the Department's interpretation of the former regulation. The Department had argued that under the former regulation an administrative law judge's decision and order should be considered filed on the date that the ALJ mailed it to the parties. The proposal adopted the view that the date of actual receipt of an administrative law judge's decision and order by the Division of Coal Mine Workers' Compensation (DCMWC) constitutes its filing date and renders the decision effective. Thus, the date of DCMWC's receipt triggers the running of the 30-day period for challenging an administrative law judge's decision. The proposal conformed the regulation to existing caselaw. 62 FR 3362–63 (Jan. 22, 1997). The Department also proposed moving the last two sentences of the former regulation to a more appropriate location in § 725.502. The Department did not discuss this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment stated that the revised regulation would extend the appeal time by several days, presumably because of the time used to send the file from the Office of Administrative Law Judges to DCMWC. The courts, however, rejected the Director's interpretation of the former regulation because it impermissibly shortened the 30-day statutory appeal time. *Trent Coal Co.* v. *Day,* 739 F.2d 116, 118 (1984); *Daugherty* v. *Director, OWCP,* 897 F.2d 740, 742 (1990). Following the reasoning of these decisions, the revision does not lengthen the appeal time, but simply recognizes the appeal time guaranteed by the statute.

(c) No further comments have been received concerning this section, and no changes have been made in it.

20 CFR 725.479

(a) In its first notice of proposed rulemaking, the Department proposed adding subsection (d) to provide that the 30-day period to appeal an administrative law judge's decision and order will commence upon a party's receipt of that document even though it was not served by certified mail or there was some other defect in service. 62 FR 3363 (Jan. 22, 1997). The Department did not discuss this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Several comments suggest that subsection (d) is unnecessary because strict adherence to the requirement in § 725.478 for service of an administrative law judge's decision by certified mail would eliminate any question as to the date of receipt of that decision. Subsection (d) does not supplant the requirement for serving decisions by certified mail. It simply establishes that actual receipt of a decision overcomes any technical defect in service for purposes of triggering appeal and reconsideration rights. These defects are not limited to cases where service is not made by certified mail. For example, a decision may be mailed to the wrong address but the party to whom it should have been sent later learns of the decision and obtains a copy. The revised regulation would begin the 30-day appeal period upon that party's receipt. The provision thus provides an element of finality to decisions while protecting the parties' rights to pursue litigation in a timely manner.

(c) One comment objects to subsection (d) as too technical and subject to violation by unwary litigants. The Department disagrees with this characterization. Subsection (d) eliminates any doubt that a party must exercise its options for challenging a decision in a timely manner once the party has received the decision and despite any defect in service. This provision therefore protects the litigants' rights and interests by dispelling any confusion as to the effectiveness of any decision which reaches the parties despite technical nonconformance with the service process.

(d) No other comments were received concerning this section, and no changes have been made in it.

Subpart G

20 CFR 725.490

In its first notice of proposed rulemaking, the Department proposed the reorganization and renaming of the rules governing the identification of responsible coal mine operators. Section 725.490 retained its title and much of its language. The Department proposed deleting the last clause of the last sentence of subsection (b), however, in order to reflect a move to part 726 of the regulations governing the obligations of coal mine operators to secure the payment of benefits. 62 FR 3363–65 (Jan. 22, 1997). No comments were received concerning this section, and no changes have been made in it.

20 CFR 725.491

(a) The Department proposed revising section 725.491 in order to clarify the meaning of the statutory term ''operator.'' 62 FR 3363 (Jan. 22, 1997). Section 725.491 retains some material from the Secretary's current regulations, such as the rebuttable presumption of exposure to dust currently found in 20 CFR 725.492(c). Much of section 725.491's language is new, however. In particular, the Department sought to ensure that terms critical to the identification of a company potentially liable for the payment of benefits under the Black Lung Benefits Act, such as ''owner'' and ''independent contractor,'' were defined broadly in keeping with Congress' intent that the coal mining industry bear liability for individual claims to the maximum extent feasible. The Department's goal in proposing these revisions was to insure that any company, partnership, or individual that employed a ''miner'' could be held liable under the Act. The regulation also implements the Department's view that the officers of an uninsured corporate coal mine operator should not be considered coal mine operators in their own right. The Benefits Review Board has recently accepted that view with respect to the Department's current regulations. *Lester* v. *Mack Coal Co.,* 21 Black Lung Rep. (MB) 1–126, 1–130–131 (Ben. Rev. Bd. 1999).

In its second notice of proposed rulemaking, the Department revised subsection (a)(2)(i) in response to one comment to ensure the consistent use of the term ''coal mine dust'' rather than ''coal dust.'' 64 FR 54998 (Oct. 8, 1999). In addition, the Department responded to comments about its definition of independent contractors in subsection (c) and its exclusion of the federal government and state governments as operators in subsection (f). 64 FR 54997–98 (Oct. 8, 1999).

(b) One comment suggests that retroactive application of the Department's revised responsible operator regulations is impermissible. Although these new regulations will apply only to claims filed after the date on which the revisions become effective, *see* § 725.2, the commenter argues that the Department is expanding the scope of the term ''operator,'' and that with respect to refiled claims, the newly amended definition will be applied retroactively. In this regard, the commenter argues that the Department's reliance on the jurisdiction of the Mine Safety and Health Administration to regulate under the Black Lung Benefits Act is inappropriate. We understand the commenter's argument to be that the Department should not have relied on cases decided under the Federal Mine Safety and Health Act (FMSHA) in promulgating its definition of the term ''operator.'' The Department cited such cases in both notices of proposed rulemaking. 62 FR 3364 (Jan. 22, 1997); 64 FR 54997–98 (Oct. 8, 1999). The commenter suggests that the MSHA's jurisdiction is based on an agreement with the Occupational Safety and Health Administration (OSHA) to ensure that all American workplaces are subject to inspection by one of the two agencies, and that the Department's adoption of FMSHA criteria represents an expansion of coverage under the Black Lung Benefits Act.

The Department disagrees with the premise of the argument. The Black Lung Benefits Act, which is subchapter IV of the Federal Mine Safety and Health Act, has incorporated the definition of the term ''operator'' found in section 3(d) of the FMSHA, 30 U.S.C. 802(d), since its enactment in 1969. The Secretary's regulations do not attempt to expand that definition, either by imposing liability on companies that are not currently liable for benefits, or by increasing the number of employees for which a coal mine operator may be held liable. The Black Lung Benefits Act and the Secretary's implementing regulations have consistently contained expansive definitions of terms such as ''operator'' and ''independent contractor,'' *see, e.g.,* 20 CFR 725.491(b)(1)(company need not directly supervise work in order to be considered an operator). In addition, regardless of any agreement between MSHA and OSHA, the definitions set forth in the FMSHA create an outer limit for MSHA's jurisdiction; MSHA simply cannot exercise authority over employers and activities not covered by the FMSHA. These definitional provisions also govern the extent of coverage under the Black Lung Benefits Act. Accordingly, the regulations implementing the Black Lung Benefits Act must recognize and account for the extent of coverage provided by the FMSHA.

(c) One comment argues that even if certain individuals, such as food service workers, may be considered ''miners'' under the BLBA, the Department should not require the employers of such individuals to bear liability for the payment of any benefits to which they become entitled. The commenter suggests that the Department's regulation would require a number of companies with only a tenuous relationship to the mining of coal to purchase insurance in order to cover the risk that they will be liable for the payment of benefits. Adopting the commenter's suggestion that these companies should be exempt from liability, however, would require imposing potential liability for their employees' claims on the Black Lung Disability Trust Fund. In its initial proposal, the Department took note of Congress' intent that the coal mining industry, rather than the Black Lung Disability Trust Fund, bear liability for the payment of individual claims to the maximum extent feasible. *See* 62 FR 3363 (Jan. 22, 1997). Accordingly, if individuals whose work is integral to the extraction or preparation of coal but who may not be considered traditional coal miners are determined to be entitled to benefits under the Act as a result of occupational exposure to coal mine dust, their employers must bear responsibility for the payment of those benefits. For example, individuals who transport coal during the extraction or preparation process, *Norfolk & Western Railway Co.* v. *Roberson,* 918 F.2d 1144, 1149–50 (4th Cir. 1990), *cert. denied,* 500 U.S. 916, and who deliver supplies essential to the extraction or preparation of coal, *Pinkham* v. *Director, OWCP,* 7 Black Lung Rep. (MB) 1–55, 1–57 (Ben. Rev. Bd. 1984), have been determined to be ''miners'' under the Black Lung Benefits Act. The regulatory definition of the term ''operator'' must be broad enough to ensure that the employer of such an individual bears direct liability for any benefits to which the miner is entitled.

(d) One comment objects to the Department's exclusion in subsection (f) of state and federal governments from the term ''operator.'' With respect to state governments, the commenter argues that there is no indication that Congress intended to exempt the states from the Act's broad coverage of coal mine operators. As the Department has previously explained, however, the test

under relevant Supreme Court decisions is not whether Congress indicated its intention to exempt the states from coverage, but whether Congress indicated a clear intention to include the states. *See* 64 FR 54998 (Oct. 8, 1999), discussing *Gregory* v. *Ashcroft,* 501 U.S. 452 (1991). The commenter does not allege that the BLBA meets this test with respect to state governments, noting only that the language of the Act could easily be construed to cover state employees. Although the commenter also objects to the exemption from liability under the Black Lung Benefits Act of the federal government, it argues that federal mine inspectors, the only federal employees who could be potentially covered by the BLBA, should not be considered ''miners.'' The Department agrees, and has taken the same position in litigation.

The commenter's true complaint appears to be that the liability for benefits payable to a claimant who was a miner before he became a coal mine inspector will fall on the operator that employed the claimant as a miner. The Fourth Circuit interpreted the Department's current regulations to require this result in *Eastern Associated Coal Corp.* v. *Director, OWCP,* 791 F.2d 1129, 1131–32 (4th Cir. 1986). Specifically, the court held that to the extent that an individual contracts pneumoconiosis as a result of work as a federal coal mine inspector, his exclusive remedy against the government lies under the Federal Employees' Compensation Act (FECA), 5 U.S.C. 8101 *et seq.* If such an individual is also able to obtain benefits under the Black Lung Benefits Act, based on other work as a miner, liability for those benefits rests with the coal mine operator that most recently employed the individual as a miner. *See also Consolidation Coal Co.* v. *Borda,* 171 F.3d 175, 179 (4th Cir. 1999). The commenter has offered no reason for the Department to revise its regulation to produce a different outcome.

(e) No other comments have been received concerning this section, and no changes have been made in it.

20 CFR 725.492

(a) The Department proposed revising section 725.492 to specifically define the term ''successor operator'' and address the issues posed by this category of coal mine operator. 62 FR 3364 (Jan. 22, 1997). The revised regulation largely tracks the language of section 422(i) of the Act, 30 U.S.C. 932(i), and provisions contained in the current version of 20 CFR 725.493. In addition, the Department clarified the definition to give effect to Congress' demonstrated interest in ensuring that a wide variety of commercial transactions was sufficient to give rise to successor liability under the Black Lung Benefits Act. 30 U.S.C. 932(i)(3). The Department did not make any additional revisions to this regulation in its 1999 proposal, 64 FR 54998–99 (Oct. 8, 1999), but did respond to two comments relating to the purchase of coal assets in a corporate reorganization or liquidation and the primary liability of a prior operator's insurance company.

(b) One comment states that subsection (e) exceeds the scope of the Act by suggesting that a purchase of mineral rights alone may be sufficient to attach liability to the purchaser as a successor operator. The commenter argues that the BLBA imposes liability only on operators of coal mines. Subsection (e) defines ''acquisition'' of a coal mine to include any transaction that transfers the right to extract or prepare coal at a mine. This regulation is based on the statutory definition of an ''operator,'' which includes not only the operator of a mine but also the mine's owner. 30 U.S.C. 802(d). In addition, the Department's regulations have long recognized that the lessor of coal mining property may bear liability for the payment of benefits in certain cases. *See* 20 CFR 725.491(b)(2) (1999). The Department does agree, however, that, in order to become liable as a successor operator, the acquirer of mining property must continue to derive an economic benefit from the coal on the property. Thus, the mere acquisition of mineral rights alone, without the actual extraction, preparation, or transportation of coal, or coal mine construction, will not subject the acquirer to successor operator liability.

(c) No other comments have been received concerning this section. The Department has added a comma in subsection (c) and deleted a comma in subsection (d)(1) in order to clarify the punctuation of the regulation.

20 CFR 725.493

(a) In its first notice of proposed rulemaking, the Department proposed revising section 725.493 to define the required relationship between a coal mine operator and a coal miner, the statutory basis for an operator's liability for the miner's claim under the Black Lung Benefits Act. 30 U.S.C. 932(a). 62 FR 3364 (Jan. 22, 1997). The Department made a technical change in its second notice of proposed rulemaking. It also added more specific language to subsection (a)(1) to recognize as sufficient to establish the requisite employment relationship a variety of arrangements between a worker and the entity that supervises that work. 64 FR 54999 (Oct. 8, 1999).

(b) One comment states that the Department's regulation will eliminate the current operator practice of leasing employees. The Department's response to this comment is set forth under section 726.8. No other comments have been received concerning this section, and no changes have been made in it.

20 CFR 725.494

(a) Section 725.494 provides the criteria for the identification of one or more ''potentially liable operators'' with respect to a claim for benefits. 62 FR 3364 (Jan. 22, 1997). For each claim, the group potentially includes all of those operators who meet the criteria currently contained in 20 CFR 725.492 and 725.493 (*e.g.,* employment of the miner for a year, including at least one day after December 31, 1969). This revised regulation also explains the factors used to consider whether a company is financially capable of assuming liability for the payment of benefits. In the second notice of proposed rulemaking, the Department made several technical changes to the regulation to make it easier to read. 64 FR 54999 (Oct. 8, 1999). The Department responded to one comment contending that the presumption in subsection (a) was illegal by citing the broad statutory grant of authority given the Department to create regulatory presumptions and by noting that the presumption appears in the current regulations at 20 CFR 725.493(a)(6). The Department responded to a comment concerning subsection (e) by explaining that subsection (e) did not contain a presumption, but simply recited the evidence needed to support a finding that an operator is financially capable of assuming liability for the payment of benefits. The Department further explained that the criteria in section 725.494 have no effect on a miner's eligibility for benefits.

(b) One comment received in connection with the Department's consideration of alternatives under the Regulatory Flexibility Act urges the Department to identify only the coal mine operator that is most likely to be liable for the payment of benefits as the responsible operator. The commenter does not distinguish between processing the claim at the district director level and the formal adjudication of the claim beyond that level. The commenter's main concern, however, appears to be the transaction costs imposed by the proposed ''joint defense'' requirement. The Department has eliminated the requirement that operators participate in the joint defense of the claimant's

entitlement by prohibiting more than one operator from participating in a case beyond the district director level, and by requiring the district director to exclude from the record any documentary medical evidence submitted by an operator other than the finally designated responsible operator. *See* explanation accompanying §§ 725.414, 725.415, 725.421. This revision does not require any alteration in the text of § 725.494. To the extent that the commenter is objecting to the district director's notification of more than one operator as potentially liable operators, the Department's explanation of the need for this requirement is set forth in the preamble to § 725.407.

In addition, a number of courts have been critical of the length of time it takes to resolve individual black lung benefits claims, *see, e.g., C&K Coal Co.* v. *Taylor,* 165 F.3d 254, 258 (3d Cir. 1999), and have held that the delays may deprive operators of their due process rights. *Lane Hollow Coal Co.* v. *Director, OWCP,* 137 F.3d 799, 807 (4th Cir. 1998). Some of these delays have been caused by remands from the Office of Administrative Law Judges in order to require the identification of additional responsible operators and the development of more evidence on responsible operator issues. The Department's revised regulations governing the identification and adjudication of the liable coal mine operator are intended to prevent such delays from occurring in the future. In all claims filed after the effective date of these revisions, the Department will have only one opportunity, while the case is pending before the district director, to obtain evidence from the operators that employed the miner. To facilitate the district director's resolution of the responsible operator issue, the regulations require the submission of evidence relevant to the criteria in section 725.494 to the district director and enhance the district director's ability to use subpoenas to compel the production of additional documents. Once all of this evidence is forwarded to the Office of Administrative Law Judges for a formal hearing, the administrative law judge assigned to the case will determine, in light of the evidentiary burdens imposed by section 725.495, whether the district director designated the proper responsible operator. If the administrative law judge determines that the district director did not designate the proper responsible operator, liability will fall on the Trust Fund. No remand for further development of the responsible operator issue is permissible.

(c) No comments have been received specifically relating to this section, and no changes have been made in it.

20 CFR 725.495

(a) Section 725.495 contains the criteria for deciding which of the miner's former employers will be the responsible operator liable for the payment of benefits to the miner and/or his survivors. 62 FR 3364–65 (Jan. 22, 1997). From among the employers that meet the criteria in § 725.494 for a potentially liable operator, section 725.495 assigns liability to the company that most recently employed the miner. In addition, the regulation explicitly assigns burdens of proof in the adjudication of the responsible operator issue. The regulation thus fills the regulatory void noted by the Fourth Circuit in *Director, OWCP* v. *Trace Fork Coal Co.,* 67 F.3d 503, 507 (4th Cir. 1995). In its second notice of proposed rulemaking, the Department again addressed this issue, rejecting arguments that the Department's assignment of burdens of proof violated the Fourth Circuit's decision. 64 FR 54999 (Oct. 8, 1999).

(b) The Department has revised the language of the first sentence of subsection (d) to reflect changes in the manner in which the district director will process claims, set forth in §§ 725.410–725.413, as well as the change in § 725.418(d) which prohibits the district director from forwarding a case to the Office of Administrative Law Judges with more than one operator as a party. *See* explanation accompanying § 725.414. The district director will identify the designated responsible operator in a document titled a schedule for the submission of additional evidence rather than in an initial finding. *See* explanation accompanying §§ 725.410–725.413. Moreover, to help ensure that the district director properly identifies the responsible operator, sections 725.415 and 725.417 permit the district director to re-designate the responsible operator, by issuing another schedule for the submission of additional evidence, if he determines that his initial designation may have been erroneous. *See* explanation accompanying §§ 725.415 and 725.417. Accordingly, the Department has replaced the reference in subsection (d) to the operator ''initially found liable'' with a reference to the operator that is ''finally designated'' as the responsible operator.

(c) One comment suggests that a miner's prior employer should not have to bear liability for a claim when the financial inability to pay benefits of another coal mine operator who more recently employed the miner is the responsibility of the Department. For example, the commenter notes, the Department accepted as insurers a number of ''group self-insurance associations'' that are currently unable to make benefit payments because they did not adequately secure the payment of claims for which they were ultimately held liable. Under section 423(a)(2) of the Act, 30 U.S.C. 933(a)(2), however, the Department is obligated to accept insurance coverage from any company, association, person or fund that is authorized under the laws of any State to insure workmen's compensation. *Compare* 33 U.S.C. 932(a)(1)(B) (Longshore and Harbor Workers' Compensation Act provision giving the Department authority to approve insurers under that Act). Accordingly, the Department's ''decision'' to accept these state group associations as insurers was not based on an exercise of discretion but rather on the understanding that they were authorized under the laws of their states to insure workers' compensation. The Department thus did not voluntarily assume the risk that these associations would become insolvent.

By contrast, the Department does have the authority to accept or reject applications for self-insurance and to set the minimum standards applicable for qualifying as a self-insurer. 30 U.S.C. 933(a)(1). To the extent that the security deposited by a self-insured coal mine operator pursuant to § 726.104 proves insufficient to pay individual claims, the Department agrees that the liability for those claims should not be placed on operators that previously employed the miner. Rather, in establishing the amount of security required, the Department voluntarily accepts the risk that self-insured operators will not have deposited sufficient security to pay claims if they are liquidated or become bankrupt.

Accordingly, the Department has added paragraph (a)(4) to section 725.495. The regulation does not affect the liability of any operator that employed the miner after his employment with the self-insured operator ended, even if that latter employment only lasted one day, provided the miner's cumulative period with that employer totalled at least one year. In determining the length of this cumulative period, the factfinder should include any period for which the employer is considered a successor operator to the miner's actual employer, *see C&K Coal Co.* v. *Taylor,* 165 F.3d 254, 257 (3d Cir. 1999). Like the

remainder of section 725.495, this provision shall be applicable only to claims filed after the date upon which these revisions become effective. This provision does not affect the liability of any operator that employed the miner after he left employment with the self-insured operator.

(d) Several comments continue to object to the imposition of a burden of proof on the potentially liable operator that the Department designates as the responsible operator. The regulation imposes on the Department the initial burden of establishing that the designated operator is a potentially liable operator, assisted by a presumption in subsection (b) that the designated operator is financially capable of assuming liability for the payment of benefits. In addition, if the district director designates as the responsible operator any operator other than the miner's most recent employer, he must include in the record a statement explaining the reasons for his finding and, if appropriate, an explanation of the Department's search of its insurance files. The burden then shifts to the designated responsible operator to prove either that it is financially incapable of assuming liability for the payment of benefits or that another potentially liable operator (*i.e.,* an operator that meets the criteria in § 725.494) employed the miner more recently. The Department's rationale for this revision is fully set forth in its explanation of the original proposal. 62 FR 3363–65 (Jan. 22, 1997).

(e) One comment argues that the Department's imposition of the burden of proof on the designated responsible operator violates the Supreme Court's decisions in *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994) and *Metropolitan Stevedore Co.* v. *Rambo,* 117 S. Ct. 1953 (1997), as well as the Administrative Procedure Act. The Department's response to this comment is fully set forth at 64 FR 54972–74 (Oct. 8, 1999). Congress gave the Department particularly broad authority to promulgate regulations governing the identification of the operator responsible for the payment of benefits, 30 U.S.C. 932(h), including the authority to create ''appropriate presumptions'' for determining whether pneumoconiosis arose out of a miner's employment with an individual coal company, and to establish ''standards for apportioning liability among more than one operator, where such apportionment is appropriate.'' This authority has been construed to permit the assignment of liability to a single operator. *See National Independent Coal Operators Association* v. *Brennan,* 372 F. Supp. 16, 24 (D.D.C.), *aff'd,* 419 U.S. 955 (1974). The burdens imposed by section 725.495 are thus fully consistent with the statutory authority granted the Department.

(f) Two comments argue that potentially liable operators should not be required to submit all of their evidence demonstrating the liability of other more recent of the miner's employers within the first 90 days after they receive notice of the claim. As the Department has discussed more fully in its response to comments concerning section 725.408, the 90-day time limit in that regulation is applicable only to the submission of evidence, generally within the control of an operator notified by the Department, which establishes that the operator is not a potentially liable operator in the claim. This includes evidence that the employer was not an operator for any period after June 30, 1973; that the operator did not employ the miner as a miner for a cumulative period of at least one year; that the miner was not exposed to coal mine dust while working for the employer; that the miner's employment did not include at least one working day after December 31, 1969; and that the employer is financially incapable of assuming liability for the payment of benefits. *See* §§ 725.408(a)(2)(i)–(v), 725.494(a)–(e). By contrast, documentary evidence submitted to demonstrate a more recent employer's potential liability is governed by section 725.414, which states that the evidence must be submitted pursuant to a schedule established by the district director after a party has indicated its dissatisfaction with the district director's initial findings of eligibility and liability. The submission of this evidence is therefore not subject to the 90-day time limit.

(g) No other comments have been received concerning this section, and no other changes have been made in it.

20 CFR 725.497

Although the Department received comments relevant to this section, the regulation was not open for comment, *see* 62 Fed. Reg. 3341 (Jan. 22, 1997); 64 Fed. Reg. 54971 (Oct. 8, 1999). It was inadvertently omitted from the list of technical revisions. Accordingly, no changes are being made in this section.

Subpart H

20 CFR 725.502

(a) The Department proposed significant changes to the current § 725.502 in its initial notice of proposed rulemaking. 62 FR 3412–13 (Jan. 22, 1997). The most important changes were designed to make clear to responsible operators their obligations under the terms of an effective award of benefits even though the claim might still be in litigation. By clarifying the obligations of a liable party pursuant to an effective award, the Department hoped to promote operator compliance. 62 FR 3366 (Jan. 22, 1997). The Department therefore proposed that a responsible operator pay all of the benefits due under the terms of an effective award, *i.e.,* both prospective monthly benefits and retroactive benefits. The proposed regulation also defined when benefits become due after the issuance of an ''effective'' decision awarding benefits. 62 FR 3412–13 (Jan. 22, 1997). Coupled with an assessment of an additional twenty-percent of any unpaid compensation (33 U.S.C. 914(f) as incorporated by 30 U.S.C. 932(b), proposed § 725.607), proposed § 725.502 substantially clarified the responsible operator's benefit payment obligations. In its second notice of proposed rulemaking, the Department responded to comments opposing the changes. Without disputing the statutory incorporation of § 14(f), the commenters contended that the addition of twenty-percent of unpaid compensation to late payments was punitive. They also opposed the obligation to pay retroactive benefits while an award was on appeal, arguing such a requirement violated Congressional intent and that recovery of those payments was unlikely in the event the award was overturned. 64 FR 54999–55000 (Oct. 8, 1999). Citing Congressional intent that the coal industry bear primary responsibility for benefits, the Department defended the assessment of an additional twenty-percent of unpaid compensation as a means to promote prompt compliance with effective awards. The Department noted its concern that operators rarely paid benefits while an award was on appeal, thereby shifting the financial burden and ultimate risk of loss to the Trust Fund. Moreover, the Department noted that requiring payment of retroactive benefits during active litigation was consistent with Congressional intent. The liable party is generally required to pay all benefits due the claimant under the terms of an effective award, and the ''benefits due'' include retroactive benefits. Congress enacted one exception: the Trust Fund is authorized to pay only future monthly benefits when it pays on behalf of an operator. 64 FR 55000 (Oct. 8, 1999). In response to another comment, the Department agreed that the law clearly requires the Trust Fund to pay interim benefits if an

operator obtains a stay of payments. The Department also concluded the proposed regulation required the operator to continue to pay benefits despite the pendency of a modification petition until a new effective order is issued pursuant to § 725.310. Finally, the Department reiterated its view that prospective monthly benefits are due and ''shall be paid'' when an administrative law judge's award becomes effective, *i.e.,* when the order is filed in the office of the district director. The Department did propose one change to § 725.502(b)(1) in its second notice. That change made monthly benefits due on the fifteenth day of the month following the month for which the benefits are paid, instead of the first business day of that month as originally proposed. 64 FR 55050 (Oct. 8, 1999). The Department has proposed one minor change in the final rule. Subsection (b)(2) requires the district director to compute the amount of retroactive benefits and interest a responsible operator owes the claimant, and to inform the parties. The Department has added language at the end of the last sentence of subsection (b)(2) to clarify that the district director must attach a current table of applicable interest rates to the computation.

(b) The Department has received one new comment in response to the second notice of proposed rulemaking. The commenter renews the objections stated in its response to the initial notice of proposed rulemaking, contending the Department did not respond adequately to its concerns in the 1999 preamble discussion. The comment cites several objections to requiring payment of retroactive benefits while an award is on appeal, and also objects to the assessment of the twenty-percent additional compensation for failure to pay such benefits. Specifically, the comment argues that use of the twenty-percent additional compensation is inconsistent with Congressional intent because the assessment was intended only to help claimants obtain prompt payment, and not reduce Trust Fund outlays. The comment also contends Congress intended the Fund to pay interim benefits during litigation on behalf of operators, and recoup those payments from operators only after the claimant ultimately prevails. In the commenter's view, Congress intended the Fund to share the risk of unsupportable awards with operators by assuming the operator's liability until litigation concluded and the validity of the award was established. The comment criticizes § 725.502(b)(2) because it will increase operator payments and lead to larger, and more numerous, overpayments. Finally, the comment objects to § 725.502(c), which requires the payment of one month of benefits if the miner-claimant dies in the month when eligibility commences. The comment states that the provision, in effect, allows duplicate benefits for that month in the event the survivor becomes entitled to benefits.

(c) The criticisms leveled at § 725.502(b)(2) rest on one basic premise: Since 1981, Congress has intended for the Trust Fund to pay prospective monthly benefits in all awarded claims remaining in litigation in which there is potential operator liability. Based on this premise, the commenter contends that an operator cannot be compelled by means of the § 14(f) ''penalty'' to pay any benefits—retroactive or prospective—until the award is final because no retroactive benefits are due and the Trust Fund is liable for the prospective benefits pending entry of a final award. The Department disagrees with the comment's premise and the conclusions derived from it.

As an initial matter, the comment does not cite any statutory section, legal authority, legislative history or other evidence for its position as to Congressional intent and the operation of the Trust Fund. It relies, instead, on an ''understanding'' or ''agreement'' between Congress and the members of the public affected by the 1981 amendments to the Black Lung Benefits Act (BLBA). None of the available material, however, supports the comment's views.

First, the expenditures which the Fund may undertake are a matter of statutory mandate. Under the Internal Revenue Code (in which the Trust Fund provisions appear), monies are available if ''the operator liable for the payment of such benefits * * * has not made a payment within 30 days after that payment is due[.]'' 26 U.S.C. 9501(d)(1)(A)(ii). The only limitation prohibits the payment of retroactive benefits by the Fund on behalf of operators in claims filed after the 1981 amendments. 26 U.S.C. 9501(d)(1)(A). The provision is clear: The operator is liable for any benefits which are due, and the Fund will pay only prospective benefits if the operator defaults. Section 9501(d)(1)(A)(ii) does not suggest Congress intended as a routine practice to relieve the operator of the obligation to pay benefits which are due while the claimant's entitlement remains in dispute.

Second, the legislative history of the creation and later-amended operation of the Black Lung Disability Trust Fund supports the Department's position. The historical antecedents are described in detail in *Old Ben Coal Co.* v. *Luker,* 826 F.2d 688, 693–94 (7th Cir. 1987). Briefly, Congress created the Fund in 1978 to relieve the federal government of its *de facto* primary financial responsibility for the Part C program. The Fund assumed responsibility for claims for which no operator was liable or in which the responsible operator defaulted on its payment obligations. Congress intended 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. 95–209, 95th Cong., 1st Sess. 9 (1977), *reprinted in Committee on Education and Labor, House of Representatives, 96th Cong., Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977* at 612 (Comm. Print) (1979) (emphasis supplied). By the conclusion of the 1981 fiscal year, however, the Fund had accumulated a deficit of approximately $1.5 billion. H.R. Rep. 97–406, 97th Cong., 1st Sess. 4 (1981), reprinted in U.S.C. C. & A.N. 2673. Individual responsible operators had also become burdened with unanticipated retroactive liabilities from denied claims which were reopened and approved under the 1978 legislation. Congressional concern over the Trust Fund's deficit prompted changes to the BLBA in 1981; the remedial actions included raising the excise tax on coal that provided revenue for the Fund, increasing the interest rate on operator liabilities to the Fund, and tightening eligibility criteria for claimants. Congress also relieved a limited group of operators from their retroactive liabilities based on the procedural histories of certain claims. These liabilities transferred to the Fund. Finally, Congress limited the Trust Fund to paying only prospective benefits if a responsible operator failed or refused to pay after entry of an initial determination of entitlement. The 1981 Amendments, however, did not disturb the operator's legal obligation to pay all benefits due under an effective award. 127 Cong. Rec. 29,932 (1981).

