Billing Code 4510-CR-P

DEPARTMENT OF LABOR

Office of Workers' Compensation Programs

20 CFR Part 725

RIN 1240-AA10

Black Lung Benefits Act: Disclosure of Medical Information and Payment of Benefits

AGENCY: Office of Workers' Compensation Programs, Labor.

ACTION: Final rule.

SUMMARY: This final rule revises the regulations implementing the Black Lung Benefits Act to address certain procedural issues that have arisen in claim adjudications and other technical issues. To protect miners' health, assist parties without adequate legal representation, and enhance the accuracy of benefits entitlement decisions, the final rule includes a new provision that requires all parties to exchange with each other any medical information developed in connection with a claim for benefits and allows for the imposition of sanctions for failure to comply with the rule. The final rule also clarifies a liable coal mine operator's obligation to pay effective benefits awards by requiring payment before allowing the operator to challenge the award through the Act's modification procedures. In addition, the final rule resolves an ambiguity regarding how physicians' follow-up reports should be considered under the evidence-limiting rules, and allows the Department to fully participate in claims adjudications after the liable coal mine operator stops participating because of adverse financial developments, such as bankruptcy or insolvency.

DATES: This rule is effective [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

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SUPPLEMENTARY INFORMATION:

I. Background of this Rulemaking

The Black Lung Benefits Act (BLBA), 30 U.S.C. 901-944, provides for the payment of benefits to coal miners and certain of their dependent survivors on account of total disability or death due to coal workers' pneumoconiosis. 30 U.S.C. 901(a); Usery v. Turner Elkhorn Mining Co., 428 U.S. 1, 8 (1976). Benefits are paid either by an individual coal mine operator that employed the coal miner (or its insurance carrier), or the Black Lung Disability Trust Fund (Trust Fund). Dir., OWCP v. Bivens, 757 F.2d 781, 783 (6th Cir. 1985).

On April 29, 2015, the Department proposed revising the BLBA's implementing regulations to resolve several procedural issues that had arisen in claims administration and adjudication, and make other technical changes. 80 FR 23743-54 (Apr. 29, 2015) (NPRM). Each of these issues and the comments received in response to the proposed rule are fully addressed in the Section-By-Section Explanation below.

II. Statutory Authority

Congress granted the Secretary broad rulemaking authority to administer the BLBA: "The Secretary of Labor [is] authorized to issue such regulations as [he] deems appropriate to carry out the provisions of this subchapter." 30 U.S.C. 936(a). See, e.g., Elm Grove Coal Co. v. Dir., OWCP, 480 F.3d 278, 293 (4th Cir. 2007) ("[T]he Secretary has been vested with broad authority to implement the mandate of the Black Lung Act."); Caney Creek Coal Co. v. Satterfield, 150 F.3d 568, 572 (6th Cir. 1998) (describing 30 U.S.C. 936(a) as conferring "a broad grant of congressional authority" to promulgate regulations); Labelle Processing Co. v. Swarrow, 72 F.3d 308, 312 (3d Cir. 1995) ("Congress granted the Secretary of Labor broad authority to promulgate regulations under the BLBA."); Harman Mining Co. v. Dir., OWCP, 826 F.2d 1388, 1390 (4th Cir. 1987) (same); see also Dir., OWCP v. Mangifest, 826 F.2d 1318, 1330 n.21 (3d Cir. 1987) (regulation was an appropriate exercise of the Secretary's general authority where not precluded by specific statutory section). Congress further emphasized the Secretary's important role in the BLBA's administration by including many other grants of regulatory authority throughout the statute. See 30 U.S.C. 902(f)(1)(D), 921(b), 923(b), 932(a), 932(h), 936(c), and 942. Two of these supplementary grants of regulatory authority, sections 923(b) and 932(a), are particularly important to this rulemaking.

Section 923(b), which incorporates section 205(a) of the Social Security Act, 30 U.S.C. 923(b) (incorporating 42 U.S.C. 405(a)), gives the Department wide latitude in regulating evidentiary matters in claims adjudications. Specifically, section 205(a) grants the Secretary authority to "adopt reasonable and proper rules and regulations to regulate and provide for the nature and extent of the proofs and evidence and the method of taking and furnishing the same in order to establish the right to benefits hereunder." Id. As

explained in the NPRM, 80 FR 23746, section 205 has been interpreted as conferring "exceptionally broad" power to regulate. See Heckler v. Campbell, 461 U.S. 458, 466 (1983), quoting Schweiker v. Gray Panthers, 453 U.S. 34, 43 (1981).

Section 932(a), 30 U.S.C. 932(a), grants similarly strong regulatory authority to the Secretary. This section incorporates various provisions from the Longshore and Harbor Workers' Compensation Act (Longshore Act), 33 U.S.C. 901-950, but further authorizes the Secretary to "prescribe in the Federal Register such additional provisions [] as he deems necessary" and specifies that the incorporated Longshore Act sections apply "except as otherwise provided. . . by regulations of the Secretary." 30 U.S.C. 932(a); see Dir., OWCP v. Nat'l Mines Corp., 554 F.2d 1267, 1273-74 (4th Cir. 1977) (holding that Congress empowered the Secretary to depart from specific requirements of the Longshore Act).

One of the incorporated Longshore Act provisions, section 23(a), also provides important statutory authority for this rulemaking. 33 U.S.C. 923(a), as incorporated by 30 U.S.C. 932(a). This section relieves the Department from traditional rules of procedure or evidence in claims determinations and plainly elevates truth seeking over litigation gamesmanship: "the [adjudication officer] 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; but may make such investigation or inquiry or conduct such hearing in such manner as to best ascertain the rights of the parties." Id.

III. Discussion of Significant Comments

The Department received 18 comments, some joined by multiple individuals or entities, in response to the NPRM. Commenters included miners, benefits claimants,

their representatives, a labor union, a coal mine company, an insurance company, industry and insurance trade associations, and one member of Congress. Five of the comments expressed general concerns about the black lung program and the difficulties miners face in obtaining benefits. The remaining comments addressed the proposed rules more specifically and are discussed below in the Section-by-Section Explanation. The Department appreciates these comments and has made several revisions to the final rule in response.

The Department received no comments on the proposed revisions replacing the word "shall" with the word "must" or other appropriate plain-language phrase throughout the amended regulatory sections. See generally 80 FR 23743-44. Accordingly, the Department has retained those revisions in the final rule.

Section-by-Section Explanation

20 CFR 725.310 Modification of awards and denials.

(a) Section 725.310 implements section 22 of the Longshore Act, 33 U.S.C. 922, as incorporated into the BLBA by 30 U.S.C. 932(a). Section 22 generally allows for the modification of claim decisions based on a mistake of fact or a change in conditions up to one year after the last payment of benefits or denial of a claim.

The Department proposed adding a new paragraph (e) to this regulation to ensure that responsible operators (and their insurance carriers) fully discharge their payment obligations while pursuing modification of a benefits award. 80 FR 23744-45, 23751. In the absence of a Benefits Review Board or court-ordered stay of payments, the proposed rule required that an operator's request to modify an effective award be denied unless the operator proved that it had complied with all of its payment obligations under

that award and any other currently effective award (such as a medical benefits award) in the claim. The Department noted that an "effective" award is generally an uncontested award entered by a district director or any award entered by an administrative law judge or higher tribunal. 80 FR 23744; 20 CFR 725.502(a). The Department proposed the rule both to ensure that claimants are fully compensated and to protect the Trust Fund, which must pay effective awards when an operator fails to do so. 80 FR 23744-45.

(b) The Department received several comments addressing proposed paragraph (e). Four commenters expressed support for the proposal. Noting that modification proceedings can add years to the claims process and citing examples, one commenter praised this rule as pragmatic because it allows operators with legitimate defenses to pursue modification while reducing the incentive for operators to improperly use modification as a means to delay payment of benefits. Another commenter praised the proposal as clearly consistent with the Act and agreed with the Department's position that the Trust Fund should not be burdened with paying benefits on behalf of operators during the modification period. Two additional commenters expressed general support for the rule.

Six commenters opposed the rule, arguing either that the Department should withdraw the rule completely or that it should be revised. Several of these commenters argue that the proposed rule should be withdrawn because it is unauthorized by law, unfair, and unnecessary. These commenters also argue that the rule will effectively deprive operators of the opportunity to challenge medical expenses and attorneys' fees.

The Department has fully considered the comments received and determined that the rule should not be withdrawn. The Department has, however, revised the final rule to address the commenters' concerns regarding medical expenses and attorneys' fees.

(c) As explained in the NPRM, 80 FR 23744-45, Congress established the Trust Fund in 1977 to serve as a secondary payor when there is no operator that may be held liable or when the liable operator defaults on its payment obligations. Congress envisioned the Trust Fund as a payor of last resort, and intended to "ensure that individual coal operators rather than the trust fund bear the liability for claims arising out of such operators' mines to the maximum extent feasible." S. Rep. No. 95-209 at 9, reprinted in Committee on Education and Labor, House of Representatives, 96th Cong., Black Lung Benefits Act and Black Lung Benefits Revenue Act of 1977 at 612 (Comm. Print) (1979).

Yet operators were not always meeting their payment obligations under effective benefit awards, relying instead on the Trust Fund to pay benefits while they appealed or sought modification. The Department attempted to resolve any confusion on this issue when it promulgated extensive revisions to the black lung program regulations in 2000. 65 FR 80009-11 (Dec. 20, 2000). In that rulemaking, the Department revised § 725.502 with the specific intent of clarifying when a benefits award was "effective," and thus payable by the liable operator. 62 FR 3366 (Jan. 22, 1997) (with revisions to § 725.502, "[t]he Department hopes to increase operator compliance with effective awards."); 65 FR 80009 (Dec. 20, 2000) ("The most important changes [to § 725.502] 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."). The Department

noted that operators, contrary to Congressional intent, routinely used the Trust Fund as a surrogate to "reduce the risk of losing interim payments in the event the award is reversed." 64 FR 55000 (Oct. 8, 1999). The Department clearly expressed its position that operators, and not the Trust Fund, are required to pay benefits pursuant to an effective award notwithstanding the pendency of a modification petition. 64 FR 55000-01.

The Department's efforts in 2000, however, have not remedied the problem. Operators often do not meet their legal obligation to pay benefits while challenging effective awards, whether by appeal to the Benefits Review Board or appropriate court, or by seeking modification. Cases like those cited in the NPRM—including Crowe ex rel. Crowe v. Zeigler Coal Co., 646 F.3d 435, 445 (7th Cir. 2011), and Hudson v. Pine Ridge Coal Co., LLC, No. 2:11-00248, 2012 WL 386736, *5 (S.D. W.Va. Feb. 6 2012)—continue to arise. See, e.g., Bull Creek Coal Corp. v. Dir., OWCP, 6th Cir. No. 14-3573, operator's appeal dismissed Nov. 6, 2014 (in post-2000 claim, operator sought modification after appealing effective benefits award to the court, but later moved to dismiss its appeal; modification petition remains pending and the Department's records indicate that the operator has not paid pursuant to the award); Dalton v. Dir., OWCP, 738 F.3d 779 (7th Cir. 2013) (in post-2000 claim, Department's records indicate operator delayed Trust Fund reimbursement for approximately ten years while pursuing appeals of initial awards and a later modification petition). Indeed, the Department has identified more than nine hundred claims in which the Trust Fund has paid effective benefits awards in the operator's stead since October 1, 2010. And, as explained in the NPRM, the existing enforcement mechanisms are difficult to use in these circumstances. 80 FR

23744-45. Thus, the Trust Fund is routinely forced to pay interim benefits to entitled claimants and bear the risk that the benefits award was in error, contrary to Congress' intent. At the time of the 2000 rulemaking, the Trust Fund was indebted to the U.S. Treasury in the amount of $5.487 billion. As of the end of fiscal year 2012 and after a restructuring, which included a one-time non-refundable allocation of $6.497 billion to the Fund, the Trust Fund's debt remained over $6 billion. See Emergency Economic Stabilization Act of 2008, Public Law 110-343, section 113 (Oct. 3, 2008); OWCP Annual Report to Congress for FY 2012 at 63.

Thus, the rule addresses a longstanding problem; it is not, as some commenters suggest, simply a reaction to the concerns Judge Hamilton expressed in his Crowe concurring opinion over this type of operator misconduct. The rule is intended to curb an unlawful practice. It will prevent operators from indefinitely delaying payments to claimants or reimbursement of the Trust Fund for payments made on the operator's behalf. As a result, the rule will prevent operators from taking advantage of the safeguards built into the Act to protect claimants, mainly the payment of benefits from the Trust Fund when the liable operator fails to pay. The Department has a fiduciary duty to protect the Trust Fund from such misconduct. 26 U.S.C. 9501(a)(2); see also Marfork Coal Co. v. Weis, 251 F. App'x 229, 233 (4th Cir. 2007) ("The OWCP Director, who acts as trustee for the Black Lung Benefits Fund, is responsible for conserving its assets."); Boggs v. Falcon Coal Co., 17 Black Lung Rep. 1-62, 1-65 (Ben. Rev. Bd. 1992) (noting that the Director is a trustee of the Trust Fund charged with a duty to protect its assets); Truitt v. N. Am. Coal Corp., 2 Black Lung Rep. 1-199, 1-202 (Ben. Rev. Bd. 1979) (same).

(d) Several commenters argue that no language in either the text or legislative history of Longshore Act section 22 authorizes this proposed rule. While section 22 does not contain explicit language contemplating this rule, other sections of the Longshore Act require employers to pay benefits under an effective award and therefore require payment of compensation due even while modification proceedings are pending. See, e.g., 33 U.S.C. 918, 921(a) (requiring payment of benefits pursuant to an award regardless of whether the award is final unless the order is stayed by an appellate tribunal); Williams v. Jones, 11 F.3d 247, 259 (1st Cir. 1993) (holding that employers must continue to pay pursuant to an effective award unless they are able to prove that doing so would result in irreparable injury). It is common practice for Longshore employers to comply with their obligations to pay compensation pursuant to an effective award while pursuing modification. There simply is no secondary payor—like the Trust Fund in black lung claims—available to serve as an alternative source of compensation payments in every case in which an employer does not meet its legal obligations, so there is no need for the Longshore Act to address this issue explicitly. Thus, the absence of any explicit language in section 22 mandating such compliance does not make the black lung rule inconsistent with Longshore Act practice.

This scenario also demonstrates why Congress incorporated the Longshore Act provisions into the BLBA with the qualification that the Department has authority to promulgate rules tailoring the incorporated provisions to the black lung program's specific needs. As discussed above (see Section II, supra), the Secretary's broad rulemaking authority under the BLBA specifically includes the "discretion to deviate from the LHWCA procedures and to prescribe 'such additional provisions, not

inconsistent with those specifically excluded by this subsection, as [the Department] deems necessary.'" Bethenergy Mines Inc. v. Dir., OWCP, 854 F.2d 632, 634-35 (3d Cir. 1988) (quoting 30 U.S.C. 932(a)). The existence of the Trust Fund creates a need for a specific rule in the black lung program. Because the Department is authorized by statute to alter the procedures for modification, this rule is well within the Department's regulatory authority, even if section 22 does not explicitly require operators to demonstrate compliance with outstanding effective orders as a precondition to modification.

These same commenters also argue that the proposed regulation violates the Black Lung Benefits Revenue Act of 1977, which created the Trust Fund and specifies the circumstances under which it may pay benefits. The Revenue Act, codified at 26 U.S.C. 9501(d), authorizes the Trust Fund to pay benefits if the responsible operator either has not commenced payment within 30 days of an initial determination of eligibility, or has not made a payment within 30 days of its due date. 26 U.S.C. 9501(d). By regulation, the Department has provided that such payments by the Trust Fund are mandatory. See 20 CFR 725.420(c); 725.522. The commenters reason that because that statute authorizes (and the regulations compel) the Trust Fund to pay benefits to an entitled claimant when a liable operator fails to pay, the statute necessarily endorses the operator's refusal to pay. The statute contains no such endorsement. In fact, the statutory and regulatory enforcement provisions demonstrate that when Congress created the Trust Fund, it did not suspend operators' obligations to pay benefits once an effective or final order is issued. See 33 U.S.C. 918(a), incorporated by 30 U.S.C. 932(a) and implemented by 20 CFR 725.605 (establishing procedures for enforcement of effective

awards even if those awards are not final); 33 U.S.C. 921(d), incorporated by 30 U.S.C. 932(a) and implemented by 20 CFR 725.604 (allowing for enforcement of final awards of benefits in federal court); Hudson v. Pine Ridge Coal Co., LLC, No. 2:11-00248, 2012 WL 386736, at *5 (S.D. W.Va. Feb. 6, 2012) (enforcing BLBA compensation order notwithstanding pendency of operator's modification petition). The comment provides no support for its assertion that Congress, in effect, approves of employers ignoring their BLBA payment obligations. See also 65 FR at 80011 (Dec. 20, 2000) (in revising § 725.502, rejecting similar comment and concluding that Congress did not intend the Trust Fund "to absorb all operators' liabilities as a matter of course until the conclusion of litigation in every approved claim").

(e) Several commenters allege that the proposed rule effectively denies the modification remedy to operators by eliminating their financial incentive to pursue modification. They contend that even if operators are successful on modification, they will be unable to recoup the benefits that were paid pursuant to previously effective awards. See 20 CFR 725.540(a) (allowing for recoupment of overpaid benefits). The Department does not believe that the commenters' perceived problems with the system for recovering overpayments justify withdrawing this rule.