Against this background, the comment's position is untenable. In 1981, Congress amended the BLBA, in large part because the Fund was in economic crisis. The objective of the amendments was to eliminate the deficit by increasing revenues and revising eligibility criteria. A fiscally-concerned Congress would not then impose on the Fund the operators' collective liability for benefits pending conclusion of entitlement litigation in every claim.

The ability to recoup from the operator the amount paid by the Fund if the award survived litigation, plus interest, would restore only some of the revenues expended on interim benefits. Initial awards which were eventually overturned would become overpayments; recovering overpayments from a largely elderly and unemployed population was problematic at best. Given these circumstances, the Department rejects the argument that Congress intended the Fund to absorb all operators' liabilities as a matter of course until the conclusion of litigation in every approved claim.

The Department also rejects the comment's argument that vigorous use of the payment of additional compensation pursuant to section 14(f) is contrary to Congressional intent. The Department provided a detailed response to this argument in its second notice of proposed rulemaking. 64 FR 54999–55000 (Oct. 8, 1999). The response cited Congress' intention to impose liability on the operators to the maximum feasible extent, together with the provision's purpose to ensure the operator's prompt compliance with its benefit obligations. The only significant concern shown by Congress with respect to the use of section 14(f) was the caveat that the provision not apply until the operator ''has the right to contest the claim.'' 127 Cong. Rec. 19, 645 (1981). This concern is met by the requirement that § 14(f) does not apply until an effective award is in place, and an effective award arises only after the operator has had an opportunity for a hearing. The Department believes § 725.502(b) promotes Congress' overall objective to shift liability for the payment of benefits to those operators who owe the benefits. The significance of this objective has become more obvious since the 1981 amendments. The Fund's indebtedness to the U.S. Treasury at the conclusion of fiscal year 1997 was $ 5.487 billion. OWCP Annual Report to Congress for FY 1997 at 24.

(d) The comment challenges the allowance of one month of benefits if the miner dies in the first month during which all eligibility requirements are established. The comment contends that such a payment is not authorized by statute, and that a duplicate payment occurs if the miner-claimant dies and the survivor establishes entitlement independently because the miner's death was due to pneumoconiosis. The Department rejects this argument as a reason for eliminating the provision. As an initial matter, this provision was first promulgated as part of the original § 725.502. *See* 43 FR 36806 (Aug. 18, 1978). No comments were received then in response to the regulation, nor did the Department receive any comments in response to its initial notice of proposed rulemaking. *See also* 20 CFR 410.226(a). In any event, the payment of benefits twice for the same month of eligibility in these circumstances is proper. The program has always paid benefits for periods during which the miner established (s)he was totally disabled by pneumoconiosis arising out of coal mine employment. 33 U.S.C. 906(a), as incorporated by 30 U.S.C. 932(a), 922(a)(1). Although generally a miner's entitlement terminates in the month before the month of death (§ 725.203(b)(1)), § 725.502(c) creates an exception to that rule to recognize the successful prosecution of a claim, albeit only for one month of benefits. The program also pays survivor's benefits to eligible recipients if a miner dies due to pneumoconiosis, 30 U.S.C. 922(a)(2), and begins such benefit payments with the month of the miner's death, 20 CFR 725.212–725.213. The statute does not prohibit the payment of benefits twice in one month in the rare event a miner entitled to benefits for disability dies due to pneumoconiosis in the first month of his or her eligibility. No change in the regulation is necessary.

(e) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 725.503

(a) In its initial notice of proposed rulemaking, the Department proposed adding § 725.503(d) to provide specific guidelines for determining the onset date for benefits awarded based on a modification petition. The proposed rule set forth the date from which benefits would be payable based either on a mistake in a determination of fact or on a change in the miner's condition. 62 FR 3366, 3412–13 (Jan. 22, 1997). In the case of a mistaken factual determination, the proposal employed the rules used in a miner's or a survivor's claim. If the award was based on a change in conditions and if the precise month in which the miner became disabled could not be ascertained, the proposed rule pegged the onset date to the earliest evidence supporting an element of entitlement not previously found in the claimant's favor, provided the evidence was developed after the most recent factfinder's denial of benefits. The proposed regulation drew criticism both for setting the onset date too late and for setting it too early, thereby allegedly violating a statutory requirement prohibiting the payment of benefits before the onset of the miner's entitlement. In the second notice of proposed rulemaking, the Department altered § 725.502(d)(2), noting a concern that the regulation as originally proposed would generate too much litigation. 64 FR 55001, 55050 (Oct. 8, 1999). The reproposed version required the actual onset date of entitlement to be determined if possible. If that date could not be ascertained, however, § 725.503(d)(2) set a default onset date using the date the miner filed the modification petition. The Department adopted this approach because the filing date of the application for benefits is the default onset date for approved miners' claims (20 CFR 725.503(b)), and that method had worked well in the adjudication of black lung claims in general. The Department therefore proposed using a similar method in change in conditions cases. 64 FR 55001 (Oct. 8, 1999). Use of a filing date reflects ''the logical premise'' that the miner would file a claim or a modification petition when (s)he believed (s)he is entitled to benefits. In the final rule, the Department has made two minor changes to § 725.503(b) and (c). Each subsection begins with similar language referring to the entitled individual to whom benefits are payable, *i.e.,* the miner entitled to benefits (subsection (b)), and the survivor entitled to benefits (subsection (c)). The purpose of this change is simply to use parallel language in each subsection to identify the individual receiving benefits.

(b) One comment opposes the use of default onset dates for both claims and modification petitions. The comment contends the default date creates a presumption of entitlement to benefits as of the filing date when the claimant has not proven this fact. The commenter believes such a presumption violates the Administrative Procedure Act (APA), 5 U.S.C. 556(d), and the Supreme Court's decision in *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994). The Department disagrees with the general proposition that a default onset date based on a presumption of entitlement as of a certain date violates the APA and *Greenwich Collieries.* The Department addressed this issue at length in its second notice of proposed rulemaking. 64 FR 54972–74 (Oct. 8, 1999). To summarize: the Federal Mine Safety and Health Act (FMSHA), of which the Black Lung Benefits Act (BLBA) is a part, generally is exempt from the provisions of the APA. 30 U.S.C. 956. The BLBA, however, incorporates section 19 of the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 919(d), thereby making the APA applicable to the

adjudication of claims. The incorporation of the APA (and 5 U.S.C. 556(d) in particular) is subject to one important constraint: Congress conferred on the Secretary the authority to vary the terms of the incorporated provisions by regulation. 30 U.S.C. 932(a) (provisions of LHWCA apply to BLBA ''except as otherwise provided * * * by regulations of the Secretary''). *See generally Director, OWCP* v. *National Mines Corp.,* 554 F.2d 1267, 1273–74 (4th Cir. 1977); *Patton* v. *Director, OWCP,* 763 F.2d 553, 559–60 (3d Cir. 1985). In *Greenwich Collieries,* the issue before the Court concerned the Department's authority to displace 5 U.S.C. 556(d) via a regulatory presumption (20 CFR 718.3) that required a finding for the claimant if the evidence for and against a particular finding was evenly balanced. The Court considered § 718.3(c) too ambiguous to vary the APA's burden of proof requirements as to the BLBA. It therefore held that the party who bears the burden of persuasion under the APA must prevail by a preponderance of the evidence. In so holding, the Court also acknowledged the Department's regulatory authority, consistent with the APA, to utilize presumptions which ease a party's burden of production. 512 U.S. at 280–81. The Court did not address the Department's argument that it has the authority to override 5 U.S.C. 556(d) by regulation and shift the burden of persuasion as well.

Since *Greenwich Collieries,* three courts have addressed the Department's authority to create presumptions which alter the parties' evidentiary burdens. Although no court has considered the Department's statutory authority to shift a burden of persuasion, all three courts have approved either directly or in dicta the Department's authority to create presumptions which shift the burden of production. In *Glen Coal Co.* v. *Seals*, 147 F.3d 502 (6th Cir. 1998), the Sixth Circuit considered whether a judicially-created presumption of medical benefits coverage for the treatment of pulmonary disorders was consistent with circuit caselaw. *See Doris Coal Co.* v. *Director, OWCP*, 938 F.2d 492 (4th Cir. 1991) (holding miner previously found totally disabled due to pneumoconiosis who receives treatment for pulmonary disorder is presumed to receive treatment for pneumoconiosis for purposes of medical benefits coverage). The majority held that the decisions below erroneously relied on the *Doris Coal* opinion when Sixth Circuit law applied and was inconsistent with Fourth Circuit precedent. 147 F.3d at 514 (Dowd, D.C.J.), 515 (Boggs, J.). Judge Boggs (concurring), however, agreed with Judge Moore (dissenting) ''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*.'' 147 F.3d at 517. In *Gulf & Western Indus.* v. *Ling*, 176 F.3d 226 (4th Cir. 1999), the Fourth Circuit upheld the validity of the *Doris Coal* presumption under the APA as interpreted by *Greenwich Collieries*. The Court agreed with *Seals* that the presumption shifts the burden of production, not persuasion, and therefore was valid under the APA. 176 F.3d at 233–34. Most recently, the Eighth Circuit considered whether, for purposes of a subsequent claim, a ''material change'' in a miner's condition could be presumed if the miner established one element of entitlement not previously proven in connection with a prior denied claim. *Lovilia Coal Co.* v. *Harvey*, 109 F.3d 445 (8th Cir. 1997); *see* 20 CFR 725.309 (miner must show ''material change in condition'' between denial of one claim and filing of later claim). The Court rejected the operator's argument that the presumption of change violated 5 U.S.C. 556(d) and *Greenwich Collieries*. In so doing, the Court cited *Greenwich Collieries'* explicit approval of burden shifting presumptions which ease a party's obligation to produce evidence in support of its claim. 109 F.3d at 452–53.

Thus, the courts have upheld the Department's authority to shift the burden of production to the party opposing entitlement upon a showing of the predicate facts which support the presumption without violating the APA. Section 725.503 does create a presumption of entitlement to benefits as of the filing date of the claim absent contrary evidence. The presumption rests on a twofold basis: (i) The miner has established he is entitled to benefits; and (ii) the Department's belief that an individual will file a claim when he believes himself entitled to benefits. *See* 43 FR 36828–36829 (Aug. 18, 1978). The presumption, however, shifts only the burden of production to the party opposing benefits. That party may overcome the presumed entitlement date by introducing credible medical evidence that the miner was not disabled for some period of time after he filed his claim. *See Ling*, 176 F.3d at 233 (holding, in context of another black lung presumption which shifts burden of production, party must introduce ''credible'' evidence supporting its position). ''Credible'' evidence means medical opinions which are consistent with the adjudicator's findings in the underlying award of benefits. If the adjudicator has accepted evidence that the miner is totally disabled as of a certain date, then any later medical opinion contradicting this evidence is necessarily not credible. Medical opinions pre-dating the evidence of entitlement, however, may establish the miner was not disabled when he filed his application. *See Rochester & Pittsburgh Coal Co.* v. *Krecota*, 868 F.2d 600, 603 (3d Cir. 1989) (holding ALJ erroneously awarded benefits from filing date when evidence proved miner was not disabled at that time). The burden of *persuasion* remains with the claimant to provide medical evidence sufficient to overcome the opponent's. Similarly, a claimant may also prove he is entitled to benefits commencing before he filed his benefits application. In such a situation, the burden of persuasion remains, as always, with the claimant. The comment does not provide any other rationale for its position that default onset dates violate the APA. The Department therefore declines to abandon its use of such onset dates when the medical evidence fails to establish the date on which the miner became totally disabled due to pneumoconiosis.

(c) The same comment contends that using default dates based on filing dates violates section 6 of the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 906, as incorporated by the Black Lung Benefits Act (BLBA), 30 U.S.C. 932(a). The comment suggests using as an alternative default date the date of the earliest medical evidence the adjudicator accepts as sufficient to prove the miner is totally disabled by pneumoconiosis. The Department rejects this position. Section 6(a) of the LHWCA provides in relevant part that ''[n]o compensation shall be allowed for the first three days of the disability * * * Provided, however, That in case the injury results in disability of more than fourteen days, the compensation shall be allowed from the date of the disability.'' 33 U.S.C. 906(a). As discussed above, Congress expressly granted the Secretary the power to tailor incorporated Longshore Act provisions to fit the black lung program: the LHWCA sections apply to the BLBA ''except as otherwise provided * * * by regulations of the Secretary.'' 30 U.S.C. 932(a); *Director, OWCP* v. *National Mines Corp.*, 554 F.2d 1267, 1273–1274 (4th Cir. 1977).

In 1978, the Secretary promulgated 20 CFR 725.503 to implement section 6(a). 43 FR 36806 (Aug. 18, 1978). Like the revised § 725.503, the 1978 regulation

prescribed two alternative means for determining the entitlement date. The adjudicator had to first consider whether the evidence established the month during which the miner became totally disabled due to pneumoconiosis. If the evidence was insufficient to identify the specific month, the adjudicator resorted to the default date: the month in which the miner filed his or her claim. Section 725.503(d)(2) adopts the same general approach for modification petitions, and substitutes the month the claimant filed the modification petition as the default date if the award is premised on a change in the miner's condition. 64 FR 55050 (Oct. 8, 1999). In the comments accompanying the promulgation of 20 CFR 727.302, the Secretary explained the reasoning behind the adoption of a default entitlement date:

> This approach was adopted in view of the great difficulty encountered in establishing a date certain on which pneumoconiosis, often a latent, progressive, and insidious disease, progressed to total disability. The filing date was thought to be fair since proof of onset, which was usually obtained after filing, would likely fix the date of total disability at the time at which the medical tests were administered. The filing date, on the other hand, was likely to be a more accurate measure of onset since it would be the date, or close to the date, on which the claimant felt the need to file for benefits, presumably because disability had become total.

43 FR 36828–36829 (August 18, 1978). The Secretary also emphasized that ''a reasonable effort will always be made to establish the month of onset.'' 43 FR 36806 (August 18, 1978).

Section 725.503 therefore deals with the difficulties inherent in identifying the particular month a miner's lung condition deteriorated to the point he became totally disabled due to pneumoconiosis. As noted above, the Department has long since concluded that pneumoconiosis is a latent and progressive disease which may manifest itself pathologically over a lengthy period of time. *See generally* § 718.201, responses to comments. As a result, detecting the precise month when the deterioration reached the level of compensable disability is problematic at best. In addition, clinical evidence of disability on a particular date does not mean the miner became disabled that day. The test may simply detect a condition which developed sometime earlier. *Green* v. *Director, OWCP*, 790 F.2d 1118, 1119 n.4 (4th Cir. 1986). Notwithstanding these difficulties, however, an award of benefits must set a date from which those benefits are payable. 20 CFR 725.503(f); 64 FR 55050 (Oct. 8, 1999). If the medical evidence in a particular case pinpoints the disability date, that date must be used. In many cases, the evidence is inconclusive or contradictory over time. Even if the earliest positive evidence establishes the miner's entitlement, that evidence only proves the miner was disabled on that date. Such evidence is entirely consistent with a compensable disability antedating the medical testing for some unknown period of time. *See Green,* 790 F.2d at 1119 n. 4. Consequently, the Department has consistently found a default entitlement date necessary, as a rule of administrative convenience, in order to implement the black lung program in an effective manner. *See generally* 30 U.S.C. 936(a) (authorizing Secretary to ''issue such regulations as [she] deems necessary to carry out the provisions of'' title IV). The choice of the filing date reflects the rational assumption that claimants, by and large, file claims or modification petitions when they believe themselves entitled to benefits (although compensable disability may in fact have occurred either prior to, or after, the application date). The Department recognizes claimants may file modification petitions for other reasons as well, *e.g.,* the claimant may secure the services of an attorney, obtain new medical evidence, or intend to prevent the underlying claim from becoming finally denied. These reasons do not detract from the underlying logic of the default onset date; rather, they simply explain why a claimant takes a particular action at a particular time. The natural impetus to pursue benefits at all is the individual's belief that (s)he is entitled to them. Like the default onset date for claims, the same explanation supports a similar approach for awards obtained on modification if the miner's condition has changed to the point of compensable disability and the actual onset date cannot be ascertained.

The Department believes the filing date strikes a reasonable balance between overcompensating and undercompensating the miner. Section 6(a) requires the liable party to pay benefits ''from the date of the disability.'' 33 U.S.C. 906(a), as incorporated. If the medical evidence does not identify that date, the miner might receive either more, or less, compensation than the amount to which (s)he is entitled by using the filing date. Obviously, if the medical evidence proves that the miner became disabled only after he filed, then the filing date is inapplicable; the adjudicator must select some later date to avoid compensating the miner for a period of time when (s)he was not eligible. *See Rochester & Pittsburgh Coal Co.* v. *Krecota*, 868 F.2d 600, 603 (3d Cir. 1989) (holding that ALJ erroneously relied on filing date when medical evidence clearly indicated miner was not disabled until several years later). Absent such evidence, however, the rationale underlying section 725.503 ensures the miner will receive the approximately correct amount of compensation. Accordingly, the Department rejects the comment's position that a default onset date based on a filing date—of either a claim or a modification petition—violates section 6(a).

The same comment also states that the use of default onset dates originated under part B of the BLBA and derives from the Social Security Act. The commenter contends that section 6(a) supersedes the Social Security Act rule for purposes of part C of the BLBA. As discussed above, default onset dates are entirely consistent with section 6(a). Furthermore, the comment does not explain why their origin has any legal relevance. The comment does not state a basis for eliminating default onset dates for part C claims.

(d) One comment opposes using the date the claimant petitioned for modification as the default onset date if benefits are awarded based on a change in the miner's condition. The commenter contends the proper default date should be immediately after the date of the adverse decision which was overturned on modification. For the reasons set out in comment (c), the Department rejects this suggestion. The filing date is the most rational point to begin benefits if the date on which the miner's pulmonary condition changed sufficiently to make him or her entitled to benefits is not established by the evidence of record. If, however, the record contains credible evidence of the miner's entitlement predating the modification petition, the onset date should be the date of that evidence provided no later credible evidence refuting entitlement exists, and the evidence was developed after the date on which the most recent denial by a district director or administrative law judge became effective.

(e) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.515

(a) The Department did not open § 725.515 for comment when it issued the initial notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). The Department proposed amending § 725.515 in its second notice of

proposed rulemaking to conform it to changes in federal law which make black lung benefits payable by the Black Lung Disability Trust Fund subject to garnishment for child support and alimony. 64 FR 54971, 55001 (Oct. 8, 1999).

(b) Although one comment has suggested the Department allow claimants and responsible operators to negotiate settlements rather than fully litigate every claim, the Department opposes this suggestion. The Department's principal response to the issue of settlements appears in the Final Regulatory Flexibility Analysis, below. The Department takes the same position with respect to any assignment, release or commutation of benefits except to the extent authorized by the Black Lung Benefits Act (BLBA) or the Secretary's regulation. Such agreements are void. *Norfolk Shipbuilding & Drydock Corp.* v. *Nance,* 858 F.2d 182, 186 (4th Cir. 1988), *cert. den.* 492 U.S. 911 (1989). The BLBA prescribes precisely the amount of monthly benefits to which a claimant is entitled. 30 U.S.C. 922(a). This statutory compensation schedule represents Congress' judgment as to the reasonable level of monthly benefits a totally disabled miner or his or her survivor should receive. By incorporating section 16 regarding releases (and 15 regarding waiver, *see Brown* v. *Forest Oil Corp.,* 29 F.3d 966, 968 (5th Cir. 1994)) of the Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 916, 915, into the BLBA, 30 U.S.C. 932(a), Congress demonstrated its intent to ensure that claimants receive the full amount of benefits to which they become entitled, thereby having less need to resort to other means of support, including public assistance. *See generally* 1 *Larson's Workers' Compensation Law* (MB) § 1.03[2] (1999). Moreover, making agreements to reduce, divert or bargain away benefits absolutely void also provides some level of protection to claimants' rights; no party who negotiates such an agreement can rely on its terms in the event the claimant elects to pursue his or her full rights under a claim. Such protections are especially appropriate given the claimant population most affected by the BLBA, *i.e.,* elderly, disabled and less educated retired workers and their survivors. Prohibiting settlements also recognizes the progressive nature of pneumoconiosis. Because this disease may evolve over a period of years, the availability of settlements may encourage a miner-claimant to forego a future claim for full benefits after the pneumoconiosis has progressed to the point of compensable disability in lieu of the present payment of a lesser amount. The Department therefore considers settlements ill-suited to the BLBA program. Finally, although it incorporated sections 16 and 15 of the LHWCA into the BLBA, Congress did not incorporate section 8 (allowing for district director approval of certain settlements under the LHWCA). The Department does not believe Congress meant to allow settlements to occur under the BLBA in the absence of an express and direct incorporation of such intent.

(c) No comments were received concerning this section, and no further changes have been made in it.

20 CFR 725.522

In its initial notice of proposed rulemaking, the Department proposed a shortened § 725.522, in which subsections (a) and (b) of 20 CFR 725.522 were combined in proposed § 725.522(a). Discussion of when benefit payments are due was moved to a newly expanded § 725.502. These proposed changes were part of a general rewriting of the regulations governing the payment of benefits, Part 725, Subpart H. 62 FR 3365–67 (Jan. 22, 1997). Although no comments were received concerning this section, the Department reiterates that the cost of a miner's complete pulmonary examination at Trust Fund expense—defined as a ''benefit'' under § 725.101(a)(6)—is not a payment included within ''overpayments'' for purposes of subsection (b). *See* 62 FR 3351 (Jan. 22, 1997); 64 FR 54982 (Oct. 8, 1999). No changes have been made in this section.

20 CFR 725.530

(a) In its initial notice of proposed rulemaking, the Department proposed a new § 725.530(a), setting out an operator's or carrier's obligation to pay benefits immediately when they become due pursuant to an effective order, and the consequences of an operator's failure to pay such benefits. 62 FR 3415–16 (Jan. 22, 1997). This proposed change was part of a general rewriting of the regulations governing the payment of benefits, Part 725, Subpart H. 62 FR 3365–67 (Jan. 22, 1997).

(b) Two comments object generally to the imposition of a ''penalty'' for an operator's failure to pay benefits when due, citing comments addressed to § 725.502. For the reasons expressed in the response to those comments, no changes are made to either regulation.

(c)(i) Several comments object to the imposition of a ''penalty'' for failure to pay a benefit within ten days after the payment is due, arguing that ten days is not enough time to calculate correct benefit amounts under the Black Lung Benefits Act (BLBA). The Department disagrees. This regulation does not change existing law in any material manner. The BLBA incorporates § 14 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 914, which governs the payment of compensation under that Act. 30 U.S.C. 932(a). Section 14(f) provides that additional compensation, in the amount of twenty percent of unpaid benefits, shall be paid if an employer fails to pay within ten days after the benefits become due. The twenty-percent additional compensation provision has been an incorporated provision of Part C since the inception of the statute. Consequently, § 725.530 merely restates existing law: failure to pay the full amount of benefits owed the claimant within ten days after the benefits are due shall result in the payment of an additional twenty percent of the unpaid benefits. *See also* § 725.607(a) (twenty-percent additional compensation assessed on unpaid benefits); *Sproull* v. *Director, OWCP,* 86 F.3d 895, 900–01 (9th Cir. 1996), *cert. den. sub nom. Stevedoring Services of America, Inc.* v. *Director, OWCP,* 117 S.Ct. 1333 (1997) (holding twenty percent additional compensation applies to late payment of interest notwithstanding employer timely paid underlying benefits) This assessment is self-executing, and attaches automatically upon the failure to make timely payment regardless of any equitable considerations explaining the untimeliness. *Severin* v. *Exxon Corp.,* 910 F.2d 286, 288 (5th Cir. 1990). The Department also notes that monthly benefit amounts are fixed by law and adjusted only once a year. Most black lung benefits are paid by insurance companies or self-insured coal companies who have ready access to current monthly benefits rates and the expertise to make any necessary computations. Finally, the Department notes that the actual amount of time available to the party liable for benefits to make a timely payment has been enlarged by virtue of changes made in § 725.502(b). That regulation requires the liable party to pay the benefits due, pursuant to an effective order, for any given month by the fifteenth day of the following month. 64 FR 55050 (Oct. 8, 1999). Liability for additional compensation in the amount of twenty-percent for defaulting on a payment cannot be invoked until an additional ten calendar days have passed after the monthly benefit becomes due. *See Pleasant-El* v. *Oil Recovery Co., Inc.,* 148 F.3d 1300, 1303 (11th Cir. 1998); *Burgo*

v. *General Dynamics Corp.,* 122 F.3d 140, 143 (2nd Cir. 1997) *cert. den.* 118 S.Ct. 1839 (1998); *Reid* v. *Universal Maritime Serv. Corp.,* 41 F.3d 200, 202 (4th Cir. 1994); *Irwin* v. *Navy Resale Exchange,* 29 Ben. Rev. Bd. Serv. 77 (1995); *contra Quave* v. *Progress Marine,* 912 F.2d 798, 800 (5th Cir. 1990) (holding ten days means ten business days). With respect to the initial payment after entry of an award, the responsible operator should always have at least 25 days (as shown by the following example) in which to make the computation and make the first payment of monthly benefits. If an award becomes effective on the last day of January, the operator has until February 15th in which to pay the benefits attributable to January; the operator also has an additional ten days to avoid liability for additional compensation. This amount of time should be sufficient to allow the calculation of the benefit amount due and pay the claimant, and therefore to comply fully with the regulatory deadlines. This minimum period of 25 days comes close to the 30 day-period suggested by one comment as ''more reasonable.'' In fact, in cases in which the order awarding benefits becomes effective at the beginning of the month, the operator will have far more than the suggested 30 days in which to issue the check. As for payments subsequent to the initial payment, the operator has ample time to calculate and issue the monthly benefits check before incurring the assessment of additional compensation for untimeliness. Continuing with the previous example: If the operator has made the initial payment on February 15th, the next installment is not due until March 15th; the operator then has an additional ten days until the § 14(f) assessment attaches in which to make the payment. (ii) The more complex computations involve retroactive benefits. Under § 725.502(b)(2), an operator need not pay retroactive benefits until the district director computes this amount, within 30 days after issuance of an effective award, and informs the responsible operator of it. Benefits and interest for periods prior to the effective date of the order are not due until the thirtieth day following issuance of the district director's computation. This time is sufficient to verify the district director's computation, and actually allows the employer considerably more time than the ten days provided by 20 CFR 725.607(a) in which to pay retroactive benefits before liability for twenty-percent additional compensation may be imposed.

(c) One comment contends the proposed changes depart from current departmental practice and penalize operators for appealing awards of benefits. The Department disagrees. Section 14(f), as noted above, is an incorporated statutory provision which has been a part of part C of the BLBA from the beginning. Its incorporation represents a policy determination by Congress to promote the prompt compliance of a responsible operator with the terms of an effective award. The proposed changes to the regulations do not vary the operation of section 14(f). Rather, they simply implement Congress' intent in placing section 14(f) into the BLBA. Whether current administrative practice does not apply section 14(f) to the maximum extent cannot change the plain meaning of the provision. Finally, imposition of additional compensation for failing to pay benefits in a timely manner is not a penalty for pursuing an appeal of an award. Section 14(f) is a tool for ensuring compliance with an operator's benefits obligations once an effective award is in place and regardless of what subsequent litigation strategy the operator chooses to pursue.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.533

The Department did not open § 725.533 for comment when it issued the initial notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). When the Department issued its second notice of proposed rulemaking, it proposed minor changes in the regulation and invited comments from the public. 64 FR 54971, 55001–02 (Oct. 8, 1999). Specifically, the Department proposed deleting provisions concerning section 415 ''transition'' claims, 30 U.S.C. 925, in both the current 20 CFR 725.403 and 725.533. Although the Department does not intend to alter the rules applicable to any section 415 claim that may remain in litigation, parties have adequate access to these rules in earlier editions of the Code of Federal Regulations. In the final rule, the Department has added a comma after the word ''circumstances'' in the first sentence of subsection (a) for grammatical purposes. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 725.537

(a) The Department proposed changing § 725.537 in the initial notice of proposed rulemaking to harmonize the regulation with proposed § 725.212(b), which requires full benefits to be paid to each surviving spouse of a deceased miner if more than one eligible survivor exists. 62 FR 3366, 3417 (Jan. 22, 1997).

(b) Two comments state that the Department cannot retroactively apply the regulation permitting more than one surviving spouse of a deceased miner to receive monthly benefits as a beneficiary without regard to the existence of any other entitled spouse (*see* § 725.212(b)). The comments contain no citation to specific precedent and no further explanation. They do not afford the Department a sufficient basis for any change to the regulation. The Department has also addressed comments concerning the retroactive effect of the regulations in connection with § 725.2, and *see* 64 FR 54981–82 (Oct. 8, 1999).

(c) One comment contends the change permitting full benefits to multiple survivors is grounded on a false premise. The commenter states that the Social Security Administration (SSA) did not grant full benefits to multiple surviving spouses under part B of the Black Lung Benefits Act (BLBA), and ''required'' the Department to use the same rules. The comment does not provide any basis for either proposition. The Department rejects the comment for several reasons. First, the commenter cites no statutory authority, SSA regulation, or other evidence for its description of SSA practice, and thus no conclusions can be drawn about that agency's official practice concerning the issue. Second, SSA administered Part B of the BLBA, but the Department has had sole authority over Part C since January 1, 1974. Whatever SSA's internal views or practice, it cannot bind the Department if the Department concludes the statute requires a different result. Third, the Department believes the law compels what the revised regulation provides. In the initial notice of proposed rulemaking, the Department provided a detailed legal analysis of the pertinent statutory authorities and legislative history, all of which support awarding full monthly benefits to more than one surviving spouse. *See* 62 FR 3350–51 (Jan. 22, 1997). Congress amended the Social Security Act in 1965 to allow benefits to a divorced surviving spouse as a ''widow'' of the miner. Pub. L. No. 89–97, section 308(b)(1), 79 Stat. 286 (1965). The legislative history of the amendment clearly established Congress' intent that payment of benefits to two (or more) ''widows'' would not reduce the benefits paid to either. S. Rep. No. 404, 89th Cong., 1st Sess. (1965), *reprinted in* 1965 U.S.C.C.