The commenters allude to substantive and procedural reasons that operators may struggle to recover overpayments. Substantively, overpayments may not be recovered when the claimant is without fault in receiving the overpayment and if recovery would defeat the purpose of the Act or be against equity and good conscience. 20 CFR 725.542. This is true whether the overpayment is owed to an operator or to the Trust Fund. See 20 CFR 725.547. The initiation of payments prior to final adjudication is a characteristic of

workers' compensation programs generally. See, e.g., Doucette v. Hallsmith/Sysco Food Servs., Inc., 10 A.3d 692, 694 (Me. 2010) (recognizing express provision in Maine workers' compensation law that requires payment of benefits pending appeal and holding that court is not empowered to stay such payments); Coley v. Camden Assoc., Inc., 702 A.2d 1180, 1184 (Conn. 1997) (Connecticut's workers' compensation law requires employers or insurers to pay benefits to claimants during the pendency of appeal); Garcia v. McCord Gasket Corp., 534 N.W.2d 473, 478 (Mich. 1995) (affirming dismissal of employer's appeal for failure to pay benefits pursuant to effective, but not final, order as required by Michigan's workers' compensation law). Although this practice carries the risk that some claimants will receive compensation to which they were not entitled, that risk has been deemed an acceptable part of the workers' compensation compromise. Under the Act and regulations, the risk of an unrecoverable overpayment exists in every case where benefits are awarded, but the legislative history of the Act demonstrates Congress intended that operators, not the Trust Fund, should bear that risk. See, e.g., Old Ben Coal Co. v. Luker, 826 F.2d 688, 693 (7th Cir. 1987); Nowlin v. Eastern Assoc. Coal Corp., 331 F. Supp. 2d 465, 476 (N.D. W.Va. 2004) ("[T]he public is served by placing the risk of non-collection of overpayments on the coal mine operator rather than on the Trust Fund").

Procedurally, these commenters argue that operators encounter difficulties in obtaining overpayment orders from the Department, and then in enforcing them against claimants because the BLBA does not grant jurisdiction to any court for this purpose. Overpayment proceedings are governed by §§ 725.547(b) and 725.548. 20 CFR 725.547(b), 725.548. Section 725.547(b) specifies that "[n]o operator or carrier may

recover, or make an adjustment of, an overpayment without prior application to and approval" by the Department. Section 725.548(a) authorizes district directors to issue appropriate orders to protect the rights of the parties, and § 725.548(b) provides that disputes will be resolved through the same adjudication procedures that govern claims. The Department understands its essential role in processing operator overpayment requests and is committed to cooperating with the parties to ensure prompt resolution. To that end, the Department will review its procedures for handling operator overpayment requests and will ensure that all personnel are properly trained in their handling as part of this rule's implementation.

Operator enforcement of overpayment orders, however, is an issue that is outside the scope of this rulemaking. Because this rule does not impose any new obligations on operators (see 80 FR 23744 (explaining that operators are legally required to pay pursuant to effective awards notwithstanding the pendency of a modification petition)), it also does not impose a new need for an enforcement remedy. These concerns represent a general complaint about the law as it currently stands and therefore should be directed to Congress, not the Department. The Department may not create a new cause of action in the courts. See Kontrick v. Ryan, 540 U.S. 443, 452 (2004) ("Only Congress may determine a lower federal court's subject-matter jurisdiction."); Castaneda v. Immigration & Naturalization Serv., 23 F.3d 1576, 1579 n.2 (10th Cir. 1994) ("[A]dministrative agencies cannot by promulgation or interpretation of their own regulations either augment or nullify the jurisdiction of the federal courts as delimited by Congress.")

In sum, this rule does not impose any payment obligations on operators that do not exist currently, and thus should have no impact on operators' incentive to pursue

modification when they believe it is warranted. See, e.g., Crowe, 646 F.3d at 445 (Hamilton, J., concurring) (noting that a pending modification request does not suspend an operator's obligation to pay pursuant to an effective award); Hudson, 2012 WL 386736, at *5 (same). Nor does this rule remove the primary incentive for operators to pursue modification: obtaining an order relieving them from the obligation to pay any additional benefits.

(f) The commenters contend that this rule is unfair because claimants and operators are treated differently. Specifically, operators must demonstrate that they have complied with their payment obligations before seeking modification of an award, but claimants are not similarly required to repay any overpaid benefits before seeking modification of a denial.

An overpayment could occur in any case where an adjudicator awards benefits to the claimant—thereby entitling the claimant to interim benefit payments pending final adjudication—and a higher-level adjudicator or appellate body denies the claim. See 20 CFR 725.522(b). Significantly, a decision reversing an award to a denial does not compel a claimant to repay previously paid benefits because the overpaid claimant has a statutory right to seek waiver of recovery of the overpayment. See 42 U.S.C. 404(b), as incorporated by 30 U.S.C. 923(b); see also 20 CFR 725.541; 725.542; 725.547. These provisions allow each overpaid claimant to argue that he or she need not repay the benefits because he or she was without fault in incurring the overpayment, and repayment would either defeat the purpose of the Act or be against equity and good conscience.

Claimants only have one year from the date of a denial of benefits to request modification. Yet waiver determinations commonly take more than that one year to

complete. They are factually involved, requiring compilation of a completely different record addressing the claimant's role in creating the overpayment and the claimant's current financial position. As in a benefits claim proceeding, a district director's waiver decision is not binding if the claimant requests an administrative law judge hearing, and no repayment by the claimant is due until after the administrative law judge considers the waiver request. See 20 CFR 725.419(a), (d); 20 CFR 725.548(b). Thus, requiring claimants to repay overpayments before seeking modification could put them in the untenable position of having to choose between two statutory rights: (1) repaying overpaid benefits within the one-year time limit for seeking modification and foregoing their right to seek a repayment waiver; or (2) seeking a repayment waiver and foregoing the right to seek modification.

This situation is not comparable to an operator's refusal to pay benefits pursuant to an effective award. Under an effective award, an operator is legally required, by both the BLBA and its implementing regulations, to pay benefits without any further action. 33 U.S.C. 921(b)(3) and (c), as incorporated by 30 U.S.C. 932(a); 20 CFR 725.502; Crowe, 646 F.3d at 445 (operator is entitled to seek modification, but "not legally entitled simply to ignore the final order of payment."); Vincent v. Consolidated Operating Co., 17 F.3d 782, 785-86 (5th Cir. 1994) (enforcing award under the Longshore Act despite employer's modification request); Williams v. Jones, 11 F.3d 247, 259 (1st Cir. 1993) (same); Hudson, 2012 WL 386736, at *5 (denying motion to dismiss enforcement petition because of pendency of modification request). Section 725.310(e) simply requires operators to comply with their legal obligations before accessing the modification process. Moreover, the one-year period during which an operator may seek

modification is constantly shifting because it runs from the date of last payment of benefits, and benefits are paid monthly. Thus, an operator might be in a position to seek modification many years after the initial award was entered.

(g) Although the Department has determined that proposed § 725.310(e) should be promulgated, the final rule contains several revisions based on comments received.

Several commenters contend that the rule would require an operator who wants to challenge a particular medical expense or an attorney's fee award to delay seeking modification until ancillary litigation regarding the disputed amount has concluded. The comment reveals an ambiguity in the proposed rule that the Department has clarified in the final rule by more specifically describing in § 725.310(e)(1) which awards an operator must pay before pursuing modification.

Miners who meet the BLBA's entitlement criteria are entitled to medical benefits for treatments necessitated by their pneumoconiosis and resultant disability. 20 CFR 725.701(a). A typical award of benefits will order the responsible operator to pay medical benefits generally, but will not contain findings as to whether any specific medical expense is compensable under the Act and regulations. The regulations recognize several valid reasons why a particular bill may be disputed, including that the medical service or supply was not for a pulmonary disorder or was unnecessary. 20 CFR 725.701(e). Operators have the right to dispute their liability for individual medical bills or charges and to take an unresolved dispute over the compensability of a medical bill to the Office of Administrative Law Judges for resolution. See 20 CFR 725.708. Any employer contest of an individual medical bill that goes to an administrative law judge

results either in an order requiring payment or an order relieving the employer of the obligation to pay. See 20 CFR 725.701.

Thus, it is not uncommon for there to be multiple effective orders compelling an employer to pay medical benefits in a given case. While proposed § 725.310(e)(1) requires payment of only "currently effective" awards as defined by § 725.502(a), it does not identify whether a general award of medical benefits or a later award addressing specific medical charges triggers the operator's obligation to pay before being allowed to pursue modification. The Department has modified the final rule to clarify that only effective orders directing payment of specific medical bills must be paid before an operator may pursue modification. Such an order may arise in two ways. First, an effective order may arise if an operator does not timely contest specific medical bills brought to its attention by a district director. See 20 CFR 725.502(a)(2). Second, an effective order directing the payment of specific medical bills may be entered by an administrative law judge after a hearing on the compensability of those medical charges. See id. This revision ensures that operators will maintain the right to contest the compensability of each individual medical expense before an administrative law judge without burdening the right to seek modification of the underlying benefits award while review is underway. The final rule also protects claimants and the Trust Fund by requiring prompt payment or reimbursement of medical expenses that have been adjudicated to be compensable.

The commenters similarly contend that the proposed rule would require employers to delay seeking modification until ancillary litigation regarding attorneys' fees is concluded. The proposed rule requires that attorneys' fees be paid before an

employer is allowed to pursue modification provided two conditions are met: the fee must be "approved," and the underlying benefits award must be final (i.e., the time to appeal the benefits award has expired or appellate review has concluded). The proposed rule does not define the term "approved," and the Department recognizes that the term may be susceptible to multiple interpretations.

In proposing § 725.310(e)(1), the Department intended to require operators to pay only those amounts that are otherwise due and payable as a precondition to seeking modification. With regard to attorney fees, the case law construing section 28 of the Longshore Act, the source of the BLBA's attorneys' fee provision (see 33 U.S.C. 928, as incorporated by 30 U.S.C. 932(a)), is clear that attorneys' fee awards are not due and payable until the underlying benefit award is final, see Thompson v. Potashnick Constr. Co., 812 F.2d 574, 577 (9th Cir. 1987), and the fee award is final as well. See Johnson v. Dir., OWCP, 183 F.3d 1169, 1171 (9th Cir. 1999). See also 20 CFR 725.367(b) (requiring payment of attorney fee only "after the award of benefits becomes final"). Thus, the Department has amended § 725.310(e) to clarify that an employer must pay attorney fee awards prior to modification only if both the underlying benefit award and the fee award are final as defined by 20 CFR 725.419(d) (district director decision), 725.479(a) (administrative law judge decision) or 802.406 (Benefits Review Board decision).

Two commenters object to proposed § 725.310(e)(1)(ii), which requires employers to reimburse the Trust Fund for benefits paid to claimants "with such penalties and interest as are appropriate" prior to seeking modification. The commenters assert that the term "penalties" is ambiguous and confusing and that its meaning should be

clarified. They note that the Department has proposed amending other regulations (§§ 725.601 and 725.607), in part to make clear that additional compensation is not a "penalty." The commenters also suggest that the modifying clause, "as are appropriate," could be read as a grant of discretion to the adjudicator to fashion extra-regulatory penalties.

The commenters are correct that the term "penalties" is not intended to refer to the additional compensation that is payable to claimants under § 725.607, and the Department did not intend to authorize adjudicators to assess new penalties against operators. The proposed rule refers to certain statutory and regulatory civil money penalties that are payable to the Trust Fund. These penalties may be imposed for failure to secure the payment of benefits, i.e., an employer's failure either to secure commercial insurance or receive permission to self-insure its benefit liability (30 U.S.C. 933(d); 20 CFR 726.300) and for an employer's failure to file a required report (30 U.S.C. 942(b); 20 CFR 725.621(d)). After considering the commenters' objections, the Department has determined that the language requiring operators to pay civil money penalties as a condition to seeking modification of an award of benefits is unnecessary. Therefore, the Department has deleted the words "penalties" and "as are appropriate" from § 725.310(e) in the final rule.

The Department has revised § 725.310(e) in the final rule to reflect these comments and to simplify the rule. Paragraph (e)(1) now defines "effective" and "final" orders by reference to the appropriate regulations. Paragraph (e)(2) retains the general requirement that operators must meet their payment obligations before pursuing modification, which appeared in proposed paragraph (e)(1). The Department has

removed the phrase "currently effective" in describing orders that must be paid because it is redundant; orders are no longer "effective" when they are vacated by a higher tribunal or superseded by an effective order on modification. See 20 CFR 725.502(a)(1). Revised paragraphs (e)(2)(i)-(v) describe the particular obligations an operator must prove it has satisfied and implements the revisions described in detail above regarding orders awarding medical benefits or attorneys' fees, and striking the words "penalties…. as are appropriate" from obligations an operator must satisfy.

(h) No other significant comments were received concerning this section, and the Department has promulgated the remainder of the regulation as proposed.

20 CFR 725.413 Disclosure of medical information.

(a) The Department proposed a new provision that would require the parties to exchange all medical information developed in connection with a claim. 80 FR 23745-47, 23752. Currently, parties may develop medical information (subject to certain limits on examinations of the miner) in excess of the evidentiary limitations set out in § 725.414, and then select from that information those pieces they wish to submit into evidence. Medical information developed but not submitted into evidence generally remains in the sole custody of the party who developed it unless an opposing party is able to obtain the information through formal discovery.

The Department's proposed rule would change this status quo by requiring parties to share medical information developed in connection with a claim. The Department articulated several reasons for the change. See 80 FR 23746-47. First, experience has demonstrated that miners may be harmed if they do not have access to all information about their health, and the primary purpose of the Mine Safety and Health Act is to

protect the health and safety of miners. To illustrate the potential for adverse impact on the miner's health, the Department described the proceedings in miner Gary Fox's claims for benefits, where the coal-mine operator withheld medical information documenting complicated pneumoconiosis from both the miner and some of its own medical experts. Second, by requiring an exchange of medical information, the rule protects parties who do not have legal representation who can assist in the formal discovery process. Finally, allowing parties fuller access to medical information may lead to better, more accurate decisions on claims—a goal that is consistent with Congressional intent.

In addition to establishing the disclosure requirement and time frames within which parties must exchange medical information, the proposed rule set forth a non-exclusive list of sanctions an adjudication officer may impose on the party or the party's attorney for failure to disclose medical information in accordance with the rule. 80 FR 23752. But the rule provided that sanctions may be imposed only after giving the party an opportunity to demonstrate "good cause" for non-disclosure, and the sanctions imposed must be "appropriate to the circumstances." Id. The proposed rule also required the adjudication officer to consider whether sanctions should be mitigated because the party was not represented by an attorney when the non-disclosure occurred, or the non-disclosure was attributable solely to the party's attorney.

(b) The Department received several comments on the proposed rule. The comments ranged from supporting the proposed rule's promulgation without change to advocating the rule's withdrawal. Those commenters supporting the rule agreed with the Department that the rule is a fair and reasonable method of protecting the health and safety of miners, noting variously that it was "critical" and "ethical" for miners to have

access to their health records. Others described experiences in representing claimants where the operator had skewed the medical evidence by withholding various pieces of medical information from their own experts or only partially disclosing a physician's opinion. A Member of Congress praised the Department's efforts, noting that the proposed rule could prevent harm to a miner who might otherwise be unaware of medical problems he or she may suffer and would level the playing field in claims adjudications, especially for unrepresented miners who would have difficulty navigating the discovery process.

Those commenters opposed to proposed § 725.413 state that the Department does not have statutory authority to promulgate the rule, or to impose sanctions, or both. They contend that neither the incorporated Social Security Act and Longshore Act provisions (see Section II, supra) granting the Secretary regulatory authority nor the Administrative Procedure Act (APA) are sufficient to sustain promulgation of this regulation. They also argue that the rule is unnecessary because only one attorney engaged in the conduct the rule addresses. They further contend that the Department has not demonstrated a quantifiable positive impact on miners' health that would result from the rule. If the Department promulgates a medical information disclosure rule, several commenters ask for clarification of specific portions of the rule.

After giving full consideration to the comments, the Department believes the rule is important to protecting the health of miners and is promulgating it with certain revisions described below. The following discussion addresses all of the significant comments the Department received and explains each revision in the final rule.

(c) Some commenters ask the Department to withdraw the rule, arguing that the Department lacks statutory authority to promulgate it. The Department disagrees with this comment. As discussed in detail above (see Section II, supra), Congress granted the Secretary broad rulemaking authority generally, and in governing evidentiary matters specifically. See 30 U.S.C. 923(b) (incorporating 42 U.S.C. 405(a)); 936(a). The statute also plainly authorizes the Department to depart from traditional procedural and evidentiary rules (such as those governing discovery) in order to best ascertain the rights of the parties in claims adjudications. 33 U.S.C. 923(a), as incorporated by 30 U.S.C. 932(a).

The objecting commenters dispute the Department's reliance on these statutory authorities. Without acknowledging the Secretary's general rulemaking authority under 30 U.S.C. 936(a), they contend that neither the incorporated Longshore Act nor the incorporated Social Security Act provisions support promulgation of § 725.413. First, these commenters assert that the Department's reliance on Longshore Act section 23(a) is hypocritical because proposed § 725.413 is itself a technical rule of procedure. While § 725.413 is undoubtedly procedural, it will relieve the parties from the burden of complex discovery rules and will simplify claim proceedings and make them fairer, especially for those parties not represented by counsel. The rule is thus fully consistent with section 23(a)'s overarching command to "best ascertain the rights of the parties."