& A.N. 1943, 2047. In 1972, Congress amended the BLBA definition of ''widow'' to use the Social Security Act definition. 30 U.S.C. 902(e). The legislative history is equally clear that Congress intended to conform the BLBA definition to the Social Security Act definition. S. Rep. No. 743, 92nd Cong., 2d. Sess., *reprinted in* 1972 U.S.C.C. & A.N. 2305, 2332. The BLBA also reinforces this interpretation because it requires a ''widow'' to receive benefits at prescribed rates and makes no allowance for a reduction based on the existence of more than one widow. 30 U.S.C. 922(a)(2). To date, two courts of appeals and the Benefits Review Board have accepted the Department's position. *Peabody Coal Co.* v. *Director, OWCP [*Ricker*]*, 182 F.3d 637, 642 (8th Cir. 1999); *Mays et al.* v. *Piney Mountain Coal Co.,* 21 Black Lung Rep. 1–59, 1–65/1–66 (1997), *aff'd* 176 F.3d 753, 764–765 (4th Cir. 1999). No court has reached a contrary result, and no comment has addressed the substance of this analysis. Consequently, the Department has no basis for changing the regulation.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.543

(a) The Department did not open § 725.543 for comment when it issued the initial notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). The Department received a number of comments, however, offering general criticisms of the overpayment waiver and adjustment criteria; the program had been using criteria developed by the Social Security Administration (SSA) for waiver of overpayments incurred under Part B of the Black Lung Benefits Act (BLBA). In response, the Department proposed revising § 725.543 to adopt the waiver standards in 20 CFR part 404, which are used by the SSA in administering title II of the Social Security Act. 64 FR 55055 (Oct. 8, 1999). The Department explained that the part 404 criteria better reflect the current law than the part 410 criteria because the part 410 have not been revised since 1972. 64 FR 55002 (Oct. 8, 1999).

(b) One comment generally opposes the extension of the overpayment waiver and recovery procedures to claims involving responsible operators, and incorporates by reference its response to § 725.547. The comment does not specifically address the substance of proposed § 725.543. The Department responds to comments concerning § 725.547 at that provision.

(c) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.544

(a) The Department did not open § 725.544 for comment when it issued the initial notice of proposed rulemaking, 62 FR 3341 (Jan. 22, 1997). The Department did receive one comment which noted that the maximum amount subject to compromise had been raised to $100,000. 64 FR 55002 (Oct. 8, 1999). The Department proposed changing § 725.544 to reflect that fact, and to replace the reference to the Federal Claims Collection Act of 1966, now repealed, with a citation to 31 U.S.C. 3711. 64 FR 55055–56 (Oct. 8, 1999).

(b) One comment opposes in general terms the extension of the overpayment waiver and recovery procedures to claims involving responsible operators, and incorporates by reference its response to § 725.547. The comment does not specifically address the substance of proposed § 725.544. In any event, this provision only applies to the compromise of debts owed the United States government. *See* 31 U.S.C. 3711(a).

(c) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.547

(a) In the initial notice of proposed rulemaking, the Department proposed amending § 724.547 to extend the waiver and adjustment provisions to overpayments owed by claimants to responsible operators. 62 FR 3366, 3419 (Jan. 22, 1997). Formerly, these protections had applied only to claimants who had been overpaid by the Trust Fund. 20 CFR § 725.547(a). The Department concluded that the opportunity to obtain a waiver or adjustment of the debt should be made available to all claimants regardless of their benefits' source. The Department received numerous comments opposing the proposed change for a variety of reasons. 64 FR 55002–03 (Oct. 8, 1999). Comments urging the Department to limit recoveries to the adjustment of future benefits, and objections based on increased difficulties for operators in recovering overpayments, were rejected based on the policy considerations set forth in the initial notice of proposed rulemaking. 62 FR 3366–67 (Jan. 22, 1997). The Department also rejected the position that waiver of an overpayment owed an operator amounted to the unconstitutional deprivation of property, citing caselaw upholding overpayment recoveries under the more restrictive Longshore and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. 914(j), 922, as incorporated by 30 U.S.C. § 932(a). Finally, the Department addressed comments urging changes in the legal test for waiver by noting that the test is derived from an incorporated provision of the Social Security Act (SSA). The Department did, however, propose changes to § 725.543, adopting more current criteria for waiver. *See* 64 FR 55055 (Oct. 8, 1999).

(b) Two comments oppose the Department's use of the SSA waiver provisions rather than the LHWCA approach to the problem. The Black Lung Benefits Act (BLBA) incorporates the overpayment provisions of both statutes. 42 U.S.C. 404(b), as incorporated by 30 U.S.C. 923(b), 940 (SSA); 33 U.S.C. 914(j), 922, as incorporated by 30 U.S.C. 932(a) (LHWCA). The SSA requires the agency to obtain reimbursement of overpaid benefits unless the claimant can prove recovery would either deprive him of the financial resources to pay for necessary expenses, or violate equity and good conscience regardless of his financial condition. The LHWCA, however, limits recovery to the adjustment of future benefits; if no benefits will be paid, no overpayment can be recovered. In the initial notice of proposed rulemaking, the Department reviewed the reasons for using the SSA provisions: judicial precedent upholding the Department's authority to recover overpayments under the SSA scheme; adverse financial consequences for the Fund if the Department used the more restrictive Longshore provisions; and the protections afforded claimants by the waiver procedure, which limits recovery to those individuals who can afford to reimburse the overpaid benefits. 62 FR 3366–67 (Jan. 22, 1997). In the second notice of proposed rulemaking, the Department acknowledged the comments advocating use of the LHWCA model but relied on the policy considerations previously advanced. 64 FR 55002 (Oct. 8, 1999). The Department continues to believe that these considerations provide valid reasons for using the SSA provisions as the basis for the Department's overpayment recovery procedures. Moreover, adopting the more current overpayment criteria in 20 CFR part 404 will conform the Department's practice to changes in the law since 1972. *See* 64 FR 55055 (Oct. 8, 1999). The Department therefore disagrees with the commenters who urge that the SSA overpayment procedures be abandoned in favor of the LHWCA model.

(c) One comment states that the Department's response to comments in the second notice of proposed rulemaking, 64 FR 55002–03 (Oct. 8, 1999), failed to answer several concerns raised in the initial round of comments. Specifically, the original comment contended that: the LHWCA provisions supersede the SSA provisions with respect to part C claims, citing *Bracher* v. *Director, OWCP,* 14 F.3d 1157 (7th Cir. 1994); the Department must evaluate the cost of recovering overpayments against the amounts actually recovered; caselaw on waiver issues contradicts the Department's view that the standards will protect claimants from burdensome recoveries; and courts apply inconsistent interpretations of the waiver standards. None of the commenter's arguments warrant changing the basic overpayment recovery procedures. (i) The Seventh Circuit Court of Appeals' decision in *Bracher* does not support the commenter's position. The Court actually declined to address the relationship between the SSA and LHWCA overpayment provisions because the petitioner failed to make the argument in earlier proceedings. 14 F.3d at 1161. The Court also noted, in passing, that the Department has the explicit statutory authority in 30 U.S.C. 932(a) to modify incorporated LHWCA provisions by issuing regulations which vary the terms of those provisions. (ii) With respect to the costs involved in undertaking overpayment proceedings, this factor may be considered in determining whether to pursue individual cases. Cost alone is not a reason to ignore the duty to recover overpayments imposed by the BLBA. (iii) The Department disagrees that the cases cited by the commenter demonstrate that the waiver and recovery procedures provide inadequate protection of claimants' interests. The comment incorrectly states that the Seventh Circuit upheld a $47 difference between a claimant's monthly income and expenses as a sufficient cushion to allow repayment of an overpayment. *Benedict* v. *Director, OWCP,* 29 F.3d 1140 (7th Cir. 1994). The Court actually found that the claimant's monthly income exceeded his expenses by at least $110 (not including interest income), and that the available financial assets would enable the claimant to repay the overpayment without adverse effect on his living standard. The comment also cites *Bracher,* 14 F.3d 1157, as another example of the lack of protection afforded claimants by the waiver procedures. In that decision, the Seventh Circuit held an individual cannot claim reliance on ''erroneous information'' from the agency as a basis for waiver if the ''information'' is a district director's award which is later overturned. The Court correctly noted that characterizing such awards as erroneous agency information would result in waiver for virtually any overturned award, and render meaningless a regulatory provision which makes interim awards ''overpayments.'' 14 F.3d at 1162. *See also McConnell* v. *Director, OWCP,* 993 F.2d 1454, 1458 (10th Cir. 1993); *Weis* v. *Director, OWCP,* 16 Black Lung Rep. 1–56, 1–58 (1990). The comment does not explain in what manner *Bracher* proves the Department has exaggerated the extent to which the waiver and recovery regulations protect claimants' interests. (iv) Finally, the commenter contends that the circuits have reached inconsistent results in determining whether to waive recovery of overpayments, citing *Benedict,* 29 F.3d 1140, and *McConnell,* 993 F.2d 1454. Specifically, the comment expresses concern that one court granted a waiver for the claimant because he spent the benefits on a vacation while another court denied waiver to a claimant who saved the benefits. The results reached in these cases are not inconsistent. In *McConnell,* the Court granted the waiver because the miner relied on the receipt of the benefits to pay for the vacation; his detrimental reliance could be directly linked to the benefits because he would not have taken the vacation without the additional money. The Court concluded that permitting the Department to recoup the amount of benefits spent on the vacation would violate ''equity and conscience.'' 993 F.2d at 1461. With respect to the balance of the overpayment, the Court held that the miner had the financial capacity to repay the benefits because he had a $114 monthly cushion after comparing his income and expenses. 993 F.2d at 1160. Similarly, in *Benedict,* the Court considered a $110 monthly cushion sufficient. The Court rejected the argument that recovery would violate ''equity and good conscience'' because the miner did not relinquish any right or, unlike McConnell, undertake an expense because of the availability of the benefits. The Department therefore rejects the comment's interpretation of these decisions.

(d) One comment focuses on the differences between the LHWCA and BLBA programs as a basis for distinguishing caselaw under the LHWCA holding that limitations on overpayment recovery do not deprive employers of property rights. The comment stresses that LHWCA claimants generally suffer job-related traumatic injuries which are promptly known by the employer, and the claims litigation is resolved quickly. By contrast, the commenter notes that BLBA claimants generally file after retirement and the entitlement litigation is lengthy because the issues are contentious; the protracted litigation therefore causes delays and correspondingly larger overpayments since operators must pay benefits during the litigation. Based on these contrasts, the comment argues that the limitations imposed on the operator's right to recover overpayments by § 725.547 should be abandoned because the operator has no effective means of defending its interests. In effect, the commenter argues that the inherent delays in BLBA claims adjudication raise due process concerns because the delays generate large overpayments which will be uncollectible under § 725.547.

The comment rests on the premise that inherent delays exist in the adjudication of black lung claims, and that the delays amount to *per se* denial of due process. Delay alone, however, is not a due process violation. *C & K Coal Co.* v. *Taylor,* 165 F.3d 254, 259 (3d Cir. 1999). ''It is not the mere fact of the government's delay that violates due process, but rather the prejudice from such delay.'' *Consolidation Coal Co.* v. *Borda,* 171 F.3d 175, 183 (4th Cir. 1999). In the context of black lung entitlement litigation, delays have prompted courts to transfer liability from operators to the Black Lung Disability Trust Fund because agency errors have deprived the operators of the ability to defend themselves in a meaningful manner as required by due process. *Island Creek Coal Co.* v. *Holdman,* 202 F.3d 873, 883–84 (6th Cir. 2000); *Borda,* 171 F.3d at 183–84; *Lane Hollow Coal Co.* v. *Director, OWCP [Lockhart],* 137 F.3d 799, 808 (4th Cir. 1998). In each of those cases, unwarranted delays by the agency precluded the operators from asserting defenses to liability; in effect, the claimant won by default. Accordingly, delay at some point in the opportunity for adjudication of a case may constitute a denial of due process, but a mere allegation of delay without any explanation why the delay is unreasonable does not substantiate a due process violation. *Abbott* v. *Louisiana Ins. Guaranty Assoc.,* 889 F.2d 626, 632–33 (5th Cir. 1989), citing *Cleveland Bd. of Education* v. *Loudermill,* 470 U.S. 532, 547 (1985).

The commenter implies that the prejudice which establishes the denial

of due process is the unrecoverable overpayments generated by the time-consuming litigation over entitlement. The possibility exists that some claims will be approved and require years of litigation before final denial, thereby generating large overpayments that may be waived in overpayment proceedings under § 725.547. Such a possibility, however, does not establish a general violation of due process. First, the Department is not solely responsible for the delays in black lung benefits litigation, and the caselaw is clear that only prejudicial delays caused by the government are the basis for due process concerns. Second, the prejudicial effect of delay must be considered in the factual context of actual cases, and not simply in the abstract. Third, the existence of large overpayments is not necessarily evidence of due process violations. If the underlying entitlement adjudication process works in a fair manner, then due process has been provided and the size of the resulting overpayment is irrelevant. ''The Due Process Clause does not create a right to *win* litigation; it creates a right *not to lose* without a fair opportunity to defend oneself.'' *Lane Hollow Coal Co.,* 137 F.3d at 807 (emphasis in original). Finally, the fact that large overpayments may eventually be waived does not necessarily amount to a due process violation. Section 725.547 provides operators with the opportunity to recover overpayments through an adjudicatory scheme similar to the entitlement process, with rights to evidentiary development, hearing and appeal. The comment does not explain why elimination of the waiver process will enhance the operators' ability to recover overpayments. The comment does not state a sufficient basis for abandoning the regulation.

(e) One comment supports § 725.547.

(f) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.548

(a) Formerly, in any case involving an underpayment or an overpayment, § 725.547(c) and (d) empowered district directors to issue orders protecting the parties' interests and to resolve disputes over the orders using the procedures applicable to entitlement issues. 20 CFR 725.547. Based on its title, ''Applicability of overpayment and underpayment provisions to operator or carrier,'' section 725.547 applied only to cases involving responsible operators. The Department intends that these provisions should apply to overpayment and underpayment cases involving both responsible operators and the Black Lung Disability Trust Fund. Accordingly, the Department proposed § 725.548 in the second notice of proposed rulemaking as a regulation of general applicability, and moved § 725.547(c) and (d) to the proposed regulation. 64 FR 55003, 55056–57 (Oct. 8, 1999).

(b) No comments were received concerning this section, and no changes have been made in it.

Subpart I

20 CFR 725.606

(a) In its initial notice of proposed rulemaking, the Department proposed revising § 725.606 in order to require that uninsured operators, including coal mine construction and coal transportation employers, secure the payment of benefits in individual claims that have been awarded and for which they have been determined liable. 62 FR 3367 (Jan. 22, 1997). The regulation establishes a procedure under which such an operator may be compelled to post the necessary security in the absence of evidence demonstrating that the operator has taken other action to secure the benefit payments. In addition, the regulation distinguishes between operators who were required to, but did not, comply with the security requirement in 30 U.S.C. 933, and coal mine construction and coal transportation employers, who are not required to comply with that requirement. An uninsured employer that failed to comply with 30 U.S.C. 933 is required to post security worth no less than $175,000, while an uninsured employer that is either a coal mine construction or transportation employer is entitled to an individualized assessment of the amount of security required based on actuarial projections. That company also must secure the payment of all future benefits, however. The Department corrected a typographical error in subsection (c) in its second notice of proposed rulemaking, and responded to a comment regarding coal mine construction employers. The commenter argued that the proposal inappropriately imposed personal liability on the corporate officers of a coal mine construction employer that fails to comply with the post-award security requirement, and further stated that the proposal was unnecessary with respect to coal mine construction employers, who comply with their obligations to pay benefits. The Department responded by demonstrating the legal basis for its imposition of personal liability on the officers of corporate coal mine construction employers. The Department also observed that, notwithstanding compliance by coal mine construction employers, there was no basis for excluding construction companies from the requirements imposed by the Black Lung Benefits Act. 64 FR 55003 (Oct. 8, 1999).

(b) One comment continues to disagree with the requirement that coal mine construction employers secure the payment of awarded claims, arguing that the Department's experience with construction employers has been satisfactory. In its second notice of proposed rulemaking, the Department discussed a similar comment at length. 64 FR 55003 (Oct. 8, 1999). The Department did not dispute the observation that coal mine construction employers generally complied with their obligations to pay awarded claims. The Department explained, however, that the proposed revision to § 725.606 represented the Department's attempt to fulfill its responsibility to identify all parties' obligations under the Black Lung Benefits Act. The Department also noted that proposed § 725.606 represented an efficient means of enforcing the obligations of all parties.

The commenter now states that the proposal would impose an onerous and punitive burden on coal mine construction employers. The Department disagrees. The regulation does not require an uninsured employer to deposit funds with a Federal Reserve Bank in every case. Instead, such a deposit is required only if the employer cannot satisfy the adjudication officer that the award is otherwise secured. For example, a large, well-established coal mine construction employer may be able to demonstrate that its current size and assets are sufficient to allow it to pay benefits for the lifetime of the claimant. In such a case, the adjudication officer may permit the employer to meet the security requirement in a manner other than depositing funds with a Federal Reserve Bank. An employer, for example, may purchase an indemnity bond, one of the methods specifically listed in subsection (a), or may request that the adjudication officer approve another mechanism that will guarantee the payment of benefits in case the employer ever becomes unable to meet its obligations.

In addition, the Department does not accept the premise that it must allow coal mine construction employers to avoid the security requirement simply because most of them are current in their payment obligations. If even one such employer currently paying benefits seeks bankruptcy protection, all of the awarded claims for which that employer

is responsible, each of which is worth approximately $175,000, could become the responsibility of the Black Lung Disability Trust Fund. The Department has a duty to protect the assets of the Trust Fund, and thus intends to enforce the post-award security provision incorporated into the Black Lung Benefits Act from section 14(i) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 914(i), as incorporated by 30 U.S.C. 932(a).

(c) One comment states that coal transportation employers are generally unaware of their potential liability for black lung benefits, and are surprised when they are identified as a responsible operator in the adjudication of an individual claim for benefits. At that point, the commenter maintains, any insurance that they are able to purchase will not cover benefits owed to the former employee who has already filed a claim. The commenter requests that the proposed regulations prohibit the case-by-case adjudication of issues of coverage involving coal transportation employers.

The Department does not believe that it is necessary to revise the regulations to provide further guidance to coal transportation employers. Neither does the Department deem it advisable to limit the authority of adjudication officers to apply the pertinent statutory and regulatory definitions to claims for benefits filed by employees of transportation employers. Congress amended the Federal Mine Safety and Health Act in 1977 to include ''any independent contractor performing services or construction'' at the Nation's coal mines.'' 30 U.S.C. 802(d); Pub. L. 95–164, 91 Stat. 1290, § 102(b)(2) (1977). When it amended the Black Lung Benefits Act several months later, Congress specifically recognized, in two separate provisions, that coal transportation companies were now liable for the payment of benefits. First, Congress amended the definition of the term ''miner'' to include ''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.'' 30 U.S.C. 902(d); Pub. L. 95–239, 92 Stat. 95, § 2(b) (1978). In addition, Congress added language to section 422(b) that exempted coal transportation employers, as well as coal mine construction employers, from the requirement that they generally secure the payment of benefits by purchasing insurance or seeking the Department's approval to self-insure their obligations. 30 U.S.C. 932(b); Pub. L. 95–239, 92 Stat. 95, § 7(b) (1978). Congress provided, however, that coal transportation and coal mine construction employers may be required to post a bond or otherwise guarantee the payment of benefits in any awarded claim for which they have been determined liable. *Ibid.* The regulations promulgated by the Department to implement the 1978 amendments also specifically recognized the liability of coal transportation employers. *See* 20 CFR 725.491(a)(1979); 43 FR 36801–02 (Aug. 18, 1978).

Thus, since 1978, both the statute and the regulations have put coal mine transportation employers on notice that they could be held liable for the payment of any benefits owed to their former employees. *See Norfolk & Western Railway Co.* v. *Roberson,* 918 F.2d 1144, 1149–50 (4th Cir. 1990), *cert. denied,* 500 U.S. 916. Accordingly, the Department does not believe that such an employer should be surprised when it receives notification of a claim filed by one of its employees. *Federal Crop Ins. Corp.* v. *Merrill,* 332 U.S. 380, 384–85 (1947) (''Just as everyone is charged with knowledge of the United States Statutes at Large, Congress has provided that the appearance of rules and regulations in the **Federal Register** gives legal notice of their contents.'') Finally, even though a transportation employer is not required to obtain insurance to secure its black lung liability, it remains free to purchase such insurance in order to ensure that its assets are not depleted by the defense and payment of black lung claims.

(d) No other comments were received concerning this section. The Department has corrected one error in the proposed regulation, replacing the phrase ''the United States Treasurer'' in subsection (f) with the term ''a Federal Reserve Bank.'' The Department explained in its initial proposal that the funds will be deposited with the appropriate Federal Reserve Bank rather than the United States Treasurer and had changed similar language in subsection (c). *See* 62 FR 3367 (Jan. 22, 1997).

20 CFR 725.608

(a) The Department proposed revising § 725.608 in its initial notice of proposed rulemaking in order to simplify the regulation, and to allow all parties to a claim to ascertain their obligations and rights with respect to the payment of interest. The proposal recognized that black lung beneficiaries were entitled to the payment of interest on retroactive benefits, additional compensation, and medical benefits. Interest on retroactive benefits starts to accrue 30 days after the first date on which the claimant was determined to be entitled to such benefits. Interest on additional compensation starts to accrue on the date that the beneficiary becomes entitled to additional compensation, while interest on medical benefits starts to accrue on the date that the miner received the medical service or 30 days after the date on which the miner was first determined to be generally eligible for black lung benefits, whichever date is later. 62 FR 3368 (Jan. 22, 1997)

In addition, the proposal specifically required the payment of interest by responsible operators on attorneys' fee awards. 62 FR 3368 (Jan. 22, 1997). In some cases, those awards may be issued long before the award of claimant's benefits becomes final, the first point at which the attorney is able to collect his fee under § 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 928, incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a). The Department did not discuss this regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has replaced the term ''beneficiary'' with the phrase ''beneficiary or medical provider'' in two places in the last sentence of subsection (a)(4). This revision is intended to conform that sentence with the first sentence of subsection (a)(4), which clearly reflects the Department's intention that medical providers as well as beneficiaries are eligible for interest to compensate them for any delays in the payment of medical benefits.

(c) A number of comments oppose the allowance of interest on attorneys' fees in general, and the computation of that interest from the date the fee is awarded until it is paid. In its first notice of proposed rulemaking, 62 FR 3368 (Jan. 22, 1997), the Department explained that the payment of such interest is necessary to buttress the economic value of fees which may take years to become due because of the duration of the underlying litigation of claimant entitlement. Although the Black Lung Disability Trust Fund is not liable for the payment of interest in any event, *Shaffer* v. *Director, OWCP,* 21 Black Lung Rep. (MB) 1–98, 1–99 (Ben. Rev. Bd. 1998), a responsible operator is not obliged to pay attorney's fees until the claimant successfully establishes entitlement to benefits in a final award. Because appeals may delay an award's finality for years, the attorney's fees awarded at earlier stages of the litigation will diminish in real value as a result of inflation. Interest from the date of a fee award, however, will reduce the inroads made by inflation. An award of interest will therefore encourage attorneys to

represent claimants because the value of their fees will be protected, notwithstanding delays in actual payment. The Department wishes to encourage attorney representation of claimants, believing it a means to enhance the fairness of the adjudication process. The Department therefore rejects the commenters' objection to the allowance of interest on attorneys' fees in principle.

With respect to the computation of interest from the date of the attorney fee award, the Department notes that any other date would not afford an attorney maximum protection of the fee's value. Although the operator is under no obligation to pay the fee at the time it is awarded, the primary purpose of subsection (c) is to protect the value of the attorney's fee from its inception. Moreover, an operator who is able to postpone the payment of an attorney's fee by appealing the underlying award of benefits is not entitled to profit from its decision to appeal unless it succeeds in overturning the award. The operator retains the money, and the use of the money, while the appeal is pending. If the award of benefits is ultimately affirmed, the operator should not reasonably expect to be able to retain any of the profits it earned on that money during the appellate proceeding. Instead, those profits, in the form of interest designed to compensate an attorney for delay, rightfully belong to the attorney who had to wait to receive payment of his fee. Consequently, the date of the fee award is the logical date from which to calculate the interest owed.

The same commenters also argue that the Department has no statutory authority to require the payment of interest on attorneys' fees. The award of fees is governed by 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 authorizes the payment of a ''reasonable'' attorney's fee by an employer if, after the employer controverts a claimant's entitlement, the claimant obtains an award of benefits. No fee must be paid until the award is final. The Supreme Court has held that ''[a]n adjustment for delay in payment is * * * an appropriate factor in the determination of what constitutes a reasonable attorney's fee'' under a fee-shifting statute. *Missouri* v. *Jenkins,* 491 U.S. 274, 284 (1989) (decided under Civil Rights Attorney's Fees Award Act); *see also Pennsylvania* v. *Delaware Valley Citizens' Council,* 483 U.S. 711, 716 (1987) (dicta, decided under Clean Air Act); *Goodloe* v. *Peabody Coal Co.,* 19 Black Lung Rep. 1–91, 1–101–102 (1995), *vac. on other grounds sub nom Peabody Coal Co.* v. *Director, OWCP,* 116 F.3d 207 (7th Cir. 1997) (overruling prior decisions prohibiting augmentation of attorney fee for delay, citing *Jenkins*). Consequently, interest on an attorney's fee may be awarded consistent with section 28 to compensate an attorney for delay in receiving his fees.

The Court of Appeals for the Fourth Circuit recently addressed this issue in *Kerns* v. *Consolidation Coal Co.,* 176 F.3d 802 (4th Cir. 1999). A claimant's attorney was awarded fees by an administrative law judge in 1984, but was not able to collect those fees until the award became final in 1990. He then filed a motion for supplemental attorneys' fees based on the six-year delay between the award and its payment. The ALJ denied the motion, and the Benefits Review Board affirmed. In reversing the Board, the court noted that a 1995 decision of the Board, *Nelson* v. *Stevedoring Services of America,* 29 BRBS 90 (1995), had authorized the enhancement of an attorney's fee for delay under the Longshore and Harbor Workers' Compensation Act. The court concluded that ''current law'' thus required enhancement for delay, and remanded the case to allow the ALJ to consider the merits of the attorney's supplemental fee request. 176 F.3d at 805. Section 725.608 simply provides a mechanism for ensuring that claimants' attorneys receive this enhancement in each case involving a responsible operator.

The interest on a fee award provided by section 725.608, of course, provides compensation only for part of the delay that an attorney may face in collecting his fee, *i.e.,* the time between the fee award and the actual payment. It is not intended to compensate the attorney for any delay between the performance of his work and the award of fees by the appropriate adjudicator. If, for example, a claimant filed his application in 1995, and was not awarded benefits by an administrative law judge until 1999, § 725.608 will require only that interest be paid to the attorney from the date the ALJ approves the fee petition until the date that the attorney collects that amount. It will not provide interest from the date on which the attorney performed the work. In such cases, it is the responsibility of the attorney who submits a fee request to ensure that the request reflects any necessary enhancement for the delay between the performance of the work and the award of the fee. There are several methods by which an attorney may seek enhancement of his fee award to cover this delay. For example, the attorney could request the adjudication officer to use the attorney's current rate (his rate at the time he applies for the fee), rather than his historical rate (the rate at the time he performed the work), to calculate the fee to which he is entitled. Thus, the attorney in the example above, who performed 20 hours of work in 1995 but did not submit his fee petition until benefits were awarded in 1999, might use the $125 hourly rate he customarily charged in 1999 rather than the $100 hourly rate he charged in 1995. Using the current rate would permit the attorney to claim an additional $500, and would compensate him for the delay between the time he performed the work and date of the fee award. Another method of attaining the same result would be to calculate a ''lodestar'' amount by multiplying the number of hours the attorney worked by his historical rate, and then requesting the adjudication officer to augment that figure by an additional amount intended to compensate the attorney for the delay. Thus, the attorney in the example might request that the adjudication officer multiply the lodestar amount by an additional 25 percent. In either case, the fee awarded by the adjudicator, in concert with the interest provided by § 725.608, will ensure that when the attorney finally receives payment, he is fully compensated for the work he performed.

(d) One comment supports the allowance of interest on attorney fees and on medical benefits. No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.609

(a) The Department proposed revising section 725.609 in its first notice of proposed rulemaking. In the revised regulation, the Department clarified its intent and authority to enforce a final award of benefits against other parties in the event the named operator is no longer capable of assuming its liability for benefits. The revised regulation outlined the other parties against which such an award might be enforced, including corporate officers and successor operators. The regulation also outlined the circumstances under which the Department may impose liability on these parties. In proposing this regulation, the Department relied on Congress' explicit determination that such entities may be held liable for these awards. 62 FR 3368–69 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment objects to subsection (b)'s imposition of personal liability on corporate officers of companies which provide services at mine sites. The commenter suggests that liability is inappropriate because the officers have never had notice that their employees could be considered miners, and have not previously had knowledge of an obligation to obtain insurance to cover their employees' potential benefit entitlement. The Department rejects this suggestion. Congress amended the statutory definition of ''operator'' in 1977 to include ''any independent contractor performing services or construction at such mine[.]'' 30 U.S.C. 802(d). The current regulations also recognize that an independent contractor may be held liable as a ''responsible operator'' with respect to any employee who performs covered services at a coal mine site. 20 CFR 725.491(c)(1). The Black Lung Benefits Act requires an operator to secure its potential benefits liability by obtaining insurance or qualifying as a self-insurer. 30 U.S.C. 932(b), 933(a). Section 423(d)(1) of the Act authorizes the Department to impose personal liability on certain officers of a corporation if the operator is a corporation that has failed to satisfy its insurance obligations. 30 U.S.C. 933(d)(1). The Department therefore disagrees that application of these provisions to employers engaged as independent contractors providing covered services at mine sites is unfair. Such corporate entities are coal mine operators under the Act, and are liable to their employees when covered employment causes them to become totally disabled by pneumoconiosis. Any such entity is required to anticipate its obligations and take adequate measures to satisfy those obligations as a cost of doing business. Moreover, since 1977, the officers of an independent contractor who meets the Act's definition of the term ''operator'' have been subject to the Act's imposition of liability on the officers of a corporation that fails to meet its security obligations. The revised regulation does not alter the obligation of these officers to obtain the appropriate security, nor does it impose any additional consequences for failing to comply with that obligation. Instead, it simply provides more explicit notice of those consequences.

(c) One comment approves in general terms of the enforcement provisions.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.620

(a) In its first notice of proposed rulemaking, the Department proposed amending the cross-reference in subsection (a) from § 725.495 to subpart D of part 726. This amendment reflected a move to part 726 of the regulations governing the obligations of coal mine operators to secure the payment of benefits. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss § 725.620 in its second notice of proposed rulemaking. *See* Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Two comments urge the Department to revise its regulations to allow parties to settle black lung benefits claims. These comments were listed as relevant to § 725.620(d) in the Department's listing of comments by issue. *See, e.g.,* Exhibit 71 in the Rulemaking Record. They do not directly affect § 725.620, however. Subsection (d) of the regulation implements section 15(b) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 915, as incorporated by 30 U.S.C. 932(a), rather than section 16, 33 U.S.C. 916, as incorporated by 30 U.S.C. 932(a), the statutory provision governing settlements. The Department has responded to the comments concerning settlement of black lung claims in its Final Regulatory Flexibility Analysis.

(c) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 725.621

In its first notice of proposed rulemaking, the Department proposed increasing subsection (d)'s maximum penalty amount from $500 to $550 for failing to file a required report after the date on which the regulations became effective. This revision implements the Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss § 725.621 in its second notice of proposed rulemaking. *See* Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). No comments were received concerning this section. The Department has removed an unnecessary comma from subsection (b) in order to make the regulation easier to understand, but no other changes have been made in it.

Subpart J

20 CFR 725.701

(a) After a miner has been found totally disabled by pneumoconiosis arising out of coal mine employment, (s)he receives fixed monthly benefits for that condition. The miner is also entitled to medical benefits, *i.e.,* treatment, supplies and other medical services for the disabling pneumoconiosis. In its initial notice of proposed rulemaking, the Department proposed amending § 725.701 to establish a presumption of medical benefits coverage for the treatment of any pulmonary disorder. 62 FR 3423 (Jan. 22, 1997). This presumption derived from a judicially-created presumption first announced by the Court of Appeals for the Fourth Circuit in *Doris Coal Co.* v. *Director, OWCP [Stiltner,]* 938 F.2d 492 (4th Cir. 1991). The Department explained the means by which the presumption could be rebutted, and limited the type of evidence relevant to rebuttal by excluding any medical opinion premised on the absence of disabling pneumoconiosis. The Department based its exclusion of certain medical evidence in rebuttal on the fact that the existence of the miner's totally disabling pneumoconiosis had already been established in the underlying claim for monthly benefits. 62 FR 3369, 3423 (Jan. 22, 1997). The Department received a number of comments critical of the presumption. Some comments alleged the presumption would effectively compensate miners for disorders caused by smoking cigarettes and raise the operators' health care costs. Other comments contended the presumption did not have a sound medical basis. 64 FR 55003 (Oct. 8, 1999).

After considering the public's comments and intervening judicial decisions, the Department proposed additional changes to the regulation in its second notice of proposed rulemaking. 64 FR 55060 (Oct. 8, 1999). The Department reviewed the decisions in *Glen Coal Co.* v. *Seals,* 147 F.3d 502 (6th Cir. 1998), and *Gulf & Western Indus.* v. *Ling,* 176 F.3d 226 (4th Cir. 1999). 64 FR 55003–04 (Oct. 8, 1999). The Department noted both decisions agreed that the *Doris Coal* presumption shifted only the burden of production to the party opposing benefits, and was therefore valid under the Administrative Procedure Act (APA), 5 U.S.C. § 556(d) (proponent of rule bears burden of persuasion) and *Director, OWCP* v. *Greenwich Collieries,* 512 U.S. 267 (1994). The Department also pointed out that the majority in *Seals* rested on a relatively narrow point: that the administrative law judge and Benefits Review Board erroneously applied Fourth Circuit precedent when Sixth Circuit law controlled and was inconsistent with *Doris Coal.* 147 F.3d

at 514 (Dowd, D.C.J), 515 (Boggs, J.). Citing the need for a uniform standard of national applicability, the Department proposed several changes to § 725.701. 64 FR 55004 (Oct. 8, 1999). The Department eliminated the reference to ''ancillary pulmonary conditions'' in subsection (b) because the phrase was unnecessary and arguably confusing. 64 FR 55004 (Oct. 8, 1999). The Department also changed the language of subsection (e) to clarify the specific facts which might rebut the presumption that a particular medical expense is compensable. Subsection (e) contains a rebuttable presumption that a pulmonary disorder for which the miner receives a medical service or supply is caused or aggravated by pneumoconiosis. 64 FR 55060 (Oct. 8, 1999). In the second proposal, the Department also clarified subsection (f) to ensure that the party opposing benefits does not attempt to relitigate established facts by using medical evidence for rebuttal which is premised on the absence of totally disabling pneumoconiosis. Finally, the Department acknowledged the controlling weight a report from a treating physician may receive in determining the compensability of a service or supply. 64 FR 55004 (Oct. 8, 1999).

(b) The Department has revised the rebuttal provisions set forth in § 725.701(e) in light of a decision from the Court of Appeals for the Fourth Circuit issued after the second notice of proposed rulemaking entered the final stage of administrative clearance. In *General Trucking Corp.* v. *Salyers,* 175 F.3d 322 (4th Cir. 1999), the Court reviewed the various means of rebutting the *Doris Coal* presumption as presented in *Ling:*

> It is certainly true that if the treatment at issue is found to be 'beyond that necessary to effectively treat a covered disorder, or is not for a pulmonary disorder at all,' then the presumption 'shall not carry the day.' *Ling,* 176 F3d at 233. It does not follow, however, that proof of these two circumstances is the exclusive means of rebutting the presumption.
>
> An employer contesting an award of medical benefits may also rebut the presumption by adducing sufficient credible evidence that the claimant was treated for 'a pulmonary condition that had not manifested itself, to some degree, at the onset of his disability,' or for 'a preexisting pulmonary condition adjudged not to have contributed to his disability.' *Ling,* 176 F.3d at 232.

175 F.3d at 324. The *Salyers* decision emphasizes the importance of affording the party liable for medical benefits an opportunity to rebut the presumption with evidence that the service provided treated a condition which became manifest after the underlying adjudication of entitlement, or that it treated a preexisting pulmonary condition adjudged not to have contributed to disability. It is the Department's intent merely to codify the Court's coverage presumption and its rebuttal methods as outlined in Fourth Circuit precedent. In light of *Salyers* and *Ling,* the Department has revised § 725.701(e) to conform the regulation's rebuttal provisions to the decisions issued by the Fourth Circuit since *Doris Coal.* Accordingly, the Department has replaced the phrase ''was not for a covered pulmonary disorder as defined in § 718.201 of this subchapter,'' with ''was for a pulmonary disorder apart from those previously associated with the miner's disability[.]'' The foregoing explanation also responds to one comment which faulted the Department for omitting any discussion of *Salyers* in the second notice of proposed rulemaking.

(c) In response to its second notice of rulemaking, the Department received numerous comments opposing the medical benefits program in general or the § 725.701(e) presumption in particular because, in the commenters' view, coal mine operators would be forced to pay for medical treatment unrelated to pneumoconiosis, especially respiratory disorders caused by cigarette smoking. These same objections were made to the version of § 725.701(e) contained in the Department's initial notice of proposed rulemaking. 64 FR 55003 (Oct. 8, 1999). In response, the Department noted that operators may submit ''appropriate medical evidence'' showing the particular medical service or supply relates to the miner's smoking-related disease and not his pneumoconiosis. 64 FR 55004 (Oct. 8, 1999). An operator may still make such a showing, although the Department has revised the rebuttal provisions of § 725.701(e) in the final rule. The nexus between the miner's pneumoconiosis and the disorder under treatment is only presumed, and therefore subject to being disproved. The operator may produce evidence showing the treatment was for a particular pulmonary disorder apart from those conditions previously associated with the miner's disability, or exceeds the effective level of treatment for a covered disorder, or did not involve a pulmonary disorder at all. As with the *Doris Coal* presumption, invocation shifts only the burden of production, not persuasion. The operator must confront the presumption by submitting evidence which, if credited, establishes one of the means of rebuttal. Section 725.701(f), however, does preclude one defense: the operator cannot escape liability by trying to prove the medical service cannot pertain to disabling pneumoconiosis because the miner was disabled *solely* from smoking or some other non-occupational cause. Once the miner establishes (s)he is entitled to disability benefits, no element of entitlement can be relitigated or otherwise questioned via the medical benefits litigation. Consequently, the operator and its physician must accept that the miner has a totally disabling respiratory or pulmonary impairment, and that pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of that impairment. *See Ling,* 176 F.3d at 232 and n.13, *citing Doris Coal,* 938 F.2d at 497 (operator cannot rebut presumption of benefits coverage by showing miner's pneumoconiosis did not at least aggravate pulmonary condition because ''[t]he time for that argument had passed with the prior adjudication of disability'').

(d) Two comments state without explanation that the medical benefits program implemented by these regulations will force the coal industry to ''subsidize'' other private health plans and insurance as well as the Medicare program. The Department interprets this contention to mean that the industry and its insurers will be forced to financially assist other health care programs by paying for treatment expenses which are not actually related to the miner's pneumoconiosis, and should be paid by the other programs. The Department disagrees. Congress created the black lung medical benefits program as the primary payor for the treatment of miners afflicted with disabling pneumoconiosis. The program covers the costs of treatment, services and supplies only for that purpose. Consequently, the operator may avoid liability for any expense which is not for the treatment of totally disabling pneumoconiosis, and which therefore should be paid by some other health care program.

(e) One comment contends the Department misinterpreted *Seals* and *Ling* in its analysis of those cases. 64 FR 55003–04 (Oct. 8, 1999). The commenter also states the Department cannot ''overrule'' *Seals* by regulation because that decision is based on an interpretation of the APA. The Department rejects both arguments. The commenter does not identify any specific mischaracterization or other error in the Department's interpretation of either decision. The Department believes its analysis is correct, and declines to change its position on the meaning of those decisions except to the

extent reflected in changes to the rebuttal provisions contained in § 725.701(e). As for departing from the APA analysis of the majority in *Seals,* the comment is simply incorrect. The specific majority holding of *Seals* reversed the decisions of the administrative law judge and Benefits Review Board because of an incorrect application of Fourth Circuit law to a case arising in the Sixth Circuit. Judge Boggs (concurring), however, agreed with Judge Moore (dissenting) ''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.*'' 147 F.3d at 517. Consequently, the majority holding does not rest on any APA considerations, and a majority of the panel, albeit in *dicta,* acknowledges the Department's authority under *Greenwich Collieries* (and, by extension, the APA) to promulgate regulatory presumptions which reallocate burdens among parties. The Department therefore rejects this comment.

(f) One comment contends the presumption of coverage for pulmonary treatment is not supported by any scientific or medical information. The commenter relies largely on a report prepared by a physician for purposes of the rulemaking proceedings; the physician addresses several of the regulations from a medical standpoint and reviews the medical literature compiled during the rulemaking. With respect to § 725.701(e), the physician challenges the reasonableness of presuming a connection between the miner's pneumoconiosis and any pulmonary disorder for which (s)he seeks treatment. The physician notes that many pulmonary disorders bear no relationship to pneumoconiosis, and their treatment is unaffected by the presence of pneumoconiosis. The physician further contends that each patient encounter must be amply documented by evidence that the treatment is necessary for the miner's pneumoconiosis, and should include medical testing, physical examinations, etc. The Department acknowledges the concerns expressed by the comment and accompanying medical views, but does not consider any change in the regulation to be necessary.

As an initial matter, the fact that a physician might view the presumption as *medically* unwarranted does not necessarily undermine its validity as a *legal,* or evidentiary, presumption. The Department understands the physician's objection to mean a physician would not rely on such a presumption as a basis for treating a patient. Most of the statutory and regulatory presumptions in the black lung benefits program, however, draw factual inferences from a combination of medical and non-medical facts for purposes other than patient care. *See* 30 U.S.C. § 921(c)(1) (miner's pneumoconiosis presumed caused by coal mine employment if miner worked ten years); (c)(3) (miner who has complicated pneumoconiosis irrebuttably presumed totally disabled); 20 CFR. § 727.203(a)(1)–(4) (proof of one of enumerated medical facts about miner's pulmonary condition invokes presumption of all remaining elements of entitlement); 20 CFR. § 725.309 (material change in miner's medical condition presumed if miner proves one element of entitlement in duplicate claim previously not proven). ''Like all rules of evidence that permit the inference of an ultimate fact from a predicate one, black lung benefits presumptions rest on a judgment that the relationship between the ultimate and the predicate facts has a basis in the logic of common understanding.'' *Mullins Coal Co.* v. *Director, OWCP,* 484 U.S. 135, 157 n. 30 (1987), *reh'g den.* 484 U.S. 1047 (1988). The Department explained the logical basis and administrative purpose for the presumption in the notice of reproposed rulemaking. *See generally* 64 FR 55004 (Oct. 8, 1999). A miner who is entitled to disability benefits has proven three basic medical facts: (s)he has pneumoconiosis as that disease is defined by § 718.201; (s)he has a totally disabling respiratory or pulmonary impairment; and the pneumoconiosis significantly contributes to that respiratory or pulmonary impairment. Consequently, the miner has established a connection between the compensable disease and the disabling lung condition. From those proven facts, § 725.701(e) draws a rational inference that the need for treating the miner's compromised respiratory condition at any given time is necessitated, directly or indirectly, by the presence of pneumoconiosis. This inference is rebuttable, and the operator may submit evidence showing the treatment is for a particular pulmonary disorder apart from those conditions previously associated with the miner's disability, or exceeds the effective level of treatment for a covered disorder, or did not involve a pulmonary disorder at all. The Fourth Circuit endorsed the same general line of reasoning in *Ling* when it upheld the validity of the *Doris Coal* presumption. 176 F.3d at 233–34. The Department therefore disagrees with the commenter that § 725.701(e) does not have a supportable basis which satisfies the legal test for a rational presumption.

The physician-commenter also urges the Department to require rigorous medical documentation for each medical treatment service, including contemporaneous objective testing, examinations, etc., to impose quality controls on the treatment program. The Department indirectly addressed this concern in the notice of reproposed rulemaking. 64 FR 55004 (Oct. 8, 1999). The Department noted that it receives 12,000 to 15,000 bills weekly for treatment services, most of which involve relatively minor amounts in the $25.00 to $75.00 range. The Department cited cost effectiveness and promptness as practical reasons for using a presumption of coverage to expedite the administrative process. The presumption supplants the need for more elaborate medical proof that the particular service or expense involves the miner's pneumoconiosis, at least until the operator challenges the expense with credible medical evidence. The Fourth Circuit reached the same conclusion in *Ling:*

> Hence, rather than compel the miner to exhaustively document his claim for medical benefits, *i.e.,* requiring him to again laboriously obtain all the evidence that he can that his shortness of breath, wheezing, and coughing are *still* the result of his pneumoconiosis, we have fashioned the *Doris Coal* presumption as a shorthand method of proving the same thing. The proof needed is a medical bill for the treatment of a pulmonary or respiratory disorder and/or associated symptoms.

176 F.3d at 233 (emphasis in original). Section 725.701(e) does not eliminate the need for medical documentation for treatment and services. The presumption merely provides a short-hand means of identifying expenses which are likely to be legitimate unless the liable party opposes payment of particular expenses.

(g) One comment states generally that the medical benefits program, as reproposed, will promote fraud. Another comment contends that reliance on the miner's treating physician under § 725.701(f) will promote fraudulent payments because the doctor has a financial incentive to attribute the miner's pulmonary problems to pneumoconiosis. The commenter also alludes to a long-standing pattern of abuse of the black lung program by treating physicians who mix compensable and non-compensable services when billing the Trust Fund and operators as documented in *Doris Coal Co.* v. *Director, OWCP,* 938 F.2d 492, 497–98 (4th Cir. 1991). Finally, the comment

objects to the basic concept of special deference to a treating physician's opinion as proposed in § 718.104(d). With respect to allegations of fraud, the professional integrity of any physician should be accepted until particular acts of malfeasance are established in the appropriate forum. The comment's allegations that particular physicians are motivated by financial incentives can as easily be directed toward any party-affiliated physician, or group of such physicians, who may benefit by tailoring conclusions to fit the interests of the party paying for the medical opinion. As for the commenter's specific suggestion that there is no cost containment in the program and that health care providers routinely seek payment from the program for unrelated charges, the Department accepts the holding in *Doris Coal.* In this decision, the Court refused to sanction the practice of submitting an unitemized bill for multiple services because such a practice could impose liability on the insurer for services unrelated to the treatment of the miner's pneumoconiosis and encourage fraud. 938 F.2d at 497–98. The Court, however, only alluded to the potential for fraud if unitemized billing were permitted. It did not address the practice as an historical reality or beyond the facts involving the one treating physician involved in the case. The Department therefore rejects the position that miners' treating physicians should be viewed with special suspicion as a group because of a motive for fraudulent diagnoses and/or treatment. The Department responds to the objections concerning special deference to the treating physician's opinion, as proposed in § 718.104(d), in the preamble to that subsection.

(h) One comment urges the Department to join the lawsuit filed by the Department of Justice to recover money from the tobacco industry for costs incurred by the black lung program in treating sick cigarette smokers. The comment is not directed to any regulatory proposal, and no response is therefore warranted.

(i) The Department received several comments which approve of § 725.701.

(j) No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 725.706

The Department proposed changing the no-approval dollar amount in § 725.706(b) from $100.00 to $300.00 in the initial notice of proposed rulemaking. 62 FR 3424 (Jan. 22, 1997). No comments were received concerning this section, and no other changes have been made in it.

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

The Department has received one comment relevant to Part 726 in its entirety. The Department proposed revising only specific regulations in Part 726, and invited comment only on those regulations, see 62 FR 3340 (Jan. 22, 1997); 64 FR 54970 (Oct. 8, 1999). The Department either made only technical revisions to the remaining regulations in Part 726, or made no changes, *see* 62 FR 3340–41 (Jan. 22, 1997) (lists of technical revisions and unchanged regulations); 64 FR 54970–71 (Oct. 8, 1999) (same). Therefore, no changes are being made to Part 726 in its entirety.

Subpart A

20 CFR 726.2

In its initial notice of proposed rulemaking, the Department proposed adding subsection (e) to this regulation in order to recognize the addition of subpart D, implementing the civil money penalty provision of 30 U.S.C. 933, to part 726. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has capitalized the word ''subpart'' in subsection (b) to be consistent with the use of that word in subparts (c), (d), and (e). In subsection (d), the Department has replaced the phrase ''coal operator'' with the phrase ''coal mine operator'' to be consistent with subsections (c) and (e). No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.3

This regulation was not opened for comment in the Department's first notice of proposed rulemaking. *See* list of Unchanged Regulations, 62 FR 3341 (Jan. 22, 1997). The Department proposed a revision to subsection (b) in its second notice of proposed rulemaking at the request of the Office of **Federal Register** to clarify the treatment of cases in which the regulations in Part 726 appear to conflict with the regulations incorporated from Part 725. 64 FR 55005 (Oct. 8, 1999). In subsection (a), the Department has replaced the phrase ''coal operator'' with the phrase ''coal mine operator'' to be consistent with subsection (b). No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.8

(a) The Department proposed adding § 726.8 in its first notice of proposed rulemaking in order to define certain terms including ''employ'' and ''employment.'' The definition of ''employ'' and ''employment'' proposed in subsection (d), was identical to that in proposed § 725.493(a)(1). 62 FR 3369 (Jan. 22, 1997). In its second notice of proposed rulemaking, the Department incorporated into subsection (d) a change to the definition of the term ''employment'' that it had also made to § 725.493. 64 FR 55005 (Oct. 8, 1999). The Department also responded to comments concerning the retroactive effect of the proposal and the scope of the definitions. The Department stated its belief that the proposal was neither improperly retroactive nor an instrument for creating additional insurer liability. Neither did the proposal intrude on insurance functions reserved to the states. The Department noted the Court of Appeals for the Seventh Circuit's holding 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 Department also justified the scope of the proposed definition as well within the rulemaking authority granted the Department by Congress.

(b) One comment objects to the Department's definitions of the terms ''employ'' and ''employment.'' The commenter argues that the Department is improperly interfering with existing employment relationships by adopting regulations that differ from those provided by state employment and insurance laws. The Department provided a detailed explanation of both its authority and its reasoning for proposing this regulation in its October 8, 1999 proposal. *See* 64 Fed. Reg. 55005 (Oct. 8, 1999). The Department does not agree that the regulations it issues to implement the Black Lung Benefits Act interfere with employment relationships recognized by the various states. The Black Lung Benefits Act requires that a coal mine operator's liability for a miner's black lung benefits be based on that operator's employment of the miner. *See* 30 U.S.C. 932(a) (making the operator of a coal mine liable for benefits based on ''death or total disability due to pneumoconiosis arising out of employment in such

mine''). Congress did not specifically define the term ''employment,'' however. In such cases, an administrative agency is authorized to promulgate regulations to fill the gaps Congress left in the statute. *Morton* v. *Ruiz,* 415 U.S. 199, 231 (1974). In addition, the Department is authorized to promulgate regulations to ensure sufficient insurance coverage for all of the liabilities borne by operators under the Act. 30 U.S.C. 933(b)(3) (permitting the Secretary to promulgate regulations governing the content of insurance policies issued to cover liability under the Black Lung Benefits Act). The Department's definition of the terms ''employ'' and ''employment'' is intended to meet its responsibility to properly administer the Black Lung Benefits Act. The Department does not believe that its definitions will in any way affect the application of state law to the relationships between coal mine operators and the miners they employ.

(c) The same commenter also argues that the Department's regulation will eliminate the ability of a coal mine operator to enter into an employee leasing arrangement with an employee leasing company. The commenter observes that the current model employee leasing rule of the National Association of Insurance Commissioners requires the employee leasing company to provide workers' compensation coverage, including federal black lung benefits coverage, for its employees. According to the commenter, the Department's proposal, which would hold lessors responsible for the insurance of their leased employees, will make employee leasing a less viable option.

The Department does not believe that its proposal will interfere with an employer's economic decision to use leased employees in its coal mine operations. Moreover, the Department does not intend to force coal mine operators to secure the payment of benefits for leased employees when the leasing company has already obtained the necessary insurance. In such cases, the operator will be considered to have met the security requirements of the Act with respect to those employees. Such a practice is sound from the point of view of both the traditional coal mine operator and the employee leasing company. Although the commenter suggests that leasing companies are not mine operators, that is not entirely clear under the Black Lung Benefits Act. Section 423(a) of the Act, 30 U.S.C. § 933(a), requires ''each operator of a coal mine'' to secure the payment of benefits by qualifying as a self-insurer or purchasing insurance. The term ''operator,'' as used in section 423(a), includes ''independent contractors who perform services or construction at such mines.'' 30 U.S.C. § 802(d). This definition of ''operator'' thus includes companies that provide employees under a leasing arrangement. The Department therefore does not agree that employee leasing companies should not be considered ''operators'' under the Black Lung Benefits Act. The Department's ability to monitor the use of temporary contractual arrangements by the coal mining industry, however, is limited. In addition, the commenter's different interpretation of the term ''operator'' suggests that any effort to impose civil money penalties on a leasing company under Part 726, or to assign liability to such an entity under Part 725, would be vigorously contested. Accordingly, the Department has defined the terms ''employ'' and ''employment'' in a manner which maximizes its ability to ensure the insurance coverage of leased employees.

By contrast, the application of both Parts 725 and 726 to traditional coal mine operators is quite clear. The Act authorizes the Department to ensure that all of the individuals performing mining work under that operator's direction are covered by appropriate security. In addition, those coal mine operators who use leased employees are in the best position to ensure that those employees are covered by the necessary insurance. The Department does not intend to require that the traditional coal mine operator purchase insurance when the leasing company has done so, but it does intend the regulations to provide an incentive for the coal mine operator to deal only with those leasing companies that have purchased insurance meeting federal standards for black lung benefits coverage. *See* 20 CFR 726.203 (1999). Contrary to the commenter's suggestion, the rule thus does not make insurers and state funds the enforcement officers of the Department. Rather, the traditional coal mine operator is simply on notice that it may be held liable for the benefits of leased employees if the leasing company fails to procure the necessary insurance coverage, or for any civil money penalties arising as a result of that failure.

(d) Finally, the same comment objects that the Department's regulation is impermissibly retroactive. The Department has discussed the retroactive effect of its regulations in considerable detail in both its first and second notices of proposed rulemaking. *See* discussions of § 725.2 at 62 Fed. Reg. 3347–48 (Jan. 22, 1997) and 64 Fed. Reg. 54981–82 (Oct. 8, 1999). In those discussions, the Department recognized that it lacks the authority to make substantive changes to the regulations in a manner that applies retroactively. For example, if the previous civil money penalty regulation, 20 CFR 725.495 (1999), did not permit the assessment of penalties against an operator for its failure to secure the benefits payable to its leased employees, the Department may not assess a penalty against that operator under the revised regulations for any period prior to the effective date of these regulations. Although the Department believes that the previous regulation is broad enough to permit the assessment of civil money penalties in these cases, it also recognizes that the issue must be resolved on a case-by-case basis in the context of litigating penalty assessments.

It is also important to note that the revised regulation does not affect the liability of insurers for claims filed prior to the effective date of the regulations. Under the insurance endorsement set forth at § 726.203, an insurer is already liable for all of the miners employed by its insured. *See Lovilia Coal Co.* v. *Williams,* 143 F.3d 317, 322 (7th Cir. 1998). An employer's liability, in turn, is determined by the regulations set forth at 20 CFR §§ 725.491–.495. The Department has stated explicitly that the revised version of those regulations will not be applied retroactively. *See* § 725.2. Accordingly, if the prior regulations did not permit the imposition of liability against a coal mine operator for benefits owed to a miner whose services were obtained from a leasing company, they will not permit imposition of liability against that operator's insurer. The Department thus does not agree that the revised regulation is impermissively retroactive.

(e) No other comments were received concerning this section, and no changes have been made in it.

Subpart B

20 CFR 726.101

In its initial notice of proposed rulemaking, the Department proposed revising this regulation to delete the formula used in 1974 to establish the amount and types of security required for an operator to be authorized to self-insure. The proposal also removed the reference in subsection (a) to indemnity bonds and negotiable securities as the only forms of acceptable security. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised

subsections (b)(1), (2), and (3), and subsection (c) in order to clarify the meaning of the regulation. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.104

In its initial notice of proposed rulemaking, the Department proposed revising subsection (b) to recognize two additional forms of security available to an authorized self-insurer: Letters of credit and tax-exempt trusts. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised subsections (a) and (d) to clarify the meaning of those provisions. The Department received one comment concerning this regulation; that comment is addressed under § 726.106. No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.105

In its initial notice of proposed rulemaking, the Department proposed deleting the reference to the formula contained in 20 CFR 725.101(1999), in favor of a non-exclusive list of factors to be considered by the Department in determining the appropriate amount of security required to be provided by a self-insured operator. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised the first and third sentences of the regulation in order to clarify their meaning. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.106

(a) In its initial notice of proposed rulemaking, the Department proposed deleting an incorrect reference to specific sections in Title 31 of the Code of Federal Regulations and replacing the reference with a citation to the appropriate regulatory part governing deposits with the United States. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) One comment urges the Department to include language in this regulation confirming the sole liability of a surety company which writes the most recent indemnity bond for a responsible operator, and the exoneration of all previous sureties. No change in the regulation is necessary. In *United States of America* v. *Insurance Co. of North America,* 83 F.3d 1507 (D.C. Cir. 1996), the Department argued that a surety assumes liability for all of an operator's existing obligations when the bond is written and continuing until the termination of the bond. The Court rejected this argument. It held that a surety is liable only for those obligations which actually accrue to the responsible operator during the lifetime of the bond, and not for all outstanding liabilities of the insured entity. 83 F.3d at 1511. The Court also rejected the notion that each successive bond exonerates any previous surety to which liability has attached. 83 F.3d at 1512–13. The Court based these holdings on its interpretation of the bond language itself. Consequently, the commenter's recommendation can be accomplished only by further specifying in the bond's language, as prescribed by the Department, the scope of the bond's coverage and its terms of release. The Department has yet to determine whether revision of the bond form is appropriate. In any event, the commenter's suggestion does not require changing the language of the regulation.

(c) The Department has revised the first sentences of subsections (b) and (c) to clarify the meaning of these provisions. No other comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.109

In its initial notice of proposed rulemaking, the Department proposed deleting specific references to indemnity bonds and negotiable securities in favor of more general references to the security required to be provided by a self-insured operator. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised the second and third sentences of the regulation in order to clarify their meaning. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.110

In its initial notice of proposed rulemaking, the Department proposed deleting references to indemnity bonds and negotiable securities in subsections (a)(3) and (b) in favor of more general references to the security required to be provided by a self-insured operator. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised the regulation to clarify its meaning. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.111

In its initial notice of proposed rulemaking, the Department proposed deleting a reference to indemnity bonds and negotiable securities in favor of a more general reference to the security required to be provided by a self-insured operator. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). The Department has revised the regulation to clarify its meaning. No comments were received concerning this section, and no other changes have been made in it.

20 CFR 726.114

In its initial notice of proposed rulemaking, the Department proposed adding subsection (c) to codify the Department's position that self-insured coal mine operators who cease mining coal nevertheless have a continuing responsibility to maintain adequate security to cover their potential liability under the Black Lung Benefits Act. The Department also replaced a specific reference to negotiable securities and indemnity bonds in subsection (b) with a more general reference to the security required to be provided by a self-insured operator. 62 FR 3369 (Jan. 22, 1997). The Department did not discuss the regulation in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999). In the third sentence of subsection (a), the Department has replaced the word ''have'' with the word ''has'' to make the sentence grammatically correct. The Department has also revised subsections (a) and (c) to clarify their meaning. No comments were received concerning this section, and no other changes have been made in it.

Subpart C

20 CFR 726.203

(a) The Department made technical revisions to § 726.203 in its first notice of proposed rulemaking, but did not open the regulation for comment. *See*

list of Technical revisions, 62 FR 3340–41 (Jan. 22, 1997). At the Department's July 22, 1997 hearing in Washington, D.C., however, the Department heard testimony indicating that, since 1984, the insurance industry had used an endorsement for black lung insurance that differed from the endorsement set forth in § 726.203. 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 industry stated that the Department had approved use of the new endorsement. Because the Department's records contained no document authorizing use of a different endorsement, the Department opened the regulation for comment, and invited the industry to produce proof that the Department had approved the change. In addition, the Department invited comment on the endorsement language that the insurance industry had supplied. 64 FR 55005–06 (Oct. 8, 1999).

(b) In response to the second notice of proposed rulemaking, the insurance industry submitted two affidavits. Rulemaking Record, Exhibit 89–37, Appendix G. One, from a former vice president and general counsel of the National Council on Compensation Insurance (NCCI), states that ''NCCI was informed by officials of the Office of Workers' Compensation Programs, in writing, that the agency had no objection to the changes.'' The affidavit also states that the changes were put into use. The other affidavit, from NCCI's current general counsel, states that NCCI's schedule for the retention of records requires the council to maintain correspondence for 10 years, and that correspondence more than 10 years old is destroyed in accordance with established policy. Accordingly, the affiant stated, NCCI was unable to produce a copy of the Department's ''acknowledgment'' of the revised insurance endorsement.

The Department has conducted a second thorough search of its files, including files in the Office of Workers' Compensation Programs, the Employment Standards Administration, and the Office of the Solicitor. Although the Department's files contain correspondence with NCCI dating back to 1984, the Department's search failed to produce any correspondence in which the Department approved NCCI's revised insurance endorsement. Moreover, the Department does not believe that it would have approved the proposed revision. The revision differs in two material respects from the endorsement set forth in § 726.203. First, the revision limits an insurer's liability for claims that are based on employment that ended before an operator first obtained insurance to secure its liability under the Act. Second, the revision limits an insurer's liability for claims that are approved as a result of amendments to the Black Lung Benefits Act.