Next, the same commenters state that the Department cannot rely on Social Security Act section 205(a), which they claim has no applicability to Part C BLBA claim proceedings (i.e., claims filed after 1973 and administered by the Department) because it is located in Part B of the Act, and provides no authority for importing Social Security

Administration procedures into Part C claim adjudications. The commenters are simply mistaken on their first point and misconstrue the Department's action on their second. The fact that the Social Security Act incorporation appears in Part B of the Act does not preclude the Secretary from basing regulations for Part C claims on that authority. 30 U.S.C. 940 (providing that "amendments made by the Black Lung Benefits Act of 1972," which included the incorporation of Social Security Act section 205(a), "shall, to the extent appropriate, also apply to this part [C]."). Indeed, both the District of Columbia and Fourth Circuit Courts of Appeals have upheld the Department's procedural regulations governing Part C claims by relying at least in part on this statutory authority. See Nat'l Min. Ass'n. v. Dep't. of Labor, 292 F.3d 849, 873-7 (D.C. Cir. 2002) (holding that section 205(a) and 5 U.S.C. 556(d)—which allows agencies to exclude "unduly repetitious evidence" as "a matter of policy"—constituted sufficient authority for the regulatory evidence limitations at 20 CFR 725.414, which are applicable to Part C claims); Elm Grove Coal Co. v. Dir., OWCP, 480 F.3d 278, 293 (4th Cir. 2007) (holding in Part C claim that incorporation of section 205(a), Administrative Procedure Act section 556(d), and grant of general rulemaking authority in 30 U.S.C. 936 authorize the Secretary "to adopt reasonable regulations on the nature and extent of the proofs and evidence in order to establish rights to benefits under the Act"). Moreover, § 725.413 does not import Social Security Administration procedures but instead provides a new rule applicable to Part C claims.

Promulgating a procedural rule requiring parties to exchange medical information developed in connection with a claim—a rule that governs proceedings before the

agency, is party-neutral, protects a miner's health, and assists unrepresented parties—falls well within these statutory authorities.

(d) Apart from requiring the exchange of medical information, several commenters contend that the Department lacks statutory authority to promulgate regulations permitting the imposition of sanctions on parties or their attorneys who fail to properly disclose medical information. In support, they assert that: the Administrative Procedure Act (APA), 5 U.S.C. 501 et seq., and section 558(b) in particular, 5 U.S.C. 558(b), prohibit an agency from imposing sanctions; only courts established under Article III of the Constitution (i.e., federal district and appellate courts) may impose sanctions of fines and imprisonment; and neither the APA nor the BLBA authorizes sanctioning of attorneys in any event.

To the extent these commenters base their objections on the APA, their comments misapprehend how the APA's provisions interface with the BLBA. By statute, the APA does not apply to BLBA adjudications except as "otherwise provided" in the Mine Safety and Health Act. 30 U.S.C. 956 ("Except as otherwise provided in this chapter, the provisions of sections 551 to 559 and sections 701 to 706 of Title 5 shall not apply to the making of any order, notice, or decision made pursuant to this chapter[.]"). The BLBA otherwise provides for application of the APA provisions governing hearings—specifically, 5 U.S.C. 554 (which, in turn, refers to 5 U.S.C. 556)—by incorporating Longshore Act section 19(d). 33 U.S.C. 919(d), as incorporated by 30 U.S.C. 932(a). But as explained above (see Section II, supra), that incorporation is subject to an important limitation: the Longshore Act provisions are incorporated "except as otherwise provided ... by regulations of the Secretary." 30 U.S.C. 932(a). Thus, "under the express

language of the BLBA, the APA does not trump [a black lung program] regulation." Amax Coal Co. v. Dir., OWCP, 312 F.3d 882, 893 (7th Cir. 2002); accord Midland Coal Co. v. Dir., OWCP, 149 F.3d 558, 563 (7th Cir. 1998) (overruled on other grounds by Saban v. U.S. Dep't of Labor, 509 F.3d 376 (7th Cir. 2007)).

Unlike the APA hearing provisions, neither the BLBA nor the Department's implementing regulations calls for application of section 5 U.S.C. 558, the APA section the commenters rely upon most heavily to challenge the Department's authority to impose sanctions under § 725.413. Section 558(b) provides that "[a] sanction may not be imposed. . . except within jurisdiction delegated to the agency and as authorized by law." 5 U.S.C. 558(b). The Mine Safety and Health Act specifically excludes this APA section from incorporation unless "otherwise provided," and the BLBA does not "otherwise provide" for its application. 30 U.S.C. 956. Nor is this provision incorporated through the circuitous Longshore Act route that brings the APA's hearing-related provisions into the BLBA. Thus, the commenters' reliance on section 558 is misplaced.

Even assuming that (1) all provisions of the APA apply and (2) the Department may not vary them by regulation, solid authority holds that agencies may impose sanctions, short of fines and imprisonment, to enforce compliance with their discovery rules, particularly discovery orders made in the context of judicial-type proceedings. See Atlantic Richfield Co. v. U.S. Dep't of Energy, 769 F.2d 771, 794 (D.C. Cir. 1984). The District of Columbia Circuit recognized in Atlantic Richfield that it would be "incongruous to grant an agency authority to adjudicate – which involves vitally the power to find the material facts – and yet deny authority to assure the soundness of the factfinding process" through use of discovery sanctions. See also Roadway Express Inc.

v. U.S. Dep't of Labor, 495 F.3d 477, 485 (7th Cir. 2007) (approving of ALJ's use of discovery sanction to "level the playing field" where party's non-compliance "made it impossible" for the ALJ to decide the case on the merits); McAllister Towing & Transp. Co., Inc. v. NLRB, 156 Fed. App'x 386, 388 (2d Cir. 2005) (affirming ALJ's imposition of discovery sanctions, citing Atlantic Richfield). But see NLRB v. Int'l Medication Sys., Ltd., 640 F.2d 1110, 1114 (9th Cir. 1981) (agency was required to enforce a subpoena through federal district court and could not preclude employer from introducing evidence on issue as sanction for failure to comply with subpoena). And while it is true that the APA prohibits an agency's imposition of sanctions "except within jurisdiction delegated to the agency and as authorized by law," 5 U.S.C. § 558(b), this provision, even if applicable, does not preclude sanctions aimed at protecting the integrity of the administrative process. Am. Bus Ass'n v. Slater, 231 F.3d 1, 7 (D.C. Cir. 2000). See also Davy v. SEC, 792 F.2d 1418, 1421 (9th Cir. 1986) (general grant of regulatory authority to SEC was sufficient to allow adoption of rule providing for sanctioning accountants practicing before the agency).

Contrary to the commenters' implication, no different rule applies when sanctioning parties' representatives. Agencies have the inherent authority to discipline lawyers who appear before them. See Polydoroff v. I.C.C., 773 F.2d 372, 374 (D.C. Cir. 1985). See also 80 FR 28768, 28769-75 (May 19, 2015) (rejecting same concerns raised in response to the proposed Office of Administrative Law Judges Rules of Practice and Procedure, which also allowed imposition of sanctions in certain circumstances).

Nor does section 27 of the Longshore Act, 33 U.S.C. 927, incorporated into the BLBA by 30 U.S.C. 932(a), preclude the Department from imposing discovery sanctions.

That provision authorizes adjudication officers to refer acts of contempt to a United States district court for punishment by fine or imprisonment. It does not preclude the Department from imposing the lesser sanctions set out in the proposed rule. See Atlantic Richfield, 769 F.2d at 795 (noting that "[a]n evidentiary preclusion order falls far short of an effort to exact compliance with a subpoena by a judgment of fine or imprisonment").

Two commenters state that the list of possible sanctions in proposed § 725.413(c)(2) is unclear because it is non-exclusive, suggesting that the Department strike the sanctions list from the rule. The Department anticipates that in most instances, an adjudication officer will impose one of the listed sanctions, and therefore the presence of a sanctions list leads to greater clarity. An adjudication officer, who is charged with governing the conduct of proceedings and resolving contested issues of fact or law (see generally 20 CFR 725.455), should be free, however, to fashion a remedy unique to the particular case at hand when warranted. But to clarify this provision and allay any concerns that the non-exclusive list could lead to the imposition of fines or imprisonment, the Department has revised the rule to preclude these sanctions. Fines and imprisonment are inherent in contempt powers, which section 27 of the Longshore Act vests in the federal courts. 33 U.S.C. 927, as incorporated by 30 U.S.C. 932(a). This revision appears at § 725.413(e)(3) in the final rule.

Finally, one commenter proposed expanding available sanctions to include permanent disbarment of attorneys from all BLBA practice. The Department does not believe that this sanction is necessary to enforce the medical information disclosure rule effectively. An adjudicator's authority extends to determining the merits of an individual claim. See, e.g., 33 U.S.C. 919(a), as incorporated by 30 U.S.C. 932(a) (the adjudicator

has the "authority to hear and determine all questions in respect of [a] claim"). Thus, the Department believes that any sanction's impact should be confined to the claim under consideration. The sanctions listed in § 725.413 are claim-specific and should be sufficient to protect the integrity of the claims process. The Department therefore declines to adopt this suggestion.

(e) Three commenters argue that requiring parties to exchange medical information is an overreaction to an isolated case, claiming that only one attorney engaged in the conduct addressed by proposed § 725.413. These commenters state that the Department cited only one case involving undisclosed medical information in the NPRM, and failed to fully assess the need for the rulemaking.