The current black lung insurance endorsement obligates an insurer to provide coverage to an operator in two different types of claims. First, the insurer is liable when the miner's last exposure to coal mine dust in the employment of the insured ''occurs during the policy period.'' Thus, if a miner is last employed by XYZ Coal Company on March 1, 1990, and XYZ Coal Company is the coal mine operator responsible for the payment of that miner's benefits, the insurer whose policy covered XYZ on March 1, 1990 will be liable for the payment of those benefits. In addition, however, the endorsement covers a second type of claim. Prior to the Black Lung Benefits Reform Act of 1977, the Black Lung Benefits Act obligated employers to pay benefits to former employees who were totally disabled due to pneumoconiosis arising out of coal mine employment, no matter when their employment ended. *See Usery* v. *Turner Elkhorn Mining Co.,* 428 U.S. 1, 15–16 (1976) (observing that the Act has ''some retrospective effect''). Because operators were not required to purchase insurance until January 1, 1974, however, the endorsement contained a second clause providing coverage if the miner's last exposure in the employment of the insured operator ''occurred prior to (effective date) and claim based on such disease is first filed against the insured during the policy period.'' Thus, if a miner last worked for XYZ Coal Company in 1972, but did not file a claim until July 1, 1978, the insurer whose policy covered XYZ on the 1978 filing date would be liable for the miner's benefits.

The regulations define the term ''effective date'' in the endorsement as the effective date of the operator's first insurance policy providing coverage for the operator's federal black lung benefits liability. 20 CFR 726.203(b) (1999). Thus, if the operator did not obtain its first policy until January 1, 1974, that policy would cover any claims based on employment that ended prior to that date. The revised endorsement offered by the insurance industry replaces the term ''effective date'' with the date ''July 1, 1973.'' Although a number of operators did purchase insurance before January 1, 1974, none did so until after July 1, 1973. Accordingly, the industry's revised endorsement would potentially leave coal mine operators uninsured for certain claims. For example, if an operator did not purchase insurance until November 1, 1973, the revised endorsement would cover the miner's last exposure in the employment of the insured operator only if it ''occurred prior to July 1, 1973,'' and therefore would not cover any claims based on employment that ended between July 1, 1973 and November 1, 1973. If the coal company is still in business, the claim would be the responsibility of that company. If the coal company is no longer in business, the claim would become the responsibility of the Black Lung Disability Trust Fund. Either result is unacceptable. Although the Department recognizes that this change would not affect a significant number of claims, it could materially alter the liability of the insurance industry in some cases. Thus, the Department does not believe that the revision is appropriate.

The second material change in the endorsement is potentially more serious. The current endorsement obligates an insurer for liability that arises under the Black Lung Benefits Act and ''any laws amendatory thereto, or supplementary thereto, which may be or become effective while this policy is in force.'' Following the Black Lung Benefits Reform Act of 1977, several Virginia coal mine operators sued two insurers in federal district court to obtain a declaratory judgment regarding the coverage of claims that were subject to approval under the new criteria. The court agreed with the operators and held that, under the Department's endorsement, a policy was ''in force'' as long as claims could be filed against it. *National Independent Coal Operators Association, Inc.* v. *Old Republic Insurance Co.,* 544 F. Supp. 520, 527–8 (W.D.Va. 1982). The court accordingly rejected the argument of the insurers that the term ''in force'' was synonymous with the term ''policy period,'' and that an insurer was liable only to the extent of amendatory or supplementary laws enacted during the one-year period covered by each policy. *See* 20 CFR 726.206 (a policy shall be issued for the term of one year from the date on which it becomes effective). The court stated that if the insurers had intended that meaning ''it should have been made clear to the plaintiffs [operators] by either using 'policy period' where the words 'in force' appear, or by defining 'in force' somewhere in the contract.'' *National Independent Coal Operators Association* at 528.

The court's decision was issued in 1982, and the insurance industry quickly accepted the court's invitation.

The revised endorsement, apparently submitted to the Department in 1983, replaces the language in the current endorsement that obligates the insurer to cover liability resulting from amendments while the policy is ''in force'' with a phrase obligating the insurer to cover liability resulting from ''any amendment to the law that is in effect during the policy period.'' This altered language would permit the insurance industry to accomplish what it failed to win in the 1982 litigation, *i.e.,* an exemption from liability resulting from any future amendments. Like the other proposed change, this revision would increase the exposure of coal mine operators and the Black Lung Disability Trust Fund, and is therefore unacceptable to the Department.

Because the revised black lung endorsement offered by the insurance industry materially alters the obligations and coverage provided by the insurance industry under the Black Lung Benefits Act, the Department must reject that endorsement. Accordingly, no changes are made to § 726.203.

(c) One comment urges the Department to add a sentence to subsection (d) of the regulation. The sentence, which the commenter states would conform the regulation to state regulatory regimes, would read as follows: ''The requirements of this section shall be construed to the extent possible, harmoniously with the workers' compensation rules and practices of the state is [sic] when the coverage is provided.'' Rulemaking Record, Exhibit 89–37, pp. 177–178. The commenter does not suggest any problem in the current regulations that this sentence is intended to correct, and the Department declines to add a sentence whose intent is unclear. To the extent that this sentence could be interpreted to require a result different from that reached in *Lovilia Coal Co.* v. *Williams,* 143 F.3d 317 (7th Cir. 1998), in which the Court of Appeals for the Seventh Circuit held that the federal black lung insurance endorsement was not subject to exclusions available under state law, the Department also does not believe that it would be appropriate.

The commenter also renews a suggestion, made in response to the first notice of proposed rulemaking, that subsections (b) and (c)(2) of § 726.203 should be eliminated. The commenter's first suggestion is premised on the Department's acceptance of the insurance industry's revised endorsement. As discussed above, the Department does not believe that the revised endorsement provides necessary coverage and therefore has refused to accept it. The commenter's second suggestion states that the addition of subsections (b)(1) and (b)(2) to § 725.493 have created a conflict with § 726.203(c)(2), and made the latter provision redundant. The Department disagrees because the two regulations serve wholly different purposes. Section 725.493(b)(1) governs the liability of prior and successor operators in two cases: (1) Where the miner was employed by the successor after the sale giving rise to successor liability; and (2) where the miner was never employed by the successor operator. Subsection (b)(2) governs the successor liability of companies whose relationship to the prior operator is as a parent company, as members of joint ventures, a partner, or a company that substantially owned or controlled the prior operator. Section 726.203(c)(2) governs the interpretation of the insurance contract in a case where the insured company is liable as a successor operator. Because the sections 725.493 and 726.203 govern different subjects, the Department does not believe that the regulations are in conflict, or that subsection (c)(2) is redundant.

(d) No other comments were received concerning this section, and no changes have been made in it.

20 CFR 726.208

Although the Department received comments under this section, the regulation was not open for comment, *see* 62 Fed. Reg. 3341 (Jan. 22, 1997); 64 Fed. Reg. 54970 (Oct. 8, 1999). The Department made only a technical change to the regulation in the second notice of proposed rulemaking. Accordingly, no changes are being made in this section.

20 CFR 726.211

Although the Department received comments under this section, the regulation was not open for comment, see 62 Fed. Reg. 3341 (Jan. 22, 1997); 64 Fed. Reg. 54970 (Oct. 8, 1999). The Department made only a technical change in the regulation. Accordingly, no changes are being made in this section.

Subpart D

20 CFR 726.300–726.320

(a) In its first notice of proposed rulemaking, the Department proposed a complete revision of the procedural and substantive regulations governing the imposition of civil money penalties against operators that fail to secure the payment of benefits under the Black Lung Benefits Act, 30 U.S.C. 933(d)(1). 62 FR 3370 (Jan. 22, 1997). These revisions included a series of graduated penalties based on the number of the operator's employees, the length of time the operator's uninsured status continues following notification, and its constructive and actual notice of its obligation to secure. In addition, the Department proposed allowing the initial assessment of penalties by the Office of Workers' Compensation Programs to become final if neither the operator nor its officers filed a timely notice of contest. The proposal also subjected decisions of administrative law judges on penalty issues to discretionary review by the Secretary. The Department did not discuss these regulations in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) The Department has made several minor changes to the regulations in Subpart D of Part 726. In § 726.302(c)(3) and (4), the Department replaced a reference to subsection (b) with a reference to subsection (c)(2)(i) to correctly identify the applicable provision. In § 726.308, the Department corrected the address of the Black Lung Benefits Division of the Office of the Solicitor and added a reference to § 725.311, which lists federal holidays. In § 726.313(f), the Department replaced the word ''will'' with the word ''shall'' to clarify the Department's intent. The Department has made minor revisions to §§ 726.300, 726.301, 726.302, and 726.305 to clarify their meanings.

(c) One comment is critical of the Department's failure to enforce its current requirement (20 CFR § 725.495 (1999)) that coal mine operators either purchase commercial insurance or qualify as self-insured entities. The commenter argues that if § 725.495 was enforced to its fullest extent, the Department would not find it necessary to alter the methods used to identify responsible operators. The Department provided a detailed explanation of the purpose behind its proposed revision of the civil money penalty regulations in its initial notice of proposed rulemaking. 62 FR 3370–71 (Jan. 22, 1997). Subpart D of part 726 replaces § 725.495 with a comprehensive scheme for the imposition of graduated penalties on those operators who fail to secure their liability for benefits. The previous regulation required only that an administrative law judge levy the maximum penalty possible in the absence of ''mitigating circumstances,'' and provided no guidance or criteria for determining an appropriate assessment. The revised regulations fill this void. The Department thus disagrees with the commenter's view that vigorous enforcement of penalties under 20 CFR

§ 725.495 (1999) would eliminate the need to revisit the Department's method of identifying responsible operators. Consequently, the revised regulations represent a necessary exercise of the Department's rulemaking authority.

(d) One comment generally characterizes this revision as adding ''onerous'' penalties to the current program, but makes no specific criticism of them. The revised Subpart D of part 726 does not add any penalty not specifically authorized by 30 U.S.C. § 933(d), and not contained in the previous regulations. Moreover, the graduated scale of penalties contained in the revision provides specific guidelines for computing penalties and may result in a lesser penalty being imposed than the former regulation would have required. This comment does not provide any other basis for a substantive response by the Department.

(e) One comment observes that the prospect of civil money penalties may encourage an unsecured operator to pass on its liabilities to an insured successor whose carrier has not collected a premium reflecting the additional liability. To the extent that such a possibility exists in cases where the prior operator subsequently becomes unable to pay benefits to its former employees, it implicates business considerations, not legal questions. An insured operator should weigh the potential effect of acquiring an entity with unsecured benefits liability as a factor in the financial soundness of making the acquisition. The possibility of adverse economic effects on some future mergers or acquisitions, however, does not excuse the Department's obligation to enforce compliance with the Act's insurance requirements and to penalize a failure to comply.

(f) Two comments approve of the proposed civil money penalties. No other comments were received concerning this subpart, and no other changes have been made in it.

20 CFR Part 727

(a) In its first notice of proposed rulemaking, the Department proposed deleting Part 727 from title 20 of the Code of Federal Regulations. 62 FR 3371, 3435 (Jan. 22, 1997). The Department explained that the Part 727 regulations, which govern black lung benefits claims filed prior to April 1, 1980, are relevant only to a small minority of the claims currently pending. Because the parties to those claims are already familiar with the standards in Part 727, the Department proposed to discontinue the annual publication of that part. In lieu of continued publication, section 725.4(d), as revised, will refer individuals to the 1999 version of title 20 of the Code of Federal Regulations for a copy of the regulations. *See* discussion of § 725.4, above; 62 FR 3348, 3386 (Jan. 22, 1997). The Department did not discuss Part 727 in its second notice of proposed rulemaking. *See* list of Changes in the Department's Second Proposal, 64 FR 54971 (Oct. 8, 1999).

(b) Three comments urge the Department not to discontinue its annual publication of Part 727 because the part governs claims still pending in various stages of adjudication. Although the Department recognizes that the Part 727 regulations are applicable to some pending claims, the Department does not believe that the existence of this relatively small number of cases justifies the continued publication of the part in the Code of Federal Regulations. The parties to these claims are already familiar with the regulations, and have received sufficient notice of the Department's intention to cease publication to allow them to retain their current copies of the Code. Accordingly, the Department has discontinued the annual publication of Part 727.

(c) No other comments were received concerning this part, and no changes have been made in it.

Drafting Information

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

The principal authors of this document are Rae Ellen James, Deputy Associate Solicitor; Richard Seid, Counsel for Administrative Litigation and Legal Advice; and Michael Denney, Counsel for Enforcement, Black Lung Benefits Division, Office of the Solicitor, U.S. Department of Labor. Personnel from the Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor, assisted in the preparation of the document.

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, 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 in any one year.

Executive Order 13132

The Department has reviewed this rule in accordance with Executive Order 13132 regarding federalism, and has determined that it does not have ''federalism implications.'' The rule does not have ''substantial effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.''

Paperwork Reduction Act

The changes establish no new record keeping requirements. Moreover, they reduce the volume of medical examination and consultants' reports which currently are created solely for 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). The preamble to the RFA provides in part as follows:

> It is the purpose of this Act to establish as a principle of regulatory issuance that agencies shall endeavor, consistent with the objectives of the rule and of applicable statutes, to fit regulatory and informational requirements to the scale of the businesses, organizations, and governmental jurisdictions subject to regulation. To achieve this principle, agencies are required to solicit and consider flexible regulatory proposals and to explain the rationale for their actions to assure that such proposals are given serious consideration.

Pub. L. 96–354, 94 Stat. 1165 (1980).

The RFA outlines in some detail the analysis required for compliance. Unless the agency certifies that the rule will not have ''a significant economic impact 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 impact.''

In light of the comments the Department received in response to the first notice of proposed rulemaking, the Department included in its second notice of proposed rulemaking an initial regulatory flexibility analysis. That analysis included each of the components identified by the RFA: (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 would apply; (4) a description of projected reporting, recordkeeping, and other compliance requirements of the proposed rule; and (5) an identification of any rules that would overlap, duplicate, or conflict with the proposed rule. 5 U.S.C. 603(b). Finally, as is also required by the RFA, the analysis contained a description of alternatives to the rule. 5 U.S.C. 603(c). 64 FR 55006–09 (Oct. 8, 1999).

The Regulatory Flexibility Act ''plainly does not require economic analysis.'' *Alenco Communications, Inc.* v. *FCC,* 201 F.3d 608, 625 (5th Cir. 2000). Because of the serious concerns raised in the comments to its initial notice of proposed rulemaking, however, the Department undertook an extensive analysis of the effect of its proposed rule on the coal mining industry in general and on small businesses, as defined by the Small Business Administration, in particular. Rulemaking Record, Exhibit 80. That analysis determined that the potential costs of the Department's rule would be imposed on most coal mine operators through higher insurance premiums, and that, in the long term, those insurance premiums could be expected to rise by 39.3 percent. Exhibit 80 at p. 44. The analysis assumed that all coal mine operators purchased insurance to cover their obligations, although it noted that this assumption probably overstated costs with respect to operators that are authorized to self-insure. Logically, operators self-insure only if they may do so at a lower cost. Exhibit 80 at p. 44. The analysis calculated that an increase in premiums of this magnitude would result in a total annual cost to the industry between $32.22 million and $88.32 million, with a point estimate of $57.56 million. Exhibit 80 at p. 46. The Department believes that these figures contain substantial upward biases, and that they therefore overstate, by a considerable amount, the total cost to industry. Specifically, the Department estimated the costs based on the insurance premiums paid by underground coal mine operators. The insurance premiums paid by surface mine operators, which employ a substantial percentage of the people working in coal mine employment, are significantly lower. (See the economic analysis prepared by Milliman & Robertson, Inc., at p. 6, Table 4; Rulemaking Record Exhibit 89–37, Appendix A.) In addition, coal mine operators who self-insure their liabilities under the Black Lung Benefits Act may be assumed to do so because their costs are lower than the costs of commercial insurance. Although it is conservatively high, the Department believes the $57.56 million point estimate to be the most useful indicator of industry costs. The analysis concluded that the effects of this rise in insurance costs would be most heavily felt by underground bituminous coal mine operators with less than 20 employees, who would be in a poorer position to recoup those costs. Some of those operators, the analysis observed, might be forced to suspend operations. Exhibit 80 at pp. 56–59.

The RFA also requires that agencies assure that small businesses have an opportunity to participate in the rulemaking ''through the reasonable use of techniques such as—* * * 3) the direct notification of interested small entities; * * *'' 5 U.S.C. 609(a)(3). Accordingly, the Department mailed a copy of its second notice of proposed rulemaking, including its initial regulatory flexibility analysis, to each coal mine operator identified in a database maintained by the Mine Safety and Health Administration. In addition, the Department made a copy of its economic analysis available to any interested party that requested it and posted it on the Internet. 64 FR 55008 (Oct. 8, 1999). Finally, because the Department did not complete its mailing of the proposal until November 5, 1999, it extended the comment period through January 6, 2000 to ensure that each small business was given no less than 60 days to submit comments, the length of the original comment period in the second notice of proposed rulemaking. 64 FR 62997 (Nov. 18, 1999).

Finally, the Regulatory Flexibility Act requires that when an agency promulgates a final rule after having been required to publish a notice of proposed rulemaking, the agency must prepare a final regulatory flexibility analysis. That analysis must contain:

(1) a succinct statement of the need for, and objectives of, the rule;

(2) a summary of the significant issues raised by the public comments in response to the initial regulatory flexibility analysis, a summary of the assessment of the agency of such issues, and a statement of any changes made in the proposed rule as a result of such comments;

(3) a description of and an estimate of the number of small entities to which the rule will apply or an explanation of why no such estimate is available;

(4) a description of the projected reporting, recordkeeping and other compliance requirements of the rule, including an estimate of the classes of small entities which will be subject to the requirement and the type of professional skills necessary for preparation of the report or record; and

(5) a description of the steps the agency has taken to minimize the significant economic impact on small entities consistent with the stated objectives of applicable statutes, including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected.

5 U.S.C. 604(a). The agency must make a copy of its final regulatory flexibility analysis available to the public, and must publish its analysis or a summary of its analysis in the **Federal Register**. 5 U.S.C. 604(b). The Department's final regulatory flexibility analysis is published below.

Need for, and Objectives of, the Rule

The Department discussed its need to revise the black lung regulations in its initial regulatory flexibility analysis. 64 FR 55006–07 (Oct. 8, 1999). In that analysis, the Department observed that the revisions satisfied a number of different objectives. First, many of the revisions simply updated the regulations implementing the Black

Lung Benefits Act. The Department's initial analysis provided examples of much needed regulatory updates such as those needed to reflect decisions of the courts of appeals and to clarify the Department's original intent when certain regulations were promulgated. Similarly, the Department noted the proposed regulatory revisions reflected changes that had occurred over the previous 20 years in the diagnosis and treatment of pneumoconiosis. Paragraphs (1), (3), (4), and (6) of the section entitled ''Reasons for, and Objectives of, the Proposed Rule,'' discussed areas in which the Department sought to update its regulations.

The black lung program regulations were in need of significant revision to make them current. The Department last made substantive revisions to certain regulations in 1983, *see* 48 FR 24272 (May 31, 1983), and those revisions reflected only substantive changes made to the Black Lung Benefits Act by the Black Lung Benefits Revenue Act of 1981, Pub. L. 97–119, Title I, 95 Stat. 1635 (1981) and the Black Lung Benefits Amendments of 1981, Pub. L. 97–119, Title II, 95 Stat. 1644 (1981), both of which became effective on January 1, 1982. Most of the regulations have not been revised since they were originally promulgated: Part 718 in 1980, Part 722 in 1973, and Parts 725 and 727 in 1978. *See* 45 FR 13678 (Feb. 29, 1980); 38 FR 8328 (March 30, 1973); 43 FR 36772 (Aug. 18, 1978). Some regulations, however, did not reflect the amendments to the Black Lung Benefits Act enacted over the last quarter century. For example, Part 722 sets forth criteria states must meet when seeking certification from the Secretary that their workers' compensation programs provide ''adequate coverage'' for occupational pneumoconiosis. These regulations were never revised in light of either the Black Lung Benefits Reform Act of 1977, Pub. L. 95–239, 92 Stat. 95 (1978), or the Black Lung Benefits Amendments of 1981. Similarly, the Secretary's Part 725 regulations required revision in order to reflect amendments to other statutes. For example, revised § 725.621 reflected the Debt Collection Improvement Act of 1996, Pub. L. 104–334, 110 Stat. 1358 (1996), *see* preamble to first notice of proposed rulemaking, § 725.621, 62 FR 3369 (Jan. 22, 1997). Section 725.515 was revised to reflect amendments to the Social Security Act, *see* preamble to second notice of proposed rulemaking, § 725.515, 64 FR 55001 (Oct. 8, 1999). Section 725.544 was amended to reflect the statutory increase in the dollar amount of claims which may be compromised by the United States and to reflect the repeal of the Federal Claims Collection Act, *see* preamble to second notice of proposed rulemaking, § 725.544, 64 FR 55002 (Oct. 8, 1999).

In addition, over the last two decades, many of the regulations in Parts 718 and 725 have been interpreted by both the Benefits Review Board and the federal appellate courts. The Department strongly believes that, where these interpretations represent a consensus of opinion as to the meaning and correct application of particular regulations, that consensus should be embodied in the Department's regulations. One commenter correctly observes that none of these courts specifically ordered the Department to revise its regulations. The Department believes, however, that the interests of all parties to the adjudication of a claim—coal mine operators and their insurers as well as claimants—will be better served if a judicial consensus is reflected in the explicit language of the Department's regulations. Incorporating such a consensus will allow both the parties and the adjudication officer to use a current version of the regulation that does not require constant recourse to databases of federal case law. Moreover, the black lung program serves a population of applicants—individuals who spent their working lives in the Nation's coal mines—who cannot be expected to be aware of all of the judicial decisions bearing on their eligibility for benefits, and who thus cannot be expected to bring them to the attention of the administrative law judges who conduct formal hearings on applications for benefits under the Act.

For example, the substantive criteria governing a claimant's eligibility for benefits, set forth in Part 718, have been the subject of numerous appellate decisions. The Department's preamble discussion of § 718.201 contains citations to a considerable body of case law recognizing that pneumoconiosis, as defined by the Act and the Department's regulations, includes obstructive lung disease arising from coal mine dust exposure. Similarly, the preamble discussion of § 725.309 references those decisions noting that pneumoconiosis is a latent, progressive disease. *See* preamble to § 718.201, paragraph (f), preamble to § 725.309, paragraph (b). The Department's revised definition of ''pneumoconiosis'' in § 718.201 explicitly incorporates both of these principles. The Department's revisions of §§ 718.204 (criteria for establishing that a miner suffers from total disability due to pneumoconiosis) and 718.205 (criteria for establishing that a miner died due to pneumoconiosis) codify nearly unanimous case law interpreting the Department's prior regulations. *See* preamble to § 718.204, paragraph (d), explaining that the definition of ''total disability'' requires proof of a totally disabling respiratory or pulmonary impairment, preamble to § 718.205, paragraph (d), providing practical meaning to the regulatory standard that death is due to pneumoconiosis when pneumoconiosis is a substantially contributing cause of death; *see also* 62 FR 3345 (Jan. 22, 1997) (citing cases defining when total disability is due to pneumoconiosis under 20 CFR 718.204 (1999)). Similarly, revised sections 725.309, governing subsequent claims filed by the same individual, and 725.310, governing requests for modification of a claim, reflect a body of decisional law that has developed since these regulations were promulgated in 1978. *See* preamble discussions of § 725.309, 62 FR 3351–52 (Jan. 22, 1997), 64 FR 54984–85 (Oct. 8, 1999), and above; and preamble discussions of § 725.310, 62 FR 3353–54 (Jan. 22, 1997), 64 FR 54985–86 (Oct. 8, 1999), and above.

The Department also believes that, where the Board or the appellate courts have identified issues which the regulations do not adequately address, regulatory action is appropriate to correct that omission. Thus, section 725.495 addresses a problem observed by the Fourth Circuit Court of Appeals in *Director, OWCP* v. *Trace Fork Coal Co.*, 67 F.3d 503, 507 (4th Cir. 1995), *viz.*, 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.'' Similarly, where the Board or the appellate courts have interpreted a regulation in a manner different from that intended by the Department, the only way to ensure that the Department's intent is fulfilled is to amend the regulations. *See*, *e.g.*, preamble to first notice of proposed rulemaking, § 718.101, 62 FR 3341 (Jan. 22, 1997) (noting intent that standards for ensuring the quality of medical evidence be made uniformly applicable to all new evidence developed in the claims adjudication process).

Finally, in order to update its regulations, the Department also needed to revise certain provisions in light of its experience administering the program for over 25 years. This experience had demonstrated that the regulations did not adequately address certain issues. For example, the former regulations provided little guidance as to when a claimant could reasonably expect the payment of monthly and retroactive

benefits from coal mine operators, *see* preamble to first notice of proposed rulemaking, § 725.502, 62 FR 3365–66 (Jan. 22, 1997). Similarly, the Department had learned that the rules governing overpayments and their possible waiver varied depending on whether the overpayment was made by the Black Lung Disability Trust Fund or a coal mine operator, *see* preamble to first notice of proposed rulemaking, § 725.547, 62 FR 3366 (Jan. 22, 1997).

In addition to making its regulations current, the Department intended to revise its regulations to streamline the adjudication of claims under the Act. 62 FR 3338 (Jan. 22, 1997). The Department felt this need was critical and hoped to ensure that the resulting process for determining a claimant's eligibility was both simple and equitable. For example, the Department had been widely criticized for delays in the adjudication process. In response, the Department has made considerable changes in the initial processing of claims. The Department's revisions begin with the manner in which each miner who files an application for benefits is afforded a complete pulmonary evaluation, *see* 30 U.S.C. 923(b). The Department's revisions will allow each miner to select a highly qualified physician to perform his evaluation from a list of authorized providers maintained by the Department. *See* preamble discussion of § 725.406, 64 FR 54988–90 (Oct. 8, 1999). The Department hopes thereby to provide each claimant with a realistic appraisal of his condition and to provide each claim with a sound evidentiary basis. The regulations governing the additional development and submission of evidence will ensure that the parties to a claim receive fewer documents to which they need to file a response than was formerly the case. Thus, rather than issue initial findings and a memorandum of conference, formerly provided for in the regulations (20 CFR 725.410, 725.411, 725.417 (1999)), the district director will issue only one decisional document at the conclusion of his processing: a proposed decision and order. *See* preamble discussion of §§ 725.410–725.413. In addition, the revised regulations will allow the Department to generate documents that provide a clearer and better reasoned explanation of any evidentiary evaluation made by the district director and a better understanding by the parties of their rights and responsibilities. Thus, the district director will issue a schedule for the submission of additional evidence which explains his preliminary analysis of the results of the miner's complete pulmonary evaluation. It will notify all parties of their right to submit additional evidence and to obtain further adjudication of the claim. *See* preamble discussion of §§ 725.410–725.413. One of the most important revisions made by the Department will limit the parties' submission of documentary medical evidence. This revision will require that the factfinder evaluate a claimant's eligibility based on the quality of medical evidence that the parties submit, rather than the numerical superiority of the evidence on either side. *See* preamble discussion of § 725.414, 64 FR 54994 (Oct. 8, 1999); 62 FR 3356–57 (Jan. 22, 1997).

Significant Issues Raised by Public Comments in Response to Initial Regulatory Flexibility Analysis

The comments in response to the Department's initial regulatory flexibility analysis fall into three categories: (1) Those comments urging the Department not to promulgate regulations having any adverse economic effect on the coal mining industry, or on one or more segments of that industry; (2) comments contending that the assumptions underlying the economic analysis on which the Department's initial regulatory flexibility analysis was based were flawed, and that the analysis thus underestimates the effect on small businesses subject to regulation by the rule; and (3) comments suggesting regulatory alternatives that the Department allegedly failed to consider in its initial regulatory flexibility analysis. The Department discusses those comments suggesting regulatory alternatives below, in the section entitled ''Description of Steps the Agency has taken to Minimize the Impact on Small Entities Consistent with the Stated Objectives of Applicable Statutes.'' The Department responds to comments in the first two categories in this section.

Several commenters argue that, in light of the costs identified by the Department in its initial regulatory flexibility analysis, the Department should not promulgate any revised regulations. The Department disagrees. The regulations implementing the Black Lung Benefits Act are badly in need of revision to reflect more than two decades of judicial interpretation and administrative experience. In addition, the Department believes that the process used to determine a claimant's eligibility for benefits, and an operator's liability for those benefits, needs to be made faster, fairer, and more credible. No parties have benefitted from the delays that the courts of appeals have identified in the program, *see, e.g., Venicassa* v. *Consolidation Coal Co.,* 137 F.3d 197, 198 n.2 (3d Cir. 1998) (noting ''a disturbing record of delay in processing claims for black lung benefits in prior cases''). The Department's regulations are intended to eliminate that delay by, *inter alia,* reducing the number of steps in the district director's processing of a claim, requiring the timely development of evidence relevant to the issue of operator liability and eliminating the possibility of remands from the Office of Administrative Law Judges for the development of additional evidence as to the identity of the liable party. The Department's revised regulations promote fairness and credibility in claims adjudications by providing each miner with a quality medical evaluation of his pulmonary condition when he first applies, by explaining the Department's initial assessment of that evidence and by informing all parties of their rights to submit additional evidence and to request further adjudication of the claim.

One comment suggests that ''a reasonable interpretation of the Department's own economic analysis leads to the inescapable conclusion that the proposed rule will have a significant economic impact on a substantial number of small entities.'' Rulemaking Record, Exhibit 89–37, p. 24. The Department does not disagree. 64 FR 55008 (Oct. 8, 1999). The Department recognized that the rule will have an economic impact on the coal mining industry, and in particular on underground bituminous coal mine operators that employ less than 20 people. It is for this reason that in its second notice of proposed rulemaking, the Department prepared an initial regulatory flexibility analysis in lieu of its prior certification that the proposed rule would not have a significant economic impact on a substantial number of small entities. 64 FR 55006 (Oct. 8, 1999). The existence of an economic impact, however, does not mean that the Department is foreclosed from promulgating its rule. In *Associated Fisheries,* the First Circuit quoted with approval from the Commerce Department's explanation of its responsibilities under the Regulatory Flexibility Act:

> The intent of the RFA is not to limit regulations having adverse economic impacts on small entities, rather the intent is to have the agency focus special attention on the impacts its proposed actions would have on small entities, to disclose to the public which alternatives it considered to lessen adverse impacts, to require the agency to consider public comments on impacts and

alternatives, and to require the agency to state its reasons for not adopting an alternative having less of an adverse impact on small entities.

127 F.3d at 115–116. The Regulatory Flexibility Act thus vests the Department with the responsibility for determining, in light of the recognized costs, whether the rule should nevertheless be promulgated.

The economic analysis performed in connection with the Department's initial regulatory flexibility analysis described the costs that the rule would impose on the coal mining industry. That analysis was based on a number of conservative assumptions that were designed to establish a cost ceiling, *i.e.,* the maximum additional costs that industry would face as a result of these rules. For example, the analysis assumed that all coal mine operators purchase commercial insurance. The Department did not attempt, however, to estimate precisely the number of mines which would close as a result of these increased costs. Instead, the Department concluded that there was only a significant potential for closures in the very smallest size class of underground bituminous coal mine, those with under 20 employees. Rulemaking Record, Exhibit 80, Exhibits O and Q. These mines will feel the greatest effect of the Department's rule largely because of their operating characteristics. As a group, very small coal mines are far more labor intensive (*i.e.,* much less mechanized) than larger coal mines. Because the rule will raise costs in the form of higher insurance premiums, which in turn are based on each mine's payroll, increased premiums will represent a substantially higher cost increase per ton of coal mined for a very small mine than for a larger mine. Thus, based on its preliminary economic analysis (Rulemaking Record, Exhibit 80, pp. 46–51), the Department found that larger mines—including many mines that meet the definition of a ''small'' business under the definition used by the Small Business Administration—would not face significant impacts from the rule in terms of closures.

In addition to being more labor intensive, very small underground mines also incur the higher insurance premiums associated with underground coal mining. Data contained in comments received by the Department indicate that surface bituminous coal mine insurance rates average $1.57, only 59 percent of the average underground mine insurance rate of $2.64. Similarly, surface mine rates average only 53 percent of underground rates for eastern bituminous mines; and 37 percent of underground rates for a four-state average of Pennsylvania, Kentucky, Virginia, and West Virginia. For anthracite coal, surface mine insurance rates are only 44 percent of underground mine insurance rates. Rulemaking Record, Exhibit 89–37, Appendix A, Table 4. Any increase in insurance rates, then, assuming that all other things are equal, will affect the price per ton of underground coal twice as much as it will the price of coal extracted from surface mines. This distinction renders very small underground coal mines potentially vulnerable to closures in a way that very small surface coal mines are not. Because the insurance rates for surface anthracite mines are also high, very small anthracite strip mines may also be potentially vulnerable to closure.

Additional data provided by commenters, as well as data that has become available from the Department of Energy since publication of the Department's initial regulatory flexibility analysis, allow the Department to forecast the number of potential mine closures in somewhat greater detail. This analysis confirms the Department's preliminary conclusion that, although the regulations will have a significant impact on some mines, the impact on the mining industry as a whole will not be substantial. The Department's additional analysis therefore provides no basis to reconsider the decision to promulgate final regulations.

Mine Safety and Health Administration data are useful in establishing the number of mines that are potentially at risk of closure. The Department emphasizes, however, that this data addresses only the mines that are potentially at risk of closure because of the Department's rulemaking. The actual effects of the rule can be determined only by establishing the ''base case'' of mines that could be expected to close even if the Department does not promulgate its final rule. In 1998, 1,609 mines produced bituminous coal. An additional 743 bituminous mines are listed in the MSHA data but produced no coal during 1998. Of the 1,609 producing mines, 791 were underground mines, and 263 of the underground mines had fewer than 20 employees. Of these 263 mines, 37 produced over 100,000 short tons of coal in 1998. Because mines with fewer than 20 employees that produced over 100,000 short tons have high labor productivity, the Department does not believe that they will be significantly impacted by a rule whose primary effects are felt through increased insurance premiums that are based on labor costs. Subtracting these 37 mines from the 263 very small underground mines leaves 226 mines. The mines are located in Kentucky (81 mines), West Virginia (71 mines), Virginia (52 mines), Pennsylvania (14 mines), Tennessee (5 mines), and Alabama (3 mines). These mines are extremely small, employing a total of only 2,586 people. Median 1998 employment per mine was 11; mean employment was 11.4. Median production was 25,957 short tons of coal; mean production was 34,273 short tons.

The Department's previous economic analysis demonstrated that very small underground mines with first quartile accounting profits (the one-quarter of these mines with lowest profits) might be forced to close as a result of the rule, but that mines with median accounting profits were not in such jeopardy. For purposes of estimating the potential number of mine closures, however, the Department will assume that as many as three-eighths of these mines (the half-way point between .25, representing the first quartile, and .5, representing the second) are at risk. Multiplying this figure (.375) by the total number of very small underground bituminous mines (226) yields a total of 85 mines. According to MSHA data, these 85 underground bituminous mines represent 5.3 percent of all producing bituminous coal mines, employed 1.3 percent of the miners engaged in bituminous coal mine employment, and accounted for 0.3 percent of bituminous coal production.

MSHA data indicate that 117 mines produced anthracite in 1998. An additional 87 anthracite mines are listed in the MSHA data but produced no coal during 1998. Of the 117 producing mines, 60 were strip mines, 39 were underground mines, and 18 were culm bank/refuse pile operations. Of the 117 mines, 12 (10 strip mines, 1 underground mine, and 1 culm bank operation) had 20 or more employees, and only 3 had more than 50 employees. An additional 6 mines (3 strip mines and 3 culm bank operations) produced over 100,000 short tons in 1998. Culm bank operations and mines with 20 or more employees or over 100,000 tons output do not appear to be at risk of closure. Culm banks are discussed in detail below in response to a comment regarding the Department's assumptions about price elasticity. Thus, the population of very small anthracite mines consists of 85 mines. This total includes 47 strip mines (60 total strip mines minus 10 strip mines with 20 or more employees minus 3 strip mines that produced more than 100,000 short tons of coal in 1998) and 38

underground mines (39 underground mines minus 1 mine with 20 or more employees). These mines are extremely small. They had a total of 411 employees (220 in strip mines and 191 in underground mines). Median 1998 employment was 3; mean employment was 4.8. Median production of these anthracite mines was 4,500 short tons (7,484 for strip mines and 2,598 for underground mines); mean production was 12,173 short tons (17,116 for strip mines and 6,060 for underground mines).

Profit data for anthracite mines are not available. It appears reasonable to assume, however, that very small anthracite strip mines will be potentially subject to closure because their insurance premiums are high, and that very small underground anthracite mines will be even more heavily impacted. The Department will therefore assume that three-eighths of very small anthracite strip mines (the same figure used for bituminous mines) and five-eighths of very small anthracite underground mines (a higher figure to take into account the possibility of a heavier impact on these mines) are potentially in jeopardy of closure because of costs of the rule. Thus, an estimated 42 very small anthracite mines (18 strip mines (.375 times 47 mines) and 24 underground mines (.625 times 38 mines)) are potentially in jeopardy of closing as a result of the rule.

The next step in forecasting the number of mines that may close as a result of the rule is establishing the ''base case,'' *i.e.,* the number of mines that would close regardless of whether the Department promulgated new regulations. This is particularly important for an industry such as coal mining, where the number of small mines has been declining for decades, and where a continued sharp decline is likely in the foreseeable future. Only after establishing the base case can the Department estimate the extent to which the rule may result in additional closures.

The current and predicted decline in the number of small coal mines is the result of a variety of market factors. They include electricity deregulation, reduction in coal reserves, the use of on-time delivery by coal company customers, equipment upgrades, increased use of low sulfate coals, and the reduction in the number of small mining firms due to industry consolidation over the last two decades. All of these factors put very small coal mines, particularly underground mines, in an increasingly disadvantageous competitive position. Because of their size, very small coal mines have difficulty increasing productivity. They lack the physical scale to take advantage of new, high-productivity equipment, most of which is very large, or to adopt more productive techniques, such as continuous miner operations or longwall mining. Restricted space, of course, is a greater constraint in underground coal mines than surface mines.

Many very small coal mines are also characterized by unfavorable geological conditions. These may include thin coal veins, splitting coal beds, fractures or offsets due to faulting, interruptions in coal deposits or coal quality due to sandstone-or clay-filled channels, and unstable roof rock. Such geologic conditions may well be the reason the mine is small to begin with. They also make it costly to extract coal and difficult to improve productivity. Mines with such geological problems are therefore especially vulnerable to price competition. The economic suitability of coal beds for mining is reflected in changes in committed active reserves as the price of coal changes. Culling reserves to eliminate hard-to-mine reserves, or ''high-grading'' of reserve blocks, is a logical adaptation to low coal prices. From 1991 to 1996, as coal prices fell, the reserves of small mines (annual production of 10,000 to 100,000 short tons) fell by 61.6 percent, compared with a 12.9 percent decline for the coal mining industry as a whole. U.S. Department of Energy, Energy Information Administration, ''The U.S. Coal Industry in the 1990's: Low Prices and Record Production,'' (October, 1999) p. 6 (hereafter, ''U.S. Coal Industry'').

In addition, the shift in demand to low-sulfur western coal, which has occurred in response to the Clean Air Act Amendments of 1990 and the resulting regulations of the Environmental Protection Agency, puts very small coal mines at a severe disadvantage. Very small coal mines are concentrated in areas where coal has a relatively high sulfur content. Low-sulfur coal is found predominantly in the west, particularly in the Powder River Basin. The large strip mines that produce low sulfur coal have easy geology (thin overburden and thick coal beds), and their large scale results in labor productivity approximately three times as high as that of eastern mines. This productivity differential continues to grow. Moreover, recent investments in track by western railroads are further lowering the power-plant price of Powder River Basin coal.

Finally, many very small coal mines have management that may not be well equipped with tools such as computers. Such mines are in a poor position to adapt to practices such as on-time delivery or to utilize other risk management techniques that utility deregulation is making increasingly important in coal mine operation. Independent very small coal mines are also, by virtue of their size, in a relatively poor position to participate in strategic inter-fuel alliances, an increasingly common result of utility deregulation.

Because of all of these market factors, the outlook for independent very small mines is extremely bleak. The Department's preliminary economic analysis, in fact, was based on the observation that the base case already includes extensive closures of very small mines. Over the last 15 or 20 years, the market forces discussed above have eliminated a large majority of very small mines. Data collected by the Energy Information Administration (EIA) indicate that in the 11 years between 1986 and 1997 the number of coal mines with annual production of less than 10,000 short tons decreased from 1,069 to 281 (a total of 74 percent), while production of mines of this size decreased from 4.4 million short tons to 1.2 million tons, or by 73 percent. In the same period, the number of coal mines with annual production of 10,000 to 100,000 short tons decreased from 1,956 to 638 (a 67 percent decrease), while production of mines of this size decreased from 82.8 million short tons to 27.8 million short tons, or by 66 percent. EIA, U.S. Coal Industry, p. 3, Table 1.

To estimate both baseline closures and closures that may be considered impacts of the rule, two regression models were created using EIA data for 1986 through 1998. Both used the log of the number of underground bituminous coal mines with production in the range of 10,000 to 99,999 short tons. Both models used the log of the national price of coal as an independent variable, and one also included time as an independent variable. Both models had high statistical significance by any measure. Using EIA projections of coal price changes (*see* Department of Energy, Energy Information Administration, ''Challenges of Electric Power Industry Restructuring for Fuel Suppliers'' (September 1998) (hereafter, ''Challenges,''), Table ES1, p. 13), the models were used to forecast the percentage decrease in the number of coal mines in the base case in the years 2005 and 2015, and the decreases that may result from the Department's rule during the same interval.

The log-log model with no time variable predicted a baseline decrease in underground bituminous mines of 32 percent from the year 1998 to the year 2005 and a baseline decrease in underground bituminous mines of 61 percent from 1998 to 2015. Of the 85 bituminous mines identified as in jeopardy of closure, therefore, this model forecast that 27 would close by 2005 and 52 would close by 2015, even without the costs of the rule. When costs of the rule for the very small class of mines was added, the predicted decreases in the number of mines were 39 percent (or 33 mines) between 1998 and 2005 and 66 percent (or 56 mines) between 1998 and 2015. Thus the model predicts that the costs of the rule would result in the additional closure of 6 mines (33 mines minus 27 mines) as of 2005 but only 4 more mine closures (56 mines minus 52 mines) than the baseline as of 2015.

The model with a time variable predicted much sharper baseline decreases in the number of mines (43 percent decrease by 2005 and 86 percent by 2015) and impacts of the rule of about 0.4 mine closures by both years. It should also be noted that, because complete data were not available, neither model included mines producing less than 10,000 short tons, which have been closing at a faster rate than the mines that were included in the model. Thus, use of results from the model without a time variable represents a conservatively low choice of estimate of baseline closures.

A similar procedure was used for anthracite mines, with some modifications. Separate models were estimated for underground mines and strip mines, but total mines were used for the dependent variable. The log-log form without a time variable is reported. For the 24 at-risk underground anthracite mines, the model forecasts a base-case decrease in the number of mines of 21 percent as of 2005 (5 mines) and 43 percent as of 2015 (10 mines). Considering the additional costs imposed by the rule, the forecasts were decreases of 29 percent as of 2005 (1.92 additional mines) and 48 percent as of 2015 (1.2 additional mines). For the 18 at-risk surface anthracite mines, the model forecasts a base-case decrease in the number of mines of 8 percent as of 2005 (1 mine) and 20 percent as of 2015 (4 mines). Considering the additional costs imposed by the rule, the forecasts were decreases of 10 percent as of 2005 (.36 additional mines) and 21 percent as of 2015 (.18 additional mines).

The Regulatory Flexibility Act does not require the Department to extrapolate its projection of the cost of its rulemaking activity in order to determine the rule's collateral effects, *i.e.,* the extent to which the mining industry will absorb the costs of compliance by reducing either employment or output. It is possible, however, to make a rough estimate of these effects. The number of incremental closures of bituminous mines due to the rule (rather than the base case), was projected to be 6 mines as of 2005 and 4 mines as of 2015. This conclusion is consistent with the Department's previous analysis, which observed that the largest impact of the rule would be to close some mines sooner than they would have closed in the base case. Estimated employment impacts related to closures would be 70 jobs as of 2005 and 45 jobs as of 2015. Estimated production impacts related to closures would be 208,880 short tons of bituminous coal annually as of 2005 and 133,736 short tons as of 2015. Since the mines which may close presumably have relatively low productivity, the overall effect would be to raise industry productivity. The estimated level of impacts—about one-eighth of the baseline closure rate as of 2005 and one tenth the baseline closure rate as of 2015—is much too small to have a meaningful impact on the competitive structure of the industry.

The Department projected the number of incremental closures of anthracite mines due to the rule (rather than the base case) to be 2.28 mines as of 2005 and 1.38 mines as of 2015. Under this projection, the estimated maximum employment loss related to closures would be 10 jobs as of 2005 and 7 jobs as of 2015. This projected job loss assumes that no additional jobs are created elsewhere in the anthracite industry. Estimated production loss related to closures would be 14,564 short tons of bituminous coal annually as of 2005 and 11,058 short tons as of 2015. Since the mines which may close presumably have relatively low productivity, the overall effect would be to raise industry productivity. Closure of 1 or 2 mines is not expected to have a meaningful impact on the competitive structure of the industry.

It is also possible to assess the impact of the rule on mining communities using the counties in which such operations are located. Very small underground bituminous coal mines are found in 46 counties. If closures are randomly distributed, 22 of these counties have less than a 5 percent chance of any mine closure, 13 more have less than a 20 percent chance, 5 more have less than a 30 percent chance, and 3 more have less than a 50 percent chance of any mine closing. Thus, each of the possibly affected counties can expect to lose no more than 6 jobs and have very little chance of losing more than a dozen. Nearly half (42 percent) of very small underground bituminous coal mines are located in three counties (in three separate states). Of these counties, one can be expected (as of 2005) to have one mine closure, and the other two less than one mine closure each. A majority (65 percent) of anthracite underground and strip mines are located in one Pennsylvania county. This county can expect one mine closure as a result of the rule, and the other six counties with anthracite mines can expect one closure of a very small mine among them. Closure of one very small anthracite mine would have an impact of approximately 5 jobs. Overall, then, only two counties are likely to experience community impacts as great as one very small mine closing in any given year, and in neither of those counties is the impact likely to be greater than two very small mines closing.

The nature of the rule also makes it quite unlikely that there will be significant impacts on coal mine employment or output beyond those instances where mines close. The regulation has no direct effect on mining operations. The principal effect of the rule will be a very small increase in the cost of labor. This increased cost provides an incentive to substitute capital for labor, and to increase labor productivity and production generally to provide a broader base over which to spread the costs. This substitution, like any other measure designed to increase labor productivity, will enhance rather than restrict improvements in productivity. The Department's analysis already demonstrates a strong trend of increasing productivity in the coal mining industry, and any impacts of the rule will simply reinforce this trend.

In addition, recent history and available forecasts indicate that the use of coal in generating electricity will continue to increase. Any price pass-through will be small because the costs of the rule are (for the industry as a whole) not significant. There is no other plausible mechanism (except for closure of mines) by which the rule could induce reductions in production. Enhancement of productivity, for which there are incentives, will tend to increase production. Thus, aside from mine closures, the rule will not have adverse impacts on coal production.

Finally, there is a slight possibility that the rule may result in a decreased workforce in mines that continue to operate. The principal mechanism for such an impact is the incentive to

substitute capital for labor. A number of factors, however, make any such impact minimal in its significance. Because the costs of the rule are generally not significant, the incentive itself will be quite small. Increases in production will tend to mitigate job loss. By itself, any impact of the rule on employment is almost certainly small enough to be handled by attrition in an industry with an annual labor turnover rate of approximately 7 percent. Because the base case trend toward labor saving innovation in the coal mining industry is so strong, any adverse effect on employment will be a temporary acceleration of job loss, rather than a net long-term impact. Moreover, in the current strong employment market, any unemployment effects will generally be transitory, so that their significance will be minimal. For these reasons, aside from mine closures, the rule will not have significant adverse impacts on employment.

The Department's initial regulatory flexibility analysis, as supplemented by the additional study undertaken in the final regulatory flexibility analysis, demonstrates that the Department's final rule is being promulgated following examination of the potential effects of the rule on small coal mine operators. The Regulatory Flexibility Act does not dictate substantive results, or prevent the Department from acting in such a case. *See A.M.L. International, Inc.* v. *Daley,* 107 F. Supp. 2d 90, 105 (D. Mass. 2000) (''The intent of the RFA is not to limit regulations having adverse economic impacts on small entities.''). Because the Department believes that a revision of the regulations implementing the Black Lung Benefits Act is long overdue, the Department has decided to proceed with this final rule.

The Department also received comments on its economic analysis. In its initial regulatory flexibility analysis, the Department specifically invited comment on the assumptions used in developing its economic analysis, including 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. 64 FR 55008 (Oct. 8, 1999). One of the comments received by the Department, whose conclusions were endorsed by a number of other commenters, contained an economic analysis by Milliman & Robertson, Inc. (M&R). Rulemaking Record, Exhibit 89–37, Appendix A.

As an initial matter, the M&R analysis criticizes the assumption in the Department's economic analysis that the approval rate for claims paid by responsible operators and their insurers under the revised regulations will not exceed the approval rate for claims paid by the Black Lung Disability Trust Fund under the former regulations. The Department's economic analysis had assumed that the overall approval rate for responsible operator claims (currently 7.33 percent) would not exceed 12.18 percent, the overall approval rate for Trust Fund claims. Rulemaking Record, Exhibit 80, p. 38. The M&R analysis states that ''DOL has offered no support for this assertion.'' M&R at p. 17, *see also* Rulemaking Record, Exhibit 89–37, pp. 31–32.

The Department's analysis explicitly stated, however, that ''[t]he proposed regulations represent the Department's past and current practice in Trust Fund cases,'' and that ''several factors make the Trust Fund approval rate substantially higher than the responsible operator approval rate.'' Exhibit 80 at p. 38. These factors include the age of applicants whose claims are payable by the Trust Fund and the fact that most of their exposure to coal mine dust predated the 1969 federal dust standards. Thus, the Department believes that the approval rate for Trust Fund cases will remain the same, and that the approval rate for responsible operator cases will rise, but not to the level of Trust Fund approvals. The Department's assumption is based on its more than 15 years' experience in adjudicating claims for black lung benefits under the prior regulations, and its detailed knowledge of the evidentiary showings required for those claims' approval.

The National Mining Association, whose comment incorporates the M&R analysis, suggests that the Department's revised definition of the term ''pneumoconiosis'' represents a considerable departure from past practice. Specifically, the commenter takes issue with the Department's preliminary economic analysis which refused to assign costs to the amended definition of pneumoconiosis because inclusion of chronic obstructive pulmonary disease arising from coal mine employment as pneumoconiosis simply clarified the regulation and made it consistent with past practice. Rulemaking Record, Exhibit 89–37 at 29; Rulemaking Record, Exhibit 80 at 29. In the preamble to § 718.201, the Department has cited 14 decisions from six federal appellate courts with jurisdiction over the vast majority of claims filed under the Act (the Third, Fourth, Sixth, Seventh, Eighth, and Eleventh Circuits). These courts recognize that pneumoconiosis, as it is defined in the Act and was defined in the prior regulations, includes obstructive lung disease arising from coal mine dust exposure. Similarly, in the preamble to § 725.309, the Department has cited 44 decisions from seven federal appellate courts (the six listed above plus the Tenth Circuit). These courts recognize the progressive, latent nature of pneumoconiosis. All of these decisions reflect longstanding positions of the Department. Because of these positions, the Department has not attempted to deny claims because the miner's disabling lung disease was obstructive in nature, provided that condition was shown to have arisen out of coal mine employment, or because the miner's condition was alleged to have progressed. The Department, therefore, does not expect that any additional Trust Fund claims will be approved as a result of the revised definition of pneumoconiosis. Similarly, there is simply no reason to believe that the revised definition of pneumoconiosis will result in a higher approval rate in responsible operator claims than in Trust Fund claims.

The same commenter states that the limitation on documentary medical evidence tilts the playing field toward claimants by allowing a claimant three examinations (his choice of an approved physician to conduct the complete pulmonary evaluation plus two more) as opposed to the operator's two examinations. The commenter argues that this evidentiary imbalance will increase the number of approved claims payable by responsible operators. Rulemaking Record, Exhibit 89–37, p. 29. Again, however, the Department's Trust Fund experience forms a reasonable upper bound of the approval rate expected under the revised regulations. That experience demonstrates that the Department seldom develops more than two medical reports in any individual claim for which the Trust Fund is liable. In addition, claimants under the former regulations had the ability to choose *any* physician to conduct their initial evaluation, 20 CFR 725.406(a) (1999), subject only to a district director's approval, which was seldom refused. Claimants generally submitted no more than one additional medical report in support of their applications. Thus, once again, the rate of Trust Fund awards forms a reasonable upper boundary of the approval rate expected in responsible operator cases under the revised regulations.

Finally, the commenter argues that the provision requiring that ''controlling weight'' be given to the opinion of a treating physician will result in ''numerous'' claims being approved that previously would have been denied. The Department does not accept this assessment. The revisions to § 718.104 require only that an adjudication officer evaluate certain criteria to determine whether a treating physician may have developed an in-depth knowledge of the miner's pulmonary condition. As the Department has repeatedly emphasized, the regulation does not require that the adjudication officer credit the opinion of the treating physician where there is contrary evidence in the record. To the contrary, the rule is designed to force a careful and thorough assessment of the treatment relationship. 64 FR 54976–77 (Oct. 8, 1999); *see also* preamble to § 718.104, paragraph (f). Accordingly, the Department does not agree that this revision will result in the approval of ''numerous'' additional claims. The Department stands by its assumption in the initial regulatory flexibility analysis that any increase in the approval rate of claims due to this regulation will be ''very small.'' Exhibit 80 at p. 34. The Department reiterates that ''[i]t is difficult to see how this provision would lead to an increase in approval of weak or non-meritorious claims.'' Exhibit 80 at p. 27. The commenter's assertions have thus failed to undermine the Department's assumption that the approval rate for Trust Fund claims represents an appropriate upper bound for estimating the approval rate applicable to operator claims under the revised regulations.

The M&R analysis also arrives at a higher overall approval rate for Trust Fund claims (20 percent rather than 12.18 percent) by analyzing Trust Fund claims involving only post-1981 coal mine employment and by eliminating claims filed by individuals with less than 10 years of coal mine employment. M&R at p. 17 n. 41. The Department does not agree that manipulating the data in this fashion produces a more accurate result. First, responsible operators are also liable for claims involving pre-1982 coal mine employment, so it is appropriate to include that group. Second, exclusion of all claims based on less than 10 years of coal mine employment clearly will not create a true picture of the overall claims experience. A number of miners who are employed in the mines for less than 10 years ultimately are determined to be eligible for benefits. Although the M&R analysis includes claims filed by such miners in determining the number of approved claims, Transcript, *Hearing on Proposed Changes to the Black Lung Program Regulations* (July 22, 1997), p. 106 (testimony of Robert Briscoe), it excludes denied claims filed by such miners from the total number of filed claims. In its prior analysis, M&R stated that this exclusion was justified because claims filed by miners with less than 10 years of coal mine employment will not be ''present in the population of coal miners recently leaving the coal workforce.'' Rulemaking Record, Exhibit 5–160, Appendix 5, p. 28. The Department's database of claim filing information, however, does not support the inference that this group should not be counted in determining the approval rate for claims that are being filed currently. Indeed, throughout the last decade, claims filed by miners with less than 10 years of coal mine employment have represented approximately one-quarter of the total number of responsible operator claims. Because these claims continue to represent a significant number of responsible operator claims, the Department believes that both approved and denied claims from this group should be counted. Accordingly, the Department does not agree that its approval rate must be ''corrected'' by excluding these claims.

The M&R analysis also exaggerates the effect of the Department's rule on insurance rates. M&R criticizes the Department because its analysis ''fails to test the current federal black lung insurance rates being charged to determine if they are a reasonable base from which to project future cost changes * * *.'' M&R at p. 2. M&R suggests, for example, that the rate in Kentucky is ''too low,'' M&R at p. 7, and concludes that the corrected rate for underground bituminous mines, when combined with the effects of the Department's regulatory revision, will increase premiums by at least 1,075 percent. M&R at p. 8, Table 6. The impact of the Department's regulatory revision, however, does not include the correction of inadequate rates; such correction must be factored in independently, not assigned as a cost of the regulations. Moreover, M&R states that the premiums in the three other large Eastern coal states (Pennsylvania, Virginia, and West Virginia) are ''redundant'' (and rates are ''generally redundant in the other 23 coal mining states), suggesting that insurance companies (or in West Virginia's case, its state-administered fund) are making excess profits from these markets. M&R at p. 7. In this case, correcting redundant rates should not be assigned as a benefit of the revisions. In addition, the insurance rates used by M&R, M&R at p. 6, Table 4, whose source is not identified, are generally lower than the rates used by the Department by about one percentage point (*i.e.,* by $1.00 per $100 of payroll). Because the Department's analysis of the rule's cost was based on a percentage increase of existing rates, use of the M&R figures would result in a substantially lower estimate of total dollar costs. The substantial difference between the Department's analysis of insurance rate increases and M&R's prediction derives primarily from different assumptions about the approval rate for claims filed after the regulations go into effect. Because the Department does not believe that the approval rate for responsible operator claims will exceed the approval rate for Trust Fund claims, the Department does not believe that M&R's predictions concerning insurance rates are accurate. In any event, insurance rate increases are subject to approval by state authorities.

The Department also requested comment on a possible increase in the number of claims filed as a result of this regulatory revision. The Department's economic analysis was based on the assumption that, although the revisions will not produce a significantly greater number of approved claims, expectations created by the mere issuance of regulatory revisions will cause a temporary increase in the number of claims filed, an additional 3,440 responsible operator claims over a two-year period. Rulemaking Record, Exhibit 80, pp. 39, 42. The M&R analysis did not specifically address this assumption. Instead, the M&R analysis is simply based on its own, wholly different assumption regarding the number of claims that are likely to be filed once the revised regulations take effect. M&R posits that ''the application of the reproposed regulations to the large number of denied claims from all past years will in effect rewrite the history of approvals.'' M&R, p. 21. M&R uses an actuarial model to estimate the ''number of ultimate claim filings that are likely to be received'' under the former regulations and under the newly revised regulations. M&R, p. 21. From the data provided in Table 12 of the M&R analysis, it appears that M&R estimates that 2,567 additional claims will be filed by miners whose last coal mine employment was during the years 1982 to 1999. However, the Department was unable to determine what assumptions M&R made to generate this estimate. In any case, M&R's estimate cannot be compared with the

Department's, because M&R excludes claimants with less than 10 years of coal mine employment. The Department believes that it is not necessary to change the methodology used in the initial regulatory flexibility analysis to estimate the likely increase in claims resulting from the revised regulations.

The Department also received comments disputing its assumption that coal mine operators could pass on to coal consumers by price increases the increased costs caused by the Department's rule. Rulemaking Record, Exhibit 80, p. 52. The Department agrees that it is difficult to determine with precision the ability of small coal mine operators to pass on costs to coal consumers. Indeed, the Department acknowledged in its initial economic analysis that some small coal mine operators would be unable to pass on these costs, and that this inability might represent the difference between being able to continue mining operations and suspending them. Interpreting current profit rates that are unsustainably low or negative, however, must be done carefully, because there are two distinct types of firms that may have such profit rates at any one point in time. Some firms may have such rates for a short time, because of industry cycles or the firm's unique circumstances. These firms will rebound and may or may not experience significant impacts from a regulation. Other firms will have negative profits because they are already in the process of failing.

These two cases have very different implications in the analysis of the economic impact of the Department's revisions. If a firm is in the process of failing in any event, the impact of the revised regulations will be small or non-existent. At most, the impact will hasten the firm's failure by a short period of time. Neither the failure itself, however, nor any loss of jobs, should be considered an impact of the regulations. If a firm is about to rebound, the situation is considerably more complicated. The issue is whether the firm will rebound to the level that it can absorb the economic impact. It is perfectly correct in such cases to say, as one commenter points out, that ''additional costs imposed by regulations are certainly relevant since the added cost of regulations will make it that much more difficult for the firm to achieve profitability.'' Rulemaking Record, Exhibit 89–37, p. 33. The problem is that it is extremely difficult to predict from a negative profit rate how far a firm may rebound. One reasonable assumption (given the very limited data) is that a rebounding firm will achieve median profits. If that is the case, then, as the Department's initial analysis indicated, the firm will not fail even given the economic impact of the regulations. See Rulemaking Record, Exhibit 80, Exhibit P.