These comments are not accurate. Although the Department illustrated the need for the rule with a detailed summary of miner Gary Fox's claims, it also cited two additional cases (involving different attorneys) in the NPRM. 80 FR 23746. More importantly, the issue of withholding medical information generated by non-testifying experts has persistently recurred in black lung claims and has been litigated by some members of the associations making this comment. Several other commenters listed and described additional claims in which medical evidence was withheld. These cases, along with others the Department has identified, generally fall into three categories. In the first, the adjudication officer denies the party's (either the claimant's or the operator's) motion to compel discovery of the medical information because the party did not meet the standard for gaining discovery of a non-testifying expert's opinion imposed under the Office of Administrative Law Judges Rules of Practice and Procedure (OALJ Rules). See, e.g., Keener v. Peerless Eagle Coal Co., ALJ Ruling and Order on Claimant's

Motion to Compel and Employer's Motion for Protective Order, 2004-BLA-06265 (Apr. 12, 2005), aff'd BRB Decision and Order, BRB No. 05-1008 (Jan. 26, 2007); Lester v. Royalty Smokeless Coal Co., ALJ Decision and Order on Remand Granting Benefits, 2004-BLA-05700 (Mar. 4, 2008). In the second, the claimant's motion to compel is granted, but the employer still avoids disclosure by accepting liability for benefits and paying the claim. See, e.g., Daugherty v. Westmoreland Coal Co., ALJ Order Remanding Case to District Director, 2001-BLA-00594 (Mar. 21, 2005); Renick v. Consolidation Coal Co., ALJ Order of Remand for Payment, 2002-BLA-00083 (Sept. 9, 2002); and Harris v. Westmorland Coal Co., Order Denying Claimant's Request for Reconsideration, 1998-BLA-0188 (Aug. 7, 1998). And in the third, the motion to compel is granted and the medical information is disclosed. See, e.g., Wood v. Elkay Mining Co., ALJ Decision and Order – Awarding Benefits, 2001-BLA-00701 (May 23, 2007); Huggins v. Windsor Coal Co., BRB Decision and Order, BRB No. 06-0710 (Aug. 15, 2007). It is the first two categories of cases in which § 725.413 will change the result by requiring the exchange of previously undisclosed medical information.

These commenters also assert that the Department failed to quantify the general impact of non-disclosure on miners' health. Doing so with any certainty is impractical for several reasons. By their nature, these cases come to light only when a party takes affirmative action to discover medical information; the Department cannot quantify the volume of undisclosed medical information in cases where parties do not pursue discovery of that information and, in fact, might not even know of its existence. The same is true in those instances where the employer has chosen to accept liability for the claim rather than disclosing the non-testifying expert's opinion. The Department also

cannot assess whether any particular piece of medical information would have an impact on any one miner's course of treatment or disease. But common sense dictates that better-informed miners and medical providers are able to make better decisions regarding a miner's care.

And, to the extent these commenters are correct in stating that, with very few exceptions, parties already exchange all medical information developed, they should not be affected by the final rule. Apart from a slightly earlier deadline for exchanging medical information, § 725.413 will not change those parties' current practice.

Despite the practical barriers to the suggested analysis, Congress was certain in its primary direction to the Department: "[T]he first priority and concern of all in the coal or other mining industry must be the health and safety of its most precious resource—the miner." 30 U.S.C. 801(a). Congress also explicitly recognized the importance of medical information to miners' health when it mandated medical screening to detect pneumoconiosis and provided that miners with evidence of pneumoconiosis could transfer to less-dusty areas of the mine site. 30 U.S.C. 843(a) (requiring underground coal mine operators to offer chest X-ray evaluations to miners periodically); 30 U.S.C. 843(b) ("[A]ny miner who, in the judgment of the Secretary of Health and Human Services based upon [a chest X-ray] reading or other medical examinations, shows evidence of the development of pneumoconiosis shall be afforded the option of transferring from his position to another position in any [less-dusty] area of the mine, for such period or periods as may be necessary to prevent further development of such disease[.]"). Section 725.413 fully comports with Congress' desires.

(f) The Department received several comments suggesting various clarifications and other changes to the proposed definition of "medical information" at § 725.413(a). As proposed, "medical information" includes medical data about a miner that was developed in connection with a claim for benefits (§ 725.413(a)) and that is: (1) an examining physician's assessment of the miner, including findings, test results, diagnoses, and conclusions (§ 725.413(a)(1)); or (2) any other physician's or medical professional's opinion or interpretation of tests, procedures and related documentation, but only to the extent they address the miner's respiratory or pulmonary condition (§ 725.413(a)(2)-(4)). 80 FR 23747, 23752. Thus, the medical data subject to disclosure is generally limited to data generated in the claim's litigation and relevant to the primary question in the claim—the miner's respiratory or pulmonary condition.

(1) Two commenters express concern that proposed § 725.413(a) does not specifically exclude a miner's medical treatment records from the definition of "medical information" subject to mandatory exchange between parties. As the Department explained in the NPRM, 80 FR 23747, treatment records are not medical data a party "develops in connection with a claim" and thus do not meet the definition of "medical information." Instead, these records are generated in the routine course of a miner's treatment and, if pertinent to the miner's respiratory or pulmonary condition, are admissible without limitation. 20 CFR 725.414(a)(4). But to allay any concern, the Department has revised § 725.413 to explicitly exclude treatment records from the "medical information" subject to exchange between the parties under this regulation. The new language is in paragraph (b)(1) of the final regulation.

(2) Several commenters assert that § 725.413 should exclude from "medical information" all draft medical reports. These same commenters also urge the Department to exclude all communications between a party's attorney and its medical experts. For the reasons that follow, the Department disagrees that draft medical reports should be excluded from "medical information" but has adopted the commenters' suggestion to exclude attorney communications with experts from § 725.413's disclosure requirements.

To support their request for these exclusions, the commenters point variously to Federal Rule of Civil Procedure 26(b)(4)(B) and (C) and the OALJ Rules, 80 FR 28793 (May 19, 2015) (to be codified at 29 CFR 18.51(d)), which incorporate the concepts embodied in the Federal Rule. When an expert is required to submit written reports or other disclosures, those rules protect his or her draft reports from discovery. Fed. R. Civ. P. 26(b)(4)(B); 80 FR 28793 (to be codified at 29 CFR 18.51(d)(2)). Similarly, the rules generally protect from disclosure communications between the party's attorney and the expert witness except when those communications pertain to the expert's compensation, facts or data the attorney provided to the expert, or assumptions provided by the attorney to the expert that the expert relied on in forming his or her opinion. Fed. R. Civ. P. 26(b)(4)(C); 80 FR 28793 (to be codified at 29 CFR 18.51(d)(3)). These rules are designed to allow discovery of the facts and data on which the expert bases his or her opinion without unnecessarily interfering with effective communication between the attorney and the expert or disclosing the attorney's mental impressions and theories about the case. See generally Fed. R. Civ. P. 26, Advisory Committee comment to 2010 amendments.

As noted above (see Section II, supra), formal rules of procedure do not strictly apply in black lung claims adjudications. And a program-specific regulation applies over either the Federal Rules or the OALJ Rules. 80 FR 28785, to be codified at 29 CFR 18.10 (OALJ rules do not apply "[i]f a specific Department of Labor regulation governs[,]" and the Federal Rules of Civil Procedure apply only in situations not provided for in the OALJ rules or other governing regulation). See also 80 FR 28773 (discussing 29 CFR 18.10 and stating that "[n]othing in [the OALJ] rules would prevent the Department from adopting a procedural rule that applies only in BLBA claim adjudications or other program-specific contexts.").

In this instance, the Department believes a rule governing draft reports designed specifically for the Black Lung program will serve the program's purposes better than the general rule. Exempting all draft medical reports from § 725.413's disclosure requirements could easily eviscerate the rule: the disclosure requirement could be avoided simply by labeling any medical report a "draft." Any party could solicit additional medical opinions on the miner's condition and simply not share them with the opposing party, or perhaps even their remaining expert witnesses. If an employer engaged in that conduct, a primary purpose of the rule—protecting the health and safety of the miner by ensuring access to all information about his or her health—would be thwarted. And if a claimant did the same, another primary purpose of the rule—accurate claims adjudication—could be in jeopardy.

On the other hand, the Department does not see a similarly compelling need to routinely require disclosure of communications from an attorney (or non-attorney representative, see 20 CFR 725.363(b)) to a medical expert. When prepared by an

attorney, these communications are generally protected from disclosure, except in the circumstances noted above, and are more likely to include the attorney's impressions and legal analysis of the case. And they generally do not have a direct bearing on protecting the miner's health. Accordingly, the Department believes these communications should not be considered "medical information" subject to mandatory exchange with the other parties. The Department has added new language to paragraph (b)(2) in the final rule to exclude attorney (and non-attorney representative) communications from the rule's disclosure requirements. The Department notes, however, that the exclusion would not protect disclosure of these communications when otherwise ordered. See, e.g, Elm Grove Coal, 480 F.3d at 299-303. The rule simply does not require their exchange.