The Department's analysis, moreover, is based on the assumption that coal mine operators (other than culm-bank operations, discussed below) will be unable to pass through any of the costs associated with the Department's rule. That assumption is based on a worst-case scenario for analytical purposes, and it does not necessarily reflect the current state of the energy industry. Although the recent deregulation of electric utilities has led to considerable reorganization, the use of coal is both extensive and increasing. In general, electric utilities currently are taking advantage of the opportunities presented by deregulation to deal with expanding demand by management, rather than by making major investments in new generating capacity. In this environment, natural gas and oil are attractive, in part, because they are used to meet on-peak demand for electricity. As a result, most generation capacity, now in use and currently planned, is gas-fired. The relatively low capital cost of gas- or oil-fired generation capacity (despite the relatively high fuel cost) makes these fuels cost-effective for the low capacity utilization associated with on-peak power production. Coal, however, is the mainstay of off-peak, baseline electricity generation. The different use pattern is reflected by different capacity utilization rates. In 1996, for example, capacity utilization was 63 percent for coal-fired power plants but only 20 percent for natural gas power plants and 11 percent for oil-fired plants. (EIA, ''Challenges,'' Chapter 1, p. I–4). In baseline power generation, coal faces less competitive pressure and more opportunities for investment in new capacity. Run-of-stream hydroelectric power is limited, as is the potential for its expansion. Nuclear generation capacity is declining because old plants are coming off line, and no new ones are being built. As a consequence, utilities are burning more coal—not less—and this trend is expected to continue.

It is certainly true that long-term high-price contracts for coal are giving way to shorter term contracts with more flexibility. Yet even here there are mitigating factors. Only about half of current contracts will expire by 2005. The impetus for the shift away from long-term contracts was stimulated by stabilization of other fuel prices at moderate levels, but quite recently oil prices have shot up again. The point is that the current market still offers considerable opportunities for passing costs to consumers.

Available information indicates that most of the downward pressure on coal prices is flowing from developments within the coal industry and intra-industry competition. Coal producers as a whole have increased their productivity and lowered their costs. Cost reduction has resulted from improved management of mining operations and delivery, introduction of new technology (*e.g.,* longwall mining), investment in more productive equipment, consolidation to achieve economies of scale, closure of high-cost mines, and takeover and restructuring of high cost mines to operate them more economically. The EIA has observed that ''the relationship between coal prices and productivity gains is circular: Productivity gains allow coal prices to be lowered and price declines induce actions by coal producers that raise productivity and cut costs' (EIA, ''Challenges,'' Chapter 1, p. I–12). The problem that small coal mines face is that they are less able than large mines to implement such productivity enhancing measures. As a result, small inefficient coal mine operators are being squeezed by larger more efficient mine operators.

Rapidly increasing productivity, however, does not preclude the coal industry as a whole from increasing its prices in the short run to recoup regulatory compliance costs. These costs are small. Based on West Virginia insurance rates, the increase in insurance rates would translate into a one-time increase in labor costs of 1.2 percent a year. By contrast, labor productivity (tons per miner hour) increased by an average of 6.9 percent each year from 1980 to 1996 (EIA, ''Challenges,'' Chapter 1, p. I–12). This annual productivity increase—five or six times as large as the estimated impact of the regulation—would allow the coal industry to pass through costs of the rule without raising prices at all. Only a small one-time diminution in the reduction of the price of coal would be needed.

It is true that small mines cannot increase prices beyond those of larger counterparts and stay competitive. The analysis of relative impacts indicates that very small, underground coal mines may be able to pass through one quarter to one half of their costs of the rule to consumers under the cover of larger mines passing all of their costs of the rule through to consumers. The Department's preliminary economic analysis treated pass-through of costs of the rule essentially as a factor that could mitigate to some extent—not prevent—

impacts on profits. *See* Rulemaking Record, Exhibit 80, pp. 52–56. For the reasons outlined above, the Department continues to believe that this is the case. Because of the difficulty of quantifying these effects, however, the quantitative analysis will continue to assume zero cost pass-through. The uncertainty as to the extent to which costs can be passed through does not mean that the Department is unable to estimate impacts, however. Rather, the assumptions that the analysis made to deal with the uncertainty result in estimates of impacts on profits and closures that are known to be biased upward—as is appropriate for a conservative analysis of impacts.

The market for anthracite coal is significantly more sheltered from price competition than the market for bituminous coal. Since 1996, a majority of anthracite production has been accounted for by culm bank operations. These operations salvage previously-mined anthracite from old mine tailings on the surface. The market for these operations (and potentially for other anthracite mines) is nearby power plants. Most of these plants are cogeneration plants, which produce heat or steam for industrial use as their principal output, and then generate electric power as a byproduct. Some, however, are small power plants built solely to use anthracite from culm banks. The Public Utility Regulatory Policies Act of 1978, Pub. L. 95–617, 92 Stat. 3117(1978), requires electric utilities to purchase electric energy from cogeneration facilities and other qualifying small power production facilities. The Act goes on to stipulate that the price at which utilities purchase electric energy may not exceed ''the incremental cost to the electric utility of alternative electric energy.'' 16 U.S.C. 824a–3(b). Since most of the electricity generated with the anthracite is a byproduct of steam and heat produced for other purposes and the capacity is already installed, the incremental cost of power to utilities is virtually certain to provide sufficient revenue to make these anthracite operations economically viable, despite the costs of the rule. If anything, anthracite from culm banks is likely to become more competitive as the prices of other fuels used to generate electricity rise. Indeed, anthracite culm banks are the only part of the coal mining industry in which both the number of very small operations and the number of employees have expanded substantially over the last 10 to 15 years.

The broader market for anthracite includes metallurgical uses and other specialty markets. This provides anthracite with a degree of product differentiation that bituminous coal does not have. The economic forces in the anthracite mining industry are significantly different from those in the bituminous coal mining industry. In anthracite, there are no large mines, no high-productivity mines, and generally not the geological conditions that are favorable to large-scale equipment or techniques that would allow increases in productivity. Instead of a steady increase in output, anthracite production (exclusive of culm banks) fell by 19 percent between 1986 and 1997. Together with the rise of anthracite salvage operations, this decline appears to reflect exhaustion of anthracite deposits that can be mined economically, rather than the sort of fierce competition characterized by highly elastic demand.

One comment argues that the Department's initial regulatory flexibility analysis did not properly analyze the effect of its rule on coal mine construction and transportation contractors, as well as on other small businesses performing services at mine sites. The Department acknowledged that its rule would have an effect on entities in the ''Coal Mining Services'' industry, and estimated that of 275 firms listed in data available from the Small Business Administration, no more than 209 were small businesses within the SBA's definition (less than $5 million in annual receipts). The Department recognized, however, that this number might understate the number of coal mine construction and coal transportation companies. 64 FR 55008 (Oct. 8, 1999).

The RFA does not require, however, that the Department determine precisely the economic effect on small businesses where it is not feasible to do so. Instead, it requires only that the initial regulatory flexibility analysis ''describe the impact of the rule on small entities.'' 5 U.S.C. 603(a). The Department's initial regulatory flexibility analysis described the impact of its proposed regulations based on an economic analysis. The economic analysis projected an increase in the approval rate of black lung claims payable by responsible operators and a temporary increase in the number of claims filed. To the extent that coal mine contractors obtain insurance to spread the risk of potential liability under the Act, the Department's initial regulatory flexibility analysis of the resulting increase in insurance premiums was also relevant to those entities. In the absence of a more precise estimate of the number of entities involved, however, and the manner in which those entities currently absorb the costs imposed by the Black Lung Benefits Act, the Department's initial regulatory flexibility analysis fulfilled the requirements of the RFA by identifying a potential impact on the coal mine contracting industry.

Thus, the Department does not believe the comments undermine the validity of its initial regulatory flexibility analysis, or of the economic analysis that the Department used in preparing it. Both analyses describe the impact that the revised regulations are likely to have on small coal mine operators, and both analyses acknowledge that this impact may be sufficient to make the mining of coal uneconomical for some. 64 FR 55008–09 (Oct. 8, 1999); Rulemaking Record, Exhibit 80, pp. 44–46, 52. The Department's proposal, and its discussion of possible alternatives intended to mitigate the impact of the proposal on small businesses, were made with full knowledge of the projected economic impact. Accordingly, although the Department has committed to the revision of the Part 722 regulations, *see* discussion of alternatives, below, and preamble to Part 722, the Department has not altered its proposal in response to any of the comments it received in response to the initial regulatory flexibility analysis.

Small Businesses to Which the Rule Will Apply

The revised regulations implementing the Black Lung Benefits Act will apply, like the Act itself, to coal mine operators. *See, e.g.,* 30 U.S.C. 932(b) (''each such operator shall be liable for and shall secure the payment of benefits * * * ''). The term ''operator'' includes not only traditional coal mining companies, but also employers who provide services to such companies, including coal mine construction and coal transportation companies. 30 U.S.C. 802(d). In the initial regulatory flexibility analysis published in its second notice of proposed rulemaking, the Department observed that the Regulatory Flexibility Act requires an administrative agency to use the definition of a ''small business'' promulgated by the Small Business Administration unless the agency, after consulting with the SBA's Office of Advocacy and providing an opportunity for public comment, establishes its own definition. 5 U.S.C. 601(3). (The Department's regulations do not apply to any small organizations or small governmental jurisdictions; accordingly, the Department's analysis is limited to small businesses.) The Department therefore announced its intention to use the SBA definition, which establishes

criteria for different industries, arranged by the Standard Industrial Codes (SICs) used by the Bureau of the Census. SBA's regulations define a small business in the coal mining industry (SIC Codes 1220, 1221, 1222, 1230, and 1231) as one with fewer than 500 employees. A small business in the coal mining services industry (SIC Codes 1240 and 1241) is one with less than $5 million in annual receipts. 64 FR 55007–08 (Oct. 8, 1999).

Based on 1995 data, the Department determined that of 2,822 establishments in the coal mining industry, 2,811 employed less than 500 people. Of those, 1,581 were surface bituminous mining companies, 1009 were underground bituminous mining companies, and 221 were anthracite mining companies. The Department estimated that no more than 209 of the 275 firms in the coal mining services industry would be considered small businesses. The Department observed, however, that its estimate did not necessarily include all coal mine construction and coal transportation companies, and that the precise number of such businesses could not be estimated with precision. 64 FR 55007–08 (Oct. 8, 1999).

More recent data available from the Mine Safety and Health Administration suggest that the composition of the coal industry has not changed significantly. In 1997, 2,568 of 2,578 establishments in the coal mining industry employed less than 500 people. Of these, 1,441 were surface bituminous mining companies, 913 were underground bituminous mining companies, and 214 were anthracite mining companies. Census figures available from the Small Business Administration do not allow the Department to calculate how many of the 317 firms in the coal mining services industry would be considered small businesses, because those figures do not contain sufficient information on the revenues of those firms.

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

In its initial regulatory flexibility analysis, the Department observed that its proposed revisions would not impose any additional reporting or recordkeeping requirements on small businesses. The Department stated that the compliance requirements of the rule were largely economic in impact. The Department projected its regulatory revisions would increase the cost of commercial insurance (through increased premiums) purchased by coal mine operators to secure their benefits liability under the Act. The Department also projected an increase in the potential exposure of operators who are authorized to self-insure their liability under the Act. A summary of these additional costs was published in the Department's initial regulatory flexibility analysis. 64 FR 55008–09 (Oct. 8, 1999). In addition, the Department observed that coal mine operators that did not purchase insurance, either because they were self-insured, or because they were not required to secure benefits, or because they had ignored the Act's security requirement, would face additional burdens. These burdens included responding more promptly to notice from the Department that a claim had been filed by one of their former employees, and posting security in the event that they were held liable for the payment of benefits on an individual claim. Operators that had been authorized to self-insure their liability under the Act would be required to maintain security for claims filed against them, even after they ceased mining coal. Finally, the Department observed that the regulatory revisions enhanced its ability to enforce civil money penalties against operators that failed to comply with the Act's security requirements. 64 FR 55008–09 (Oct. 8, 1999).

The regulatory revisions in the Department's final rule do not significantly change the costs identified by the Department's initial regulatory flexibility analysis. Specifically, only one of the changes that the Department has adopted in this final rule in response to public comments has cost implications. The Department has eliminated the notice of initial finding, a document that the Department currently uses to deny claims informally before the district director. Both the first and second notices of proposed rulemaking proposed the continued use of this document. Eliminating issuance of initial findings will decrease operator costs in all cases by reducing the numbers of responses that coal mine operators have to file with the Department. Eliminating this document, however, will also require that coal mine operators undertake the development of responsible operator evidence (evidence showing that another entity that employed the miner should be the responsible operator) in a number of additional cases. Under the Department's second notice of proposed rulemaking, coal mine operators would not have been required to develop responsible operator evidence in cases in which the claimant failed to respond to the Department's notice of initial finding denying their claims. Under the final rule, a coal mine operator may not know whether the claimant is interested in pursuing his claim (unless the claimant withdraws his application under § 725.306) until after that operator has developed its responsible operator evidence.

The Department believes that the costs resulting from this revision will have only a minor impact on its previous estimate of the costs of the rule. As an initial matter, the Department estimates that this revision will affect less than 10 percent of all responsible operator cases. In FY 1999, a total of 5,724 cases were filed. The Department estimates that just over 75 percent of these claims, or 4,293, were claims involving potential responsible operator liability. Ten percent of this number is 429. The Department's economic analysis assumed that an additional 1,720 operator cases will be filed each year for two years following issuance of the Department's final rules. Ten percent of this number is 172. In each of the next two years, then, the revision will cause the additional development of responsible operator evidence in only 601 claims. Under the proposed rule in the Department's second notice, however, operators would also have had to develop such evidence in the 30 percent of such cases that proceed beyond adjudication by the district director. Consequently, the Department's final rule will require additional evidentiary development in only the remaining 70 percent of cases, or 421 cases. The Department has no way of accurately estimating the costs of developing such evidence. However, a rough estimate can be made using information in M&R's first analysis. M&R estimated that the total cost to operators in defending claims that were resolved at the district director level was approximately $3,000. Rulemaking Record, Exhibit 5–160, Appendix 5, p. 24. This figure included not only the development of responsible operator evidence but, under the Department's first proposal (to which M&R was responding), of all medical evidence as well. Although the cost of developing medical evidence is typically much higher than the cost of operator evidence, because it involves payments to expert witnesses, the Department will assume that half of these defense costs represent the cost of developing responsible operator evidence. Accordingly, the total additional costs imposed by this revision are not likely to exceed $631,050 (70 percent of 601 claims times $1,500) in each of the first two years, and will drop to no more

than $450,450 (70 percent of 429 claims times $1,500) for each year thereafter. In light of the point estimate of $57.56 million in annual costs identified by the Department's economic analysis of the proposed rule, these additional costs are not significant. In any event, these additional costs will be at least partially offset by the savings realized in all cases from the reduced number of required operator responses. In addition, the Department's decision to permit the district director to refer a case to the Office of Administrative Law Judges with no more than one operator as a party to the claim will result in additional savings to coal mine operators in some cases.

Description of Steps the Agency has Taken to Minimize the Impact on Small Entities Consistent With the Stated Objectives of Applicable Statutes; Discussion of Alternatives

The primary objective of the Black Lung Benefits Act is set forth in § 901 of the Act:

> It is, therefore, the purpose of this subchapter to provide benefits, in cooperation with the States, to coal miners who are totally disabled due to pneumoconiosis and to the surviving dependents of miners whose death was due to such disease; and to ensure that in the future adequate benefits are provided to coal miners and their dependents in the event of their death or total disability due to pneumoconiosis.

30 U.S.C. 901. The statute also seeks to ensure, however, that liability for a miner's benefits is borne by the entity most responsible for the development of that miner's totally disabling pneumoconiosis. Prior to 1978, claims that were not paid by individual coal mine operators were paid by the federal government from general revenues. In 1978, Congress created the Black Lung Disability Trust Fund, financed by an excise tax on coal production, to assume the payment of benefits in cases for which no individual operator bore liability. Congress clearly indicated its preference that the Trust Fund should be considered a payment source of last resort. In discussing the successor operator provisions of the Black Lung Benefits Reform Act of 1977, enacted in 1978, the Senate Committee on Human Resources, whose bill contained the provisions ultimately included in the Act, stated: ''It is further the intention of this section, with respect to claims [in] which the miner worked on or after January 1, 1970, to ensure that individual coal mine operators rather than the trust fund bear the liability for claims arising out of such operator's mine, to the maximum extent feasible.'' S. Rep. 95–209, 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).

In its initial regulatory flexibility analysis, the Department observed that these two principles severely constrained its ability to select alternatives that the Department had identified as potentially providing relief for small coal mine operators. The Department discussed several alternatives, including adjusting a miner's entitlement criteria according to the size of the operator that would be considered the responsible operator under the Department's regulations. A second alternative would have limited the liability of certain employers. These employers might include those that met either the SBA definition of a small business (over 90 percent of the industry) or those employers with fewer than 20 employees, companies that the Department's economic analysis had identified as most vulnerable. In such cases, the Department considered imposing liability on larger operators or on the Black Lung Disability Trust Fund. The Department rejected both alternatives, however, as contrary to the intent of Congress as expressed in the Black Lung Benefits Act. 64 FR 55009 (Oct. 8, 1999). The Department did provide relief to small mining companies in its revised regulations governing the assessment of civil money penalties for an operator's failure to secure the payment of benefits, 20 CFR Part 726, Subpart D. These regulations specifically assess a smaller base penalty amount on a smaller employer, *i.e.,* one with few miner-employees. Finally, the Department invited comment from interested parties as to other alternatives that would reduce the financial impact of the rules on the small business community.

A number of comments suggest that by inviting comments as to other alternatives, the Department abdicated its responsibilities under the Regulatory Flexibility Act. The Department does not agree. Nothing in the RFA requires an agency to forego rulemaking because the regulated community is unhappy with the alternatives that the agency considered in its initial regulatory flexibility analysis, or because that community has proposed additional alternatives. On the contrary, the RFA encourages agencies to notify small businesses of proposed rulemaking activities precisely so that those small businesses may participate in the identification of additional alternatives that might reduce the impact of the rule. *See* 5 U.S.C. 609(a).

The National Mining Association (NMA), endorsed by a number of other commenters, has identified six alternatives that it believes the Department should have considered: (1) establish a fund to insure coal mine operators for federal black lung claims on a first dollar basis under the authority granted the Department by 30 U.S.C. 943; (2) establish a fund to reinsure coal mine operators for federal black lung claims on a specific or aggregate of loss basis, also under the authority granted the Department by 30 U.S.C. 943; (3) name only the most likely responsible operator; (4) establish criteria to determine when a state black lung program is sufficient to end the federal program in that state; (5) allow settlement of federal black lung claims; and (6) establish cost-containment mechanisms for health care providers. Rulemaking Record, Exhibit 89–37, p. 31. The M&R analysis similarly suggests the first four alternatives, although it would apply the third alternative (naming the most likely operator) only where that operator is a small coal mine operator. In addition, the M&R analysis suggests that the Department establish a formal, ongoing review of state workers' compensation programs to determine whether they are sufficient to permit the Secretary to declare the federal program inapplicable to miners in particular states. Rulemaking Record, Exhibit 89–37, Appendix A, M&R at pp. 17–18. The Department will consider these alternatives in order.

1. *Exercising the authority of 30 U.S.C. 943* (NMA alternatives 1 and 2, M&R alternatives 1 and 2). Section 933 of the Black Lung Benefits Act, 30 U.S.C. 943, authorizes the Secretary of Labor to establish a Black Lung Compensation Insurance Fund to allow coal mine operators to purchase insurance to secure their obligations under the Act. The Fund may be used to insure coal mine operators directly, 30 U.S.C. 943(c)(1), or to enter into reinsurance agreements with one or more insurers or pools of insurers, 30 U.S.C. 943(c)(2). The Act provides an important limitation on the Secretary's authority, however: ''The Secretary may exercise his or her authority under this section *only if, and to the extent that, insurance coverage is not otherwise available, at reasonable cost, to operators of coal mines.*'' 30 U.S.C. 943(b) (emphasis added). The record contains no evidence that would allow the Secretary to determine, under subsection (b), that insurance coverage is not currently available at reasonable cost to operators of coal mines.

Consequently, the statute does not permit the ''alternative'' suggested by the commenters. Projections provided by the mining and insurance industries, however, predict significantly higher percentage increases in the cost of commercial black lung insurance if these rules become final. The Department disagrees with these projections and has explained its reasoning above. The Department also recognizes its obligation, however, to closely monitor insurance rates, especially any increase in rates that may result from the final promulgation of the Department's regulations. To the extent that rates do increase, the Department will have to determine whether those increases have resulted in insurance becoming unavailable at a reasonable cost to coal mine operators, the statutory prerequisite for the Secretary's authority under 30 U.S.C. 943(b).

2. *Naming only the most likely responsible operator* (NMA Alternative 3, M&R alternative 3). The NMA suggests that the Department name only the most likely responsible operator, which the NMA asserts was the Department's practice under its former regulations. The M&R analysis states that the Department could form an insurance fund to reimburse the Black Lung Disability Trust Fund for claims in which the most likely responsible operator is ultimately determined not to be liable for the payment of benefits, thereby imposing an unwarranted liability on the Fund. The Department does not agree that it formerly named only the most likely responsible operator. In its discussion of § 725.408, the Department observed that, where necessary, it made more than one operator a party to a claim under the prior regulations. *See* preamble to § 725.408, paragraph (f). In addition, M&R's solution to the problem of imposing additional risk on the Trust Fund—that the Department use an ''insurance fund'' to reimburse the Trust Fund for such claims—is flawed on two counts: 1) for the reasons described above, the Department cannot establish an insurance fund absent a finding that insurance is not available at reasonable cost; and 2) reimbursement of the Trust Fund for such claims is not among the statutorily-prescribed uses for monies in an insurance fund, *see* 30 U.S.C. 943(g)(1)(A)–(C).

The Department notes, however, the continued objection of a number of commenters to the Department's proposal that operators be forced to participate in a joint defense of the claimant's eligibility, *see* preamble to § 725.414. The Department has therefore reconsidered its administrative processing of cases in which the identity of the responsible operator is in doubt. As revised, the regulations permit the district director to refer a case to the Office of Administrative Law Judges with no more than one operator included as a party to the claim. *See* preamble to § 725.418. The Department recognizes that this approach imposes additional risk on the Black Lung Disability Trust Fund. *See* preamble to § 725.414. The Department has concluded that this risk is acceptable, however, because all the potentially liable operators will be required to submit evidence relevant to the issue of operator liability while the case is pending before the district director. The district director will thus have available all of the relevant evidence when he finally designates the operator responsible for payment of a claim. That one operator will remain a party in further proceedings.

The Department does not believe that this alternative is a truly significant one—*i.e.,* one which will provide the affected small business community with significant relief from the costs of the Department's regulatory revisions. First, it will apply in only a small percentage of cases. The Department estimates that less than 10 percent of responsible operator cases involve substantial questions as to the identity of the operator that should be liable for the payment of benefits. In addition, only 33 percent of all cases filed are referred to the Office of Administrative Law Judges. Accordingly, the Department's revision will likely affect only 3 percent of responsible operator cases. Second, the additional cost that would have been required by continued operator participation is relatively small. It is true that operators will no longer have to defend against an effort by the designated responsible operator to shift liability to them beyond the district director level. Instead, once a case is referred to the Office of Administrative Law Judges, if the designated responsible operator shows that it does not meet the criteria for a responsible operator, § 725.495, liability will shift to the Trust Fund. The costs associated with an operator's continued participation in a claim before the Office of Administrative Law Judges would have been small, however, because the operator would already have had to develop and submit all evidence relevant to the liability issue while the case was pending before the district director. The final regulations do not alter that requirement. A second set of costs eliminated by the Department's revision are those associated with monitoring the designated responsible operator's litigation of the claimant's eligibility while the case is pending before the Office of Administrative Law Judges. The Department's proposal would have permitted a potentially liable operator to submit its own documentary medical evidence upon establishing that the designated responsible operator had not undertaken a full development of the evidence. The Department does not believe that this situation would have arisen often, and thus believes that the overall costs associated with exercising this right were not significant. The costs relevant to both of these issues were thus largely the costs associated with hiring an attorney to monitor the litigation and, as appropriate, attend the hearing or file a brief to argue on the operator's behalf. In preparing its economic analysis, the Department used the industry's estimate of $6,000 as the current average cost for defending a claim that proceeds beyond the district director level. See preamble to § 725.407. This cost includes not only attorneys' fees, but also the development of evidence relevant to operator liability and claimant eligibility. The Department does not believe that the fees charged by an attorney to monitor the litigation and present argument represent a large component of the estimated costs. Accordingly, in light of both the small number of affected cases and the minimal expenses involved, the Department does not consider that its adoption of this alternative will result in significant savings to small coal mine operators.

3. *Establish criteria to determine when a state's workers' compensation program provides ''adequate coverage'' for totally disabling pneumoconiosis* (NMA alternative 4, M&R alternative 4). Section 421 of the Black Lung Benefits Act, 30 U.S.C. 931, requires the Secretary to publish in the **Federal Register** a list of all states whose workers' compensation laws provide ''adequate coverage'' for occupational pneumoconiosis. The Secretary's certification that a state provides adequate coverage prevents any claim for benefits arising in that state from being adjudicated under the Black Lung Benefits Act.

The Act provides certain criteria states must meet in order to gain Secretarial certification, 30 U.S.C. 921(b)(2)(A)—(E). It also provides that the Secretary may, by regulation, establish additional criteria. 30 U.S.C. 921(b)(2)(F). In its first notice of proposed rulemaking, the Department observed that the applicable regulations, 20 CFR Part 722 (1999), had not been

amended since 1973, and that, in light of statutory amendments in 1978 and 1981, those regulations were obsolete. 62 FR 3347 (Jan. 22, 1997). Accordingly, the Department proposed to delete the specific criteria contained in Part 722. The Department proposed replacing them with a general statement that it would review any state's application for certification in light of the provisions of the then-current Act, and the principle that the state law would be certified only if it guaranteed at least the same compensation, to the same individuals, as was provided by the Act.

The NMA and M&R urge the Department to develop specific criteria that would allow a state to determine what steps it needs to take to allow the Secretary to certify its law as providing adequate coverage for occupational pneumoconiosis. M&R states that ''[n]o single alternative would be more helpful to small coal operations than to be required to provide compensation under only one mechanism.'' M&R at p. 18. This suggestion would require the Department to update the criteria previously set forth in Part 722. Although no state has sought the Secretary's certification since 1973, the Department accepts the commenters' suggestion that a revision of the Part 722 criteria will encourage states to seek the certification permitted by the Act. Publication of a current set of criteria, however, will require considerable study and additional drafting, and would needlessly delay final promulgation of the remaining regulations in the Department's proposal. Following completion of that work, the Department will issue a new notice of proposed rulemaking in order to ensure that interested parties have an opportunity to comment upon possible Secretarial certification criteria. The Department believes that, in the interim, the revised Part 722 will accommodate any state seeking certification.

M&R also suggests that the Department establish a formal and ongoing Departmental review of state laws to determine whether they provide adequate coverage. The Department does not believe that it would be productive to engage in such a review. States that revise their workers' compensation laws to meet the Department's criteria will do so in order to preempt the application of the Black Lung Benefits Act. Those states will have a clear incentive to submit an application to the Department for the appropriate certification. Relying on states to initiate the certification process thus makes the most efficient use of government resources at both the state and federal levels.

4. *Permit the settlement of black lung claims* (NMA Alternative 5). The NMA suggests, without further explanation, that permitting the settlement of black lung claims will reduce the impact of the Department's regulatory revisions on small coal mine operators. The Department believes that the Black Lung Benefits Act does not allow the settlement of claims, and that permitting the settlement of claims would be contrary to the objectives of the Act in any event.

The Black Lung Benefits Act incorporates two provisions of the Longshore and Harbor Workers' Compensation Act relevant to settlements, and specifically excludes a third provision. Section 15(b) of the LHWCA, 33 U.S.C. 915(b), renders invalid any ''agreement by an employee to waive his right to compensation under this chapter.'' Section 16, 33 U.S.C. 916, invalidates any ''release * * * of compensation or benefits due or payable under this chapter, except as provided in this chapter.'' Together, these provisions, which have been part of the LHWCA since its 1927 enactment, have been interpreted to ''prevent[] any private settlement of a claim between the employer and the employee.'' *American Mutual Liability Ins. Co. of Boston* v. *Lowe,* 85 F.2d 625, 628 (3d Cir. 1936); *see also Lumber Mutual Casualty Ins. Co. of New York* v. *Locke,* 60 F.2d 35, 37 (2d Cir. 1932).

In 1938, Congress amended section 8 of the Longshore Act to specifically provide a settlement procedure in cases in which the injured employee sought compensation for permanent or temporary partial disability. *See* Act of June 25, 1938, c. 685, § 5, 52 Stat. 1166. The federal courts have long interpreted the section 8 procedure as the only means by which an injured employee could validly settle a claim for compensation. *See, e.g., Norfolk Shipbuilding & Drydock Corp.* v. *Nance,* 858 F.2d 182, 185–6 (4th Cir. 1988), *cert. denied,* 492 U.S. 911 (1989); *Oceanic Butler* v. *Nordahl,* 842 F.2d 773, 776 n. 3 (5th Cir. 1988). In incorporating certain procedures of the LHWCA into the Black Lung Benefits Act, however, Congress specifically excluded LHWCA § 8. *See* list of excluded provisions in 30 U.S.C. 932(a). Moreover, although Congress authorized the Secretary to vary the terms of incorporated LHWCA provisions in order to administer the Black Lung Benefits Act, it forbade the Department from promulgating provisions that were ''inconsistent with those specifically excluded * * *.'' By this language, Congress expressed its intention that the Secretary not use the broad powers granted her by the Black Lung Benefits Act to provide by regulation the substance of provisions that Congress had explicitly declined to incorporate. *See* Senate Conference Committee Report, reprinted in Committee Print, 94th Cong., 1st Sess., Legislative History of the Federal Coal Mine Health and Safety Act of 1969 at 1624 (''The Secretary of Labor is also authorized to publish additional provisions by regulation, together with all or part of the applicable provisions of said Act other than those specifically excluded * * *.''), quoted in *Director, OWCP* v. *National Mines Corp.,* 554 F.2d 1267, 1274 n. 31 (4th Cir. 1977).

Congress's decision to exclude the settlement provisions of LHWCA section 8 when it incorporated other LHWCA provisions makes sense. When Congress enacted the Black Lung Benefits Act in 1969, and when it amended the list of excluded sections in 1972, section 8 permitted only the settlement of claims for partial disability. Because benefits under the Black Lung Benefits Act are available only to miners who are totally disabled due to pneumoconiosis, and to the survivors of miners who die from that disease, there was no reason to incorporate section 8. Congress amended section 8 in 1972 to allow settlement of claims for total disability, and again in 1984 to permit the settlement of survivors' claims. Pub. L. 92–576, § 20, 86 Stat. 1264 (1972); Pub. L. 98–426, § 8(f), 98 Stat. 1646 (1984). Congress did not revisit its exclusion of Longshore Act provisions from the Black Lung Benefits Act on either occasion, even though Congress specifically amended the relevant statutory section in the Black Lung Benefits Act, 30 U.S.C. 932(a), in the course of amending the LHWCA in 1984. *See* Pub. L. 98–426, § 28(h)(i), 98 Stat. 1655 (1984).

The Department thus believes that Congress has expressed its intent not to permit the settlement of claims for black lung benefits. Moreover, the Department believes that this decision is supported by sound policy considerations. The Black Lung Benefits Act is intended to provide benefits (37 and 1/2 percent of the monthly pay for a federal employee in grade GS–2, step 1, augmented for additional dependents) to miners who are totally disabled due to pneumoconiosis and to the survivors of miners who die due to the disease. 30 U.S.C. 922(a). ''Providing a minimum level of income for eligible miners disabled by black lung is at the heart of the statute.'' *Harman Mining Co.* v. *Stewart,* 826 F.2d 1388, 1390 (4th Cir. 1987). Interpreting the Act so as to

permit a totally disabled miner to accept a settlement that reduces that minimum level of benefits would thus contravene one of the basic objectives of the Act. Former coal miners tend to apply for black lung benefits shortly after they leave employment in the coal industry or when they retire, usually at the same time they file an application for Social Security benefits, rather than in response to a specific diagnosis or injury. The population of claimants thus tends to be significantly different than is the case with the population of claims under other workers' compensation programs, including the LHWCA. Because of the latent, progressive nature of pneumoconiosis, *see* preamble to § 725.309, a substantial number of applicants whose initial claims are denied are ultimately determined to be eligible for black lung benefits. In its second notice of proposed rulemaking, the Department observed that the approval rate for subsequent claims filed by miners whose initial claims were denied (10.56 percent) is higher than the approval rate for first-time applicants (7.47 percent). 64 FR 54984 (Oct. 8, 1999). These statistics demonstrate that first-time applicants may not fully appreciate the extent to which they may be affected by pneumoconiosis later in life. As a result, the Department believes that it would be inappropriate to encourage or permit such applicants to bargain away the minimum level of benefits guaranteed them by Congress. Accordingly, the Department does not accept the suggestion that permitting settlement, even if it were not forbidden by the Act, represents an alternative to the Department's rule that is consistent with the objectives of the Black Lung Benefits Act.

5. *Establish cost-containment mechanisms for health care providers* (NMA alternative 6).

Through the incorporation of LHWCA § 7, the Black Lung Benefits Act requires responsible coal mine operators and the Black Lung Disability Trust Fund to provide medical benefits to miners who meet the Act's eligibility criteria. 33 U.S.C. 907, as incorporated into the Black Lung Benefits Act by 30 U.S.C. 932(a). The Department's regulations require that a miner be provided ''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 require.'' 20 CFR 725.701(b) (1999). In Fiscal Year 1998, the Trust Fund paid approximately $82.1 million for the medical treatment of eligible miners, processing approximately 620,000 bills. OWCP Annual Report to Congress, FY 1998, p. 18.

The Department has already adopted a variety of cost-containment measures to reduce medical treatment costs paid by the Trust Fund. The Department's guidelines for the payment of medication expenses were derived from the system used by the United Mine Workers of America Health and Retirement Funds in light of the similar populations served by the UMWA Funds and the Trust Fund. The Department updates its list of allowable charges for various drugs on a monthly basis and for treatment procedures on a periodic basis to ensure that it does not reimburse miners and their medical providers an amount above what is usual and customary for the beneficiary population. The Medical Director of the Department's Office of Workers' Compensation Programs reviews medications that have not previously been approved for inclusion on the Department's list.

The Department also carefully screens inpatient service bills for both an acceptable diagnosis and an ''appropriate'' treatment based upon the diagnosis and procedure codes present on the Universal Billing Form. These diagnoses and treatments are compared to a set of algorithms that take into account whether the diagnoses are related to pneumoconiosis, the severity of covered and non-covered conditions, and the character of the procedures. The program then makes a determination as to whether a bill should be paid in full, paid in part, denied in full, or made subject to review by the Department's staff. Bills that are considered payable are subject to a series of edits to determine if specific types of services should be paid, denied, or reviewed before reimbursement. For example, the Department will deny a bill for a private room during a hospitalization in the absence of adequate justification and pay only the cost of a non-private room.

The cost-containment measures adopted by the Department have reduced the Trust Fund's expenditures for medical treatment. Operators and their insurers, organizations with considerable experience in cost-containment, are similarly free to adopt measures that ensure that they pay no more than the usual and customary amounts for necessary services. Under the Secretary's regulations, eligible miners present bills for medical services directly to the responsible operator liable for the payment of their benefits, its insurer, or its claims servicing agent. 20 CFR 725.704(a)(2) (1999). Any dispute between the miner and the operator over payment of the bill is subject to informal resolution by the district director. If that resolution is unsuccessful, either the miner or the operator may obtain an expedited hearing before the Office of Administrative Law Judges. 20 CFR 725.707 (a), (b) (1999). Similarly, an operator may request a hearing with respect to any bill which was paid from the Black Lung Disability Trust Fund while the operator was contesting the miner's eligibility for benefits. ''Though framed as contests between the particular Operator and the Fund over reimbursement, these determinations provide the means by which an Operator may challenge the validity of all or part of the miner's initial claim, including each medical expense, even though it has already been paid by the Fund.'' *BethEnergy Mines, Inc.* v. *Director, OWCP,* 32 F.3d 843, 847 (3d Cir. 1994). Thus, the statute and its implementing regulations afford an operator ample opportunity to challenge the reasonableness of any amount that a claimant seeks as payment for medical services. Although the Department will continue to refine its cost-containment procedures, it does not believe that these procedures represent an ''alternative'' to its rulemaking activities. Rather, cost-containment must take place simultaneously with any revision of the Department's regulations to ensure that the revisions do not produce any unreasonable changes in health care expenditures.

In summary, the Department does not believe that any of the alternatives suggested by the NMA and M&R offer relief to small business that is consistent with the stated objectives of the Black Lung Benefits Act. Although the Department does intend to revise the Part 722 criteria in light of the commenters' suggestion, the failure of any state to seek certification of its laws over the last quarter century indicates that this effort will not result in any quick relief to the small business community from the economic impact of the Department's regulations. With the exception of graduated civil money penalties, the requirements of the Black Lung Benefits Act simply do not permit the Department to adjudicate the issues of claimant eligibility and operator liability differently depending on the size of the coal mine operator that may be liable for the payment of those benefits. Because the Department believes that the ''no action'' alternative, discussed in detail above, would also be inappropriate, the Department has published a final rule implementing its proposed revisions.

Conclusion

The Department's final rule revising the regulations implementing the Black Lung Benefits Act will result in the increase of premiums paid by the coal mining industry to insure their obligations under the Act. The economic analysis prepared in connection with the Department's initial regulatory flexibility analysis demonstrated that this premium increase would result in additional annual costs to the industry with a point estimate of $57.56 million. The Department's revised rule will not result in any significantly higher costs. In light of the need for the revised regulations identified above, the Department believes that it is appropriate to finalize the rule.

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 first day of December, 2000.

Bernard E. Anderson,

Assistant Secretary for Employment Standards.

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), 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.

§§ 718.401–718.404 [Removed]

2. Part 718 is amended by removing subpart E (§§ 718.401–718.404), 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

Sec.

718.1 Statutory provisions.
718.2 Applicability of this part.
718.3 Scope and intent of this part.
718.4 Definitions and use of terms.

Subpart B—Criteria for the Development of Medical Evidence

718.101 General.
718.102 Chest roentgenograms (X-rays).
718.103 Pulmonary function tests.
718.104 Report of physical examinations.
718.105 Arterial blood-gas studies.
718.106 Autopsy; biopsy.
718.107 Other medical evidence.

Subpart C—Determining Entitlement to Benefits

718.201 Definition of pneumoconiosis.
718.202 Determining the existence of pneumoconiosis.
718.203 Establishing relationship of pneumoconiosis to coal mine employment.
718.204 Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis.
718.205 Death due to pneumoconiosis.
718.206 Effect of findings by persons or agencies.

Subpart D—Presumptions Applicable to Eligibility Determinations

718.301 Establishing length of employment as a miner.
718.302 Relationship of pneumoconiosis to coal mine employment.
718.303 Death from a respirable disease.
718.304 Irrebuttable presumption of total disability or death due to pneumoconiosis.
718.305 Presumption of pneumoconiosis.
718.306 Presumption of entitlement applicable to certain death claims.

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

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

Appendix C to Part 718—Blood–Gas Tables

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 January 19, 2001 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 January 19, 2001. 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.

(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. This document is available from the Division of Coal Mine Workers' Compensation in the U.S. Department of Labor, Washington, D.C., telephone (202) 693–0046, and from the National Institute for Occupational Safety and Health (NIOSH), located in Cincinnati, Ohio, telephone (513) 841–4428) and Morgantown, West Virginia, telephone (304) 285–5749. A chest X-ray classified as Category Z under the ILO Classification (1958) or Short Form (1968) shall be reclassified as Category 0 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 0, 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) Except as provided in this paragraph, 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 paragraphs (a) through (d), such X-ray may form the basis for a finding of the presence or absence of pneumoconiosis 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 developed 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) Except as provided in this paragraph, 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, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the 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), 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, where no report is in substantial compliance with paragraphs (a) and (b), a report prepared by a physician who is unavailable may nevertheless form the basis for a finding if, in the opinion of the adjudication officer, it is accompanied by sufficient indicia of reliability in light of all relevant evidence.

(d) *Treating physician.* 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 must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's 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. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officer's decision to give that physician's opinion controlling weight, provided that the weight 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 PC02, P02, 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. (e) In the case of a deceased miner, where no blood gas tests are in substantial compliance with

paragraphs (a), (b), and (c), noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the only available tests demonstrate technically valid results. This provision shall not excuse compliance with the requirements in paragraph (d) for any blood gas study administered during a hospitalization which ends in the miner's 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 a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially 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 H20/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 FEVl 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 than 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 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. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test.

(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 MVVs 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 (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), (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), (c) of this subchapter, 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 revised as follows:

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

Sec.
722.1 Purpose.
722.2 Definitions.
722.3 General criteria; inclusion in and removal from the Secretary's list.
722.4 The Secretary's list.

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 relevant 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 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

Sec.
725.1 Statutory provisions.
725.2 Purpose and applicability of this part.
725.3 Contents of this part.
725.4 Applicability of other parts in this title.
725.101 Definitions and use of terms.
725.102 Disclosure of program information.
725.103 Burden of proof.

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

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

Conditions and Duration of Entitlement: Miner

725.202 Miner defined; conditions of entitlement, miner.
725.203 Duration and cessation of entitlement, miner.

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

725.204 Determination of relationship; spouse.
725.205 Determination of dependency; spouse.
725.206 Determination of relationship; divorced spouse.
725.207 Determination of dependency; divorced spouse.
725.208 Determination of relationship; child.
725.209 Determination of dependency; child.
725.210 Duration of augmented benefits.
725.211 Time of determination of relationship and dependency of spouse or child for purposes of augmentation of benefits.

Conditions and Duration of Entitlement: Miner's Survivors

725.212 Conditions of entitlement; surviving spouse or surviving divorced spouse.
725.213 Duration of entitlement; surviving spouse or surviving divorced spouse.
725.214 Determination of relationship; surviving spouse.
725.215 Determination of dependency; surviving spouse.
725.216 Determination of relationship; surviving divorced spouse.
725.217 Determination of dependency; surviving divorced spouse.
725.218 Conditions of entitlement; child.
725.219 Duration of entitlement; child.

725.220 Determination of relationship; child.
725.221 Determination of dependency; child.
725.222 Conditions of entitlement; parent, brother or sister.
725.223 Duration of entitlement; parent, brother or sister.
725.224 Determination of relationship; parent, brother or sister.
725.225 Determination of dependency; parent, brother or sister.
725.226 ''Good cause'' for delayed filing of proof of support.
725.227 Time of determination of relationship and dependency of survivors.
725.228 Effect of conviction of felonious and intentional homicide on entitlement to benefits.

Terms Used in this Subpart

725.229 Intestate personal property.
725.230 Legal impediment.
725.231 Domicile.
725.232 Member of the same household—''living with,'' ''living in the same household,'' and ''living in the miner's household,'' defined.
725.233 Support and contributions.

Subpart C—Filing of Claims

725.301 Who may file a claim.
725.302 Evidence of authority to file a claim on behalf of another.
725.303 Date and place of filing of claims.
725.304 Forms and initial processing.
725.305 When a written statement is considered a claim.
725.306 Withdrawal of a claim.
725.307 Cancellation of a request for withdrawal.
725.308 Time limits for filing claims.
725.309 Additional claims; effect of a prior denial of benefits.
725.310 Modification of awards and denials.
725.311 Communications with respect to claims; time computations.

Subpart D—Adjudication Officers; Parties and Representatives

725.350 Who are the adjudication officers?
725.351 Powers of adjudication officers.
725.352 Disqualification of adjudication officer.
725.360 Parties to proceedings
725.361 Party amicus curiae.
725.362 Representation of parties.
725.363 Qualification of representative.
725.364 Authority of representative.
725.365 Approval of representative's fees; lien against benefits.
725.366 Fees for representatives.
725.367 Payment of a claimant's attorney's fee by responsible operator or fund.

Subpart E—Adjudication of Claims by the District Director

725.401 Claims development—general.
725.402 Approved State workers' compensation law.
725.403 [Reserved].
725.404 Development of evidence—general
725.405 Development of medical evidence; scheduling of medical examinations and tests.
725.406 Medical examinations and tests.
725.407 Identification and notification of responsible operator.
725.408 Operator's response to notification.
725.409 Denial of a claim by reason of abandonment.
725.410 Submission of additional evidence.
725.411 Initial adjudication in Trust Fund cases.
725.412 Operator's response.
725.413 [Reserved].
725.414 Development of evidence.
725.415 Action by the district director after development of evidence.
725.416 Conferences.
725.417 Action at the conclusion of conference.
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725.423 Extensions of time.

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725.463 Issues to be resolved at hearing; new issues.
725.464 Record of hearing.
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725.476 Issuance of decision and order.
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725.478 Filing and service of decision and order.
725.479 Finality of decisions and orders.
725.480 Modification of decisions and orders.
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725.492 Successor operator defined.
725.493 Employment relationship defined.
725.494 Potentially liable operators.
725.495 Criteria for determining a responsible operator.
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725.538 Reductions; effect of augmentation of benefits based on subsequent qualification of individual.
725.539 More than one reduction event.

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725.540 Overpayments.
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725.542 When waiver of adjustment or recovery may be applied.
725.543 Standards for waiver of adjustment or recovery.
725.544 Collection and compromise of claims for overpayment.
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725.710 Objective of vocational rehabilitation.
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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 Part A 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, therefore, 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 each incorporation is appropriate. Finally, Section 422(g), contained in part C of the Act, incorporates 42 U.S.C. 403(b)–(l).

§ 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 Janaury 19, 2001. This part applies to all claims filed, and all benefits payments made, after January 19, 2001. With the exception of the following sections, this part shall also apply to the adjudication of claims that were pending on January 19, 2001: §§ 725.309, 725.310, 725.351, 725.360, 725.367, 725.406, 725.407, 725.408, 725.409, 725.410, 725.411, 725.412, 725.414, 725.415, 725.416, 725.417, 725.418, 725.421(b), 725.423, 725.454, 725.456, 725.457, 725.458, 725.459, 725.465, 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, 1999, apply to the adjudications of claims that were pending on January 19, 2001. For purposes of construing the provisions of this section, a claim shall be considered pending on January 19, 2001 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 (formerly 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, 1999.

(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 Definition 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.

(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 is substituted for the term Deputy Commissioner wherever that term appears in the regulations. This substitution 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 mine dust as a result of such employment (see § 725.202). For purposes of this definition, the term does not include coke oven workers.

(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 totaling one year, during which the miner worked in or around a coal mine or mines for at least 125 ''working days.'' A ''working day'' means any day or part of a day for which a miner received pay for work as a miner, but shall not include any day for which the miner received pay while on an approved absence, such as vacation or sick leave. In determining whether a miner worked for one year, any day for which the miner received pay while on an approved absence, such as vacation or sick leave, may be counted as part of the calendar year and as partial periods totaling one year.

(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 totaling 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 totaling 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 or partial periods totaling a 365-day period amounting to one 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, 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), (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, and shall submit medical reports and other relevant evidence the Office deems necessary, 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—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 Conditions 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 part 718 on a claim filed prior to June 30, 1982.

(b) If more than one spouse meets the conditions of entitlement prescribed in paragraph (a), 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 intestate personal property; or

(d) Such individual went through a marriage ceremony with the miner, resulting in a purported marriage between them 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; or

(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)(1)(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 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.

(d) A child whose entitlement to benefits has been terminated pursuant to § 725.219(b)(2) 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 § 725.218. The individual shall not be required to reestablish the miner's entitlement to benefits (§ 725.218(a)(1)) or the miner's death due to pneumoconiosis (§ 725.212(a)(2)).

§ 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 part 718 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 in § 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 computing any period of time described in this part in which the period within which to file a response commences upon receipt of a document, it shall be presumed, in the absence of evidence to the contrary, that the document was received on the seventh day after it was mailed. 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 reasonable fees for 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 designated by the district director (see § 725.410(a)(3)) fails to accept the claimant's entitlement to benefits within the 30-day period provided by § 725.412(b) and is ultimately determined to be liable for benefits. The operator shall be liable for an attorney's fee with respect to all necessary 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 a schedule for the submission of additional evidence under § 725.410. The fund shall be liable for an attorney's fee with respect to all necessary 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 necessary 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 contests 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 necessary 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 necessary 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, *provided* that the miner may not select any physician to whom the miner or the miner's spouse is related to the fourth degree of consanguinity, and the miner may not select any physician who has examined or provided medical treatment to the miner within the twelve months preceding the date of the miner's application. 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 of this part.

(e) 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 of this part.

§ 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) 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 of this part. 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 of this part 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 § 725.410(a)(3), 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 indicating 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 any of the grounds set forth in paragraph (a)(2).

(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. 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. 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. For purposes of § 725.309,

a denial by reason of abandonment shall be deemed a finding that the claimant has not established any applicable condition of entitlement. 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. Except upon the motion or written agreement of the Director, the hearing will be limited to the issue of whether the claim was properly denied by reason of abandonment. If the hearing is limited to the issue of abandonment and 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 Submission of additional evidence.

(a) After the district director completes the development of medical evidence under § 725.405 of this part, including the complete pulmonary evaluation authorized by § 725.406, and receives the responses and evidence submitted pursuant to § 725.408, he shall issue a schedule for the submission of additional evidence. The schedule shall contain the following information:

(1) If the claim was filed by, or on behalf of, a miner, the schedule shall contain a summary of the complete pulmonary evaluation administered pursuant to § 725.406. If the claim was filed by, or on behalf of, a survivor, the schedule shall contain a summary of any medical evidence developed by the district director pursuant to § 725.405(c).

(2) The schedule shall contain the district director's preliminary analysis of the medical evidence. If the district director believes that the evidence fails to establish any necessary element of entitlement, he shall inform the claimant of the element of entitlement not established and the reasons for his conclusions and advise the claimant that, unless he submits additional evidence, the district director will issue a proposed decision and order denying the claim.

(3) The schedule shall contain the district director's designation of a responsible operator liable for the payment of benefits. In the event that the district director has designated as the responsible operator an employer other than the employer who last employed the claimant as a miner, the district director shall include, with the schedule, a copy of the statements required by § 725.495(d) of this part. 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).

(4) The schedule shall notify the claimant and the designated responsible operator that they have the right to obtain further adjudication of the claim in accordance with this subpart, and that they have the right to submit additional evidence in accordance with this subpart. The schedule shall also notify the claimant that he has the right to obtain representation, under the terms set forth in subpart D, in order to assist him. In a case in which the district director has designated a responsible operator pursuant to paragraph (a)(3), the schedule shall further notify the claimant that if the operator fails to accept the claimant's entitlement to benefits within the time limit provided by § 725.412, the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the responsible operator in the event that the claimant establishes his entitlement to benefits payable by that operator. In a case in which there is no operator liable for the payment of benefits, the schedule shall notify the claimant that the cost of obtaining additional medical and other necessary evidence, along with a reasonable attorney's fee, shall be reimbursed by the fund.

(b) The schedule shall allow all parties not less than 60 days within which to submit additional evidence, including evidence relevant to the claimant's eligibility for benefits and evidence relevant to the liability of the designated responsible operator, 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.

(c) The district director shall serve a copy of the schedule, together with a copy of all of the evidence developed, on the claimant, the designated responsible operator, and all other operators which received notification pursuant to § 725.407. The schedule shall be served on each party by certified mail.

§ 725.411 Initial adjudication in Trust Fund cases.

Notwithstanding the requirements of § 725.410 of this part, if the district director concludes that the results of the complete pulmonary evaluation support a finding of eligibility, and that there is no operator responsible for the payment of benefits, the district director shall issue a proposed decision and order in accordance with § 725.418 of this part.

§ 725.412 Operator's response.

(a)(1) Within 30 days after the district director issues a schedule pursuant to § 725.410 of this part containing a designation of the responsible operator liable for the payment of benefits, that operator shall file a response with regard to its liability. The response shall specifically indicate whether the operator agrees or disagrees with the district director's designation.

(2) If the responsible operator designated by the district director does not file a timely response, it shall be deemed to have accepted the district director's designation 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.

(b) The responsible operator designated by the district director may also file a statement accepting claimant's entitlement to benefits. If that operator fails to file a timely response to the district director's designation, the district director shall, upon receipt of such a statement, issue a proposed decision and order in accordance with § 725.418 of this part. If the operator fails to file a statement accepting the claimant's entitlement to benefits within 30 days after the district director issues a schedule pursuant to § 725.410 of this part, the operator shall be deemed to have contested the claimant's entitlement.

§ 725.413 [Reserved].

§ 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, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, 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 opposing entitlement, no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by the designated responsible 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)(i) The responsible operator designated pursuant to § 725.410 shall be entitled to obtain and submit, in support of its 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, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports. Any chest X-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, 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, the responsible operator may not 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 of this part, 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 the designated responsible 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 the designated responsible operator, the miner's claim may be denied by reason of abandonment. (See § 725.409 of this part).

(ii) The responsible operator 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, arterial blood gas study, autopsy or biopsy 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 shall 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 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 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, or has dismissed all potentially liable operators under § 725.410(a)(3), 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. In a case involving a dispute concerning medical benefits under § 725.708 of this part, the district director shall be entitled to develop medical evidence to determine whether the medical bill is compensable under the standard set forth in § 725.701 of this part.

(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, or medical treatment for a respiratory or pulmonary or related disease, 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.

(b) *Evidence pertaining to liability.* (1) Except as provided by § 725.408(b)(2), the designated responsible operator may submit evidence to demonstrate that it is not the potentially liable operator that most recently employed the claimant.

(2) Any other party may submit evidence regarding the liability of the designated 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 of this part. 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

designated responsible operator. Absent such notice, the testimony of a witness relevant to the liability of a potentially liable operator or the designated 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.

§ 725.415 Action by the district director after development of evidence.

(a) At the end of the period permitted under § 725.410(b) 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 issue another schedule for the submission of additional evidence pursuant to § 725.410, identifying another potentially liable operator as the responsible operator liable for the payment of benefits. In such a case, the district director shall not permit the development or submission of any additional medical evidence until after he has made a final determination of the identity of the responsible operator liable for the payment of benefits. If the operator who is finally determined to be the responsible operator has not had the opportunity to submit medical evidence pursuant to § 725.410, the district director shall allow the designated responsible operator and the claimant not less than 60 days within which to submit evidence relevant to the claimant's eligibility for benefits. The designated responsible operator may elect to adopt any medical evidence previously submitted by another operator as its own evidence, subject to the limitations of § 725.414. The district director may also 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 § 725.410(b) of this part 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. Any conference conducted pursuant to this paragraph shall be held no later than 90 days after the conclusion of the period permitted by § 725.410(b) of this part for the submission of evidence, unless one of the parties requests that the time period be extended for good cause shown. If the district director is unable to hold the conference within the time period permitted by this paragraph, he shall proceed to issue a proposed decision and order under § 725.418 of this part.

(b) The district director shall notify the parties of a definite time and place for the conference. The district director shall advise the parties that they have a right to representation at the conference, by an attorney or a lay representative, and that no conference shall take place unless the parties are represented. A coal mine operator which is self-insured, or which is covered by a policy of insurance for the claim for which a conference is scheduled, shall be deemed to be represented. 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 a conference or 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 paragraph (b), 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.

§ 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 appropriate cases, 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. The district director may also notify additional operators of their potential liability pursuant to § 725.407, or issue another schedule for the submission of additional evidence pursuant to § 725.410, designating another potentially liable operator as the responsible operator liable for the payment of benefits, in order to allow that operator an opportunity to submit evidence relevant to its liability for benefits as well as the claimant's eligibility for benefits.

(c) Within 20 days after the termination of all conference proceedings, the district director shall prepare and send to the parties a proposed decision and order pursuant to § 725.418 of this part.

§ 725.418 Proposed decision and order.

(a) Within 20 days after the termination of all informal conference proceedings, or, if no informal conference is held, at the conclusion of the period permitted by § 725.410(b) 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 at any time during the adjudication of any 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. It shall be served on all parties to the claim by certified mail.

(c) The proposed decision and order shall contain a notice of the right of any interested party to request a formal hearing before the Office of Administrative Law Judges. If the proposed decision and order is a denial of benefits, and the claimant has previously filed a request for a hearing, the proposed decision and order shall notify the claimant that the case will be referred for a hearing pursuant to the previous request unless the claimant notifies the district director that he no longer desires a hearing. If the proposed decision and order is an award of benefits, and the designated responsible operator has previously filed a request for a hearing, the proposed decision and order shall notify the operator that the case will be referred for a hearing pursuant to the previous request unless the operator notifies the district director that it no longer desires a hearing.

(d) The proposed decision and order shall reflect the district director's final designation of the responsible operator liable for the payment of benefits. No operator may be finally designated as the responsible operator unless it has received notification of its potential liability pursuant to § 725.407, and the opportunity to submit additional evidence pursuant to § 725.410. The district director shall dismiss, as parties to the claim, all other potentially liable operators that received notification pursuant to § 725.407 and that were not previously dismissed pursuant to § 725.410(a)(3).

§ 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 evidentiary development and adjudication without having resolved all contested issues, 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, and any schedule for the submission of additional evidence issued pursuant to § 725.410 designating a potentially liable operator as the responsible operator;

(4) All medical evidence submitted to the district director under this part by the claimant and the potentially liable operator designated as the responsible operator in the proposed decision and order issued pursuant to § 725.418, or the fund, as appropriate, subject to the limitations of § 725.414 of this part; this evidence shall include the results of any medical examination or test conducted pursuant to § 725.406, and all evidence relevant to the liability of the responsible operator 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 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) 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.

(d) 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.

(e) 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, including any physician, regardless of whether the physician has previously prepared a medical report, 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 the responsible operator, in the absence of extraordinary circumstances, 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, in the absence of a showing of good cause under § 725.456(b)(1) of this part, 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.

(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 shall apportion the costs of such cross-examination among the parties to the case. The administrative law judge shall 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 the operator designated as the responsible operator by the district director, 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

§ 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.

(4) If the miner's most recent employment by an operator ended while the operator was authorized to self-insure its liability under part 726 of this title, and that operator no longer possesses sufficient assets to secure the payment of benefits, the provisions of paragraph (a)(3) shall be inapplicable with respect to any operator that employed the miner only before he was employed by such self-insured operator. If no operator that employed the miner after his employment with the self-insured operator meets the conditions of § 725.494, the claim of the miner or his survivor shall be the responsibility of the Black Lung Disability Trust Fund.

(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 operator finally designated as responsible pursuant to § 725.418(d) 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 designation. 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 to the computation.

(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. Benefit 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 for eligibility 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 shall be determined in accordance with § 727.302 (see § 725.4(d)).

(b) *Miner's claim.* Benefits are payable to a miner who is entitled 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.* Benefits are payable to a survivor who is entitled 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 of this part 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 §§ 725.540–725.546).

(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 §§ 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 a Federal Reserve Bank 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 or medical provider shall not be entitled to interest for any period following the date on which the beneficiary or medical provider 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, 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 January 19, 2001 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 for a pulmonary disorder apart from those previously associated with the miner's disability, 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 revised as follows:

PART 726—BLACK LUNG BENEFITS; REQUIREMENTS FOR COAL MINE OPERATOR'S INSURANCE

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Sec.

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726.2 Purpose and scope of this part.
726.3 Relationship of this part to other parts in this subchapter.
726.4 Who must obtain insurance coverage.
726.5 Effective date of insurance coverage.
726.6 The Office of Workers' Compensation Programs.
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726.102 Application for authority to become a self-insurer; how filed; information to be submitted.
726.103 Application for authority to self-insure; effect of regulations contained in this part.

726.104 Action by the Office upon application of operator.
726.105 Fixing the amount of security.
726.106 Type of security.
726.107 Deposits of negotiable securities with Federal Reserve banks or the Treasurer of the United States; authority to sell such securities; interest thereon.
726.108 Withdrawal of negotiable securities.
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726.111 Notice of authorization to self-insure.
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726.316 Filing and service.
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726.318 Final decision of the Secretary.
726.319 Retention of official record.
726.320 Collection and recovery of penalty.

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 mine 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 mine 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 mine operators prescribed in part 725 of this subchapter are hereby made 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) The 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) The operator must demonstrate the administrative capacity to fully service such claims as may be filed against him; and,

(3) The 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 in accordance with 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, D.C.

(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, either deny the request 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 Office shall require the amount of security which it deems 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. The Office shall also consider such other factors as it considers relevant to any particular case. 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, the 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 based on a deposit of negotiable securities, 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. The Office may reduce the amount of security at any time on its own initiative, or upon the application of a self-insurer, when it believes the facts warrant a reduction. A self-insurer seeking a 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 benefit payments he has made.

§ 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 such authorization, 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 Act, all benefits payable on account of total disability or death of any of its employee-miners;

(2) To furnish medical, surgical, hospital, and other attendance, treatment, and care as required by 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), as elected in the application;

(4) To authorize the Office to sell any negotiable securities so deposited or any part thereof, and to pay from the proceeds thereof such benefits, medical, and other expenses and any accrued penalties imposed by law as the Office may find to be due and payable.

(b) When an applicant has provided the requisite security, he shall send to the Office in Washington, D.C. a completed agreement and undertaking, together with satisfactory proof that his obligations and liabilities under the Act have been secured.

§ 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 him 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 to self-insure 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 the Office determines 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 the Office receives satisfactory proof that the requisite amount of additional securities has 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 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 it has posted 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 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, 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
25–50	200
51–100	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 (c)(2)(i) 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 (c)(2)(i) 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 January 19, 2001 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–2117, Office of the Solicitor, U.S. Department of Labor, 200 Constitution Ave., NW., 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, *see* § 725.311 of Part 725 of this subchapter, 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 shall 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., N.W., 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, 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 422 and 426 of the Black Lung Benefits Act, 30 U.S.C. 932, 936, part 727 is removed.

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