(3) Two commenters ask the Department to revise § 725.413(a) to include "an exhaustive list" of "medical information" that must be exchanged. They claim that the proposed rule does not adequately describe the scope of covered information. To illustrate, the commenters point to several examples, such as data the Social Security Administration considers "health information" (e.g., a patient's method of bill payment) and suggest that "medical information" could be construed to include such data.

The Department has not added a complete list of "medical information" to the final rule. As explained, the rule expressly limits disclosure to medical information developed in connection with a claim for benefits and, with the exception of an examining physician's report, further limits required disclosure to data addressing the miner's respiratory or pulmonary condition. These two limitations serve to substantially narrow and define the scope of information that must be exchanged with opposing parties (e.g., data about a billing method would not meet the criteria).

Moreover, developing an exhaustive list would not be practical because it could easily omit relevant medical data. Another black lung program regulation (20 CFR 718.107(a)) correctly countenances the possibility that medical testing methods other than those explicitly addressed in the regulations may be used to evaluate a miner's respiratory or pulmonary condition. See id. (allowing for admission 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"). Adopting a finite list in § 725.413 could inadvertently exclude otherwise important data, especially as testing methods evolve in the future.

(4) Two commenters ask the Department to clarify whether the form in which the party receives the medical information (i.e., written, electronic, or orally) affects the duty under § 725.413 to exchange that information. As proposed, § 725.413(a)(1) and (2) require the parties to exchange physicians' "written or testimonial assessment of the miner." The remainder of the rule is silent regarding the form of the communication. The Department agrees that the rule should be clarified on this point and has revised paragraph (a) in the final rule. With this change, the Department intends to make all written medical information, whether received in electronic (e.g., e-mail, facsimile, Web portal or other electronic media) or hard-copy format, subject to § 725.413's requirements. This would also include testimonial medical information resulting from depositions (e.g., transcripts of depositions). But the rule is not intended to cover oral communications. The Department has no mechanism to monitor oral communications, and compliance with such a rule would be impossible to enforce.

(g) Two commenters express concern that the proposed rule does not adequately address the interplay between § 725.413's disclosure requirements and § 725.414's evidence-limiting provisions (which restrict the number of objective tests and medical reports parties may offer into evidence), and may lead to confusion as to whether the new disclosure requirements expand the amount of medical evidence a party may offer beyond that currently allowed under § 725.414. The Department agrees with this comment and has added a new paragraph (d) to § 725.413 to clarify that disclosed medical information is not considered evidence in the claim. Section 725.413's disclosure requirements essentially replace traditional discovery tools. Like information gained through traditional discovery, medical information exchanged under § 725.413 does not automatically become a part of the record on which the claim's adjudication is based. Instead, only those pieces of medical information a party chooses to submit to the adjudicator as evidence are subject to § 725.414's evidence-limiting rules.

(h) On a related note, one commenter states that because district directors serve a dual role as a party (entitled to receive disclosed medical information under this rule) and an adjudicator, they could be confused about which pieces of exchanged medical information should be considered as evidence in the claim. This commenter suggests that the rule be revised to require private parties to disclose evidence to the Director only after a hearing has been requested. The Department disagrees with the suggested approach. District directors are skilled adjudicators who routinely sort through admissible and non-admissible pieces of medical information in issuing proposed decisions and orders. For example, when parties submit more evidence than allowed under the § 725.414 evidence-limiting rules (a not infrequent occurrence), district directors must eliminate from

consideration the evidence exceeding the limits when adjudicating the claim's merits. In addition, removing the district director from early disclosures would hamper their ability to administer the rule. The Department will ensure that district directors and their staffs receive training on the appropriate disposition and use of material disclosed under the rule.

(i) Several commenters ask that attorneys (and presumably non-attorney representatives as well) be exempt from liability for a client's failure to disclose medical information received by a party prior to the attorney's hiring. The Department concurs with this comment but does not believe a change in the proposed rule is necessary. Section 725.413(b) links the duty to exchange medical information to its "receipt." An attorney or representative new to the case cannot be held responsible for the party's (or the party's prior representative's) failure to timely exchange the information because the new representative was not in "receipt" of the medical evidence prior to their entry into the case. But once the new representative actually receives any medical information generated before they entered the case—for instance, from a claimant who gives his or her new attorney all of the paperwork they have related to the claim—the representative then has a duty to ensure that the medical information is exchanged with the other parties within thirty days in accordance with § 725.413(b).

(j) Several commenters contend that the rule denies due process to sanctioned parties because the regulation authorizes no form of review for a wrongful sanctions ruling. These commenters believe that a sanctions ruling cannot be reviewed along with the merits of a claim because the ruling cannot be reversed. While the Department believes that normal claim procedures are sufficient to protect the rights of sanctioned

individuals, it has clarified the review procedure by adding a new paragraph (e)(4) to the final rule. Under this provision, a sanction imposed by a district director is subject to de novo review by an administrative law judge. The Department has adopted this approach because several of the listed sanctions—such as drawing an adverse inference against the non-disclosing party or limiting a non-disclosing party's claims, defenses, or right to introduce evidence—are closely tied to the adjudication of a claim's merits. By statute, the administrative law judge has the "authority to hear and determine all questions in respect of [a] claim." 33 U.S.C. 919(a), as incorporated by 30 U.S.C. 932(a). These questions would include whether the party had "good cause" for not making the required disclosure and the appropriateness of the sanction chosen. Any administrative law judge's order resulting in a final disposition of the claim would be subject to immediate appeal to the Benefits Review Board, followed by appeal to an appropriate court of appeals. 33 U.S.C. 921(a), (c), as incorporated by 30 U.S.C. 932(a). And in the absence of a final claim disposition, a sanctioned party could choose to immediately appeal an order imposing sanctions to the Board, whose precedent allows it to accept such interlocutory appeals merely to direct the course of the adjudicatory process. See Niazy v. Capital Hilton Hotel, 19 BRBS 266, 269 (1987).

(k) No other significant comments were received concerning this section, and the Department has promulgated the remainder of the regulation as proposed.

20 CFR 725.414 Development of evidence.

(a)(1) The Department proposed revising § 725.414, which imposes limitations on the quantity of medical evidence each party may submit in a black lung claim. 20 CFR 725.414. Sections 725.414(a)(2) and (a)(3) allow each party to submit "no more than two

medical reports" in support of its affirmative case. 20 CFR 725.414(a)(2)-(3). The current rule defines a "medical report" as a "written assessment of the miner's respiratory or pulmonary condition" that "may be prepared by a physician who examined the miner and/or reviewed the available admissible evidence." 20 CFR 725.414(a)(1).

This definition of "medical report" at times created confusion over whether supplemental reports offered by a physician whose initial opinion had already been entered into evidence counted against the parties' two-report limit. 80 FR 23747. Parties obtain supplemental reports when they ask a physician to update his or her initial report by reviewing additional material, such as medical testing results or other physicians' opinions. To eliminate this confusion, the Department proposed revising the definition of a "medical report" to codify the Director's longstanding position that a physician's supplemental report is "merely a continuation of the physician's original medical report for purposes of the evidence-limiting rules and do[es] not count against the party as a second medical report." 80 FR 23747. The Department noted that the proposed definition was consistent with the regulatory provision allowing physicians to review (either in a written report or oral testimony) the other admissible evidence, and a cost-effective means of providing medical-opinion evidence given the practical realities of black lung claims litigation. 80 FR 23747-48.

(2) Three commenters support the proposed rule as written. Four other commenters state general support for the rule, but question how a physician's supplemental medical report would be treated in a modification proceeding. See generally 20 CFR 725.310. Specifically, these commenters express concern over allowing physicians who submitted reports in the initial proceeding to submit

supplemental reports on modification without those reports being counted against the party's evidentiary limits. The commenters believe this practice could lead to the development of limitless evidence, thwarting the purpose of the evidence-limiting rules.

(3) The Department does not believe this comment warrants a change in the proposed rule. In a modification proceeding, the regulations allow each party to submit one additional medical report in support of its affirmative case. 20 CFR 725.310(b). This provision supplements the limitations contained in § 725.414(a); thus, during modification, a party may submit up to the two medical reports allowed under § 725.414(a), if they were not submitted during the original claim proceedings, plus one additional medical report, for a total of three. Rose v. Buffalo Mining Co., 23 Black Lung Rep. 1-221, 1-226-28 (Ben. Rev. Bd. 2007).

Considering a physician's supplemental report as an extension of his or her original report is consistent with the Department's longstanding position that modification proceedings are a continuation of the initial claim. See Betty B Coal Co. v. Dir., OWCP, 194 F.3d 491, 498 (4th Cir. 1999). Moreover, this conclusion logically flows from a party's right to submit evidence not submitted during the initial claim proceedings to the extent allowed under § 725.414(a). Rose, 23 BLR at 1-227-28. Because a supplemental report could have been submitted during the initial proceedings without counting against the party, it is reasonable to allow the same accommodation during modification.

Finally, the regulations provide that a physician who submits a report during the initial proceedings could testify at hearing or by deposition during modification proceedings, without it counting against the party for purposes of the evidence-limiting

rules. See 20 CFR 725.414(c) ("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."). A testifying physician may address any admissible medical evidence submitted in the claim. See 20 CFR 725.457(d); 725.458. Thus, it makes little sense not to allow supplemental reports if a party could achieve the same result by having its physician testify during modification proceedings. See 80 FR 23748. Allowing submission of a written report is also consistent with the nature of black lung proceedings, where such reports are freely admissible.

The commenters' claim that this interpretation would result in limitless evidentiary development is overstated. Allowing supplemental reports from physicians whose opinions were admitted in the initial claim proceeding does not increase the number of physicians who may evaluate the miner's condition. As explained, that total remains at a maximum of three for each party in a modification proceeding. And development of supplemental reports in an undisciplined or unreasonable way is naturally constrained by other regulations. For example, physicians may review only admissible evidence, 20 CFR 725.414(a)(1), and the amount of admissible evidence overall is limited. See 20 CFR 725.414(a)(2)-(3). The limited number of test results, such as chest X-ray reports and pulmonary function tests, each party may submit restricts the number of supplemental reports necessary to review and comment on those tests.

(b)(1) The Department proposed a separate revision to § 725.414(a)(3)(iii). Currently, this provision authorizes the Director to exercise the rights of a responsible operator for the purposes of the evidence limitations only if: (1) the district director has

not identified a potentially liable operator; or (2) all potentially liable operators have been dismissed. The Department proposed adding a third provision that would allow the Director to submit medical evidence, up to the limits allowed a responsible operator under the evidence-limiting rules, when the identified responsible operator stops defending a claim during the course of litigation because of adverse financial developments, such as bankruptcy or insolvency. 80 FR 23753.

The Department proposed this change because the current rule does not adequately protect the Trust Fund against unmeritorious claims in these circumstances. 80 FR 23748. Where an identified responsible operator ceases to defend a claim in litigation due to adverse financial developments, the current rule limits the Director's submissions to only the complete pulmonary evaluation that the Department gives to every miner as an opportunity to substantiate his or her claim. See generally 30 U.S.C. 923(b); 20 CFR 725.406, 725.414(a). This is true even though the Trust Fund may ultimately be liable for any benefits awarded. The proposed rule would give the Director the same rights to defend against a claim as if there were no responsible operator in the case. This means that in a miner's claim, the Director could submit as part of his affirmative case one medical opinion and set of testing in addition to the complete pulmonary examination afforded every miner who applies for benefits. See 20 CFR 725.414(a)(3)(iii).

(2) Two commenters support the rule as proposed. Several other commenters state that the rule needs clarification. The latter commenters agree that the Director should be able to defend unmeritorious claims in these circumstances, but only if the district director initially denied the claim. In cases initially awarded by the district

director, the commenters express concern that the Director may use medical evidence previously developed by the no-longer-defending operator. They believe this would be improper for two reasons: (1) the Director would be impeaching his own witness (i.e., the physician who performed the Department-sponsored medical evaluation and whose opinion most likely supported the initial benefits award) with operator-generated evidence, and challenging the award at a later stage would call into question the district director's role as a neutral adjudicator; and (2) medical opinions generated by operators virtually always express views contrary to the BLBA, the implementing regulations, and science. The commenters further allege, without examples, that whether the district director initially awards or denies the claim, a conflict of interest arises should the Director later decide to defend a claim because earlier routine communications between the claimant and the district director could be used against the claimant. For the reasons that follow, the Department does not believe any changes should be made in the proposed rule based on these comments.

First, the Director is not obligated to continue to advocate for an award of benefits once that award has been proven by later evidence or an intervening adjudication to be incorrect. Hardisty v. Dir., OWCP, 776 F.2d 129, 130 (7th Cir. 1985) (Director not bound by initial award of benefits in later proceedings after liability transferred from the responsible operator to the Trust Fund); Pavesi v. Dir., OWCP, 758 F.2d 956, 960 (3d Cir. 1985) (Director has obligation to protect Trust Fund and is not bound by district director's initial award of benefits). See also Cornett v. Benham Coal, Inc., 227 F.3d 569, 573 n.2 (6th Cir. 2000) (in litigation of claim, Director may take a position contrary to district director's initial finding that claim should be denied). This approach makes

sense both because the Director has a fiduciary duty to protect the Trust Fund against unmeritorious claims, see, e.g., Dir., OWCP v. Hileman, 897 F.2d 1277, 1281 n.2 (4th Cir. 1990), and later contrary evidence could prove more probative. For example, a district director could award benefits based on X-ray evidence of complicated pneumoconiosis (also known as progressive massive fibrosis) when a later autopsy report affirmatively demonstrates that the miner did not have that form of the disease. The reverse could also occur (i.e., the district director denied the claim and an autopsy shows the miner suffered from complicated pneumoconiosis), compelling the Director to argue for an award of benefits. Neither scenario calls into question the district director's neutrality in adjudicating the claim based on the evidence before him or her.

Second, the commenters' fear that the Director would rely on operator-generated medical opinions that are contrary to the BLBA, the regulations or science overlooks the Director's longstanding, consistent history arguing for rejection of these problematic medical opinions. See, e.g., Harman Mining Co. v. Dir., OWCP, 678 F.3d 305, 314-16 (4th Cir. 2012) (endorsing the Director's argument that a physician's opinion was permissibly considered less persuasive when the physician's views conflicted with the Department's rationale for amending the regulations); Sea "B" Mining Co. v. Dunford, 188 F. App'x 191, 199 (4th Cir. 2006) (agreeing with the Director that operator's physician's opinion was based on two premises that are hostile to the Act and thus appropriately discredited); Hunt v. Kentland Elkhorn Coal Corp., 159 F. App'x 659, 661-62 (6th Cir. 2005) (the Director argued that operator's physicians' opinions must be rejected because both were based on premises inconsistent with the Act); Penn Allegheny Coal Co. v. Mercatell, 878 F.2d 106, 109-10 (3d Cir. 1989) (agreeing with the Director

that the ALJ reasonably discredited physician's opinion based on premises "fundamentally at odds with the statutory and regulatory scheme"); Black Diamond Coal Mining Co. v. Benefits Review Board, 758 F.2d 1532 (11th Cir. 1985) (Director supported ALJ discounting testimony of a doctor as inconsistent with the Act when that physician stated that he would not diagnose pneumoconiosis in the absence of positive x-rays); Kaiser Steel Corp. v. Dir., OWCP, 748 F.2d 1426 (10th Cir. 1984) (Director argued that the ALJ had properly discredited as contrary to the findings and purposes of the Act the opinion of a physician who stated coal workers' pneumoconiosis was never impairing).

The Director does not intend to alter this policy. In each case—whether the claim was awarded or denied by the district director—the Director will evaluate any medical opinion evidence developed by the defunct operator and reject any evidence inconsistent with the BLBA, the regulations and supporting preambles. This is the same process the Director engages in now when an operator ceases to exist and liability for a claim in litigation is transferred to the Trust Fund.

Third, the allegation that routine information exchanged between the district director and the claimant could later be used to defeat the claim is unfounded. By statute, the Department wears two hats in black lung cases, with district directors conducting initial adjudications and the Secretary, represented by the Director, participating as a party-in-interest in all later proceedings. See generally 33 U.S.C. 919, as incorporated by 30 U.S.C. 932(a) (providing for district director determinations) and 30 U.S.C. 932(k) (making the Secretary a party in all cases). The district director receives claim filings, gathers factual information about the miner's employment history and dependents, and,

in claims filed by a miner, arranges for a complete pulmonary examination. Based on this information and any evidence submitted by the parties, the district director proposes an initial entitlement decision. Findings made by the district director are not binding on an administrative law judge, who conducts an independent de novo review of the claim. See 20 CFR 725.455(a) (In general, "any findings or determinations made with respect to a claim by a district director shall not be considered by the administrative law judge").

Given the de novo nature of the administrative law judge's adjudication, it is difficult to see how communications between the district director and the claimant could adversely impact the claimant. More importantly, for more than three decades the Director has defended proposed district director denials of benefits in claims for which the Trust Fund bears direct liability. See 26 U.S.C. 9501(d)(1)(B) (amounts in Trust Fund available to pay benefits when there is no liable operator). In these claims, the district director conducted an initial adjudication and the Director routinely participated in further proceedings, advocating for a denial of benefits unless the evidence demonstrated that the claimant was entitled to benefits. To the Department's knowledge, the Director has not used communications made between the claimant and the district director in a manner adverse to the claimant. And the commenters have pointed to no such instances.

Finally, the Department disagrees with one commenter's suggestion that operators be required to certify the reason for their inability to pay continuing benefits. Requiring certification from a bankrupt or insolvent operator would place too high an administrative burden on the Department. In some instances, locating a person who could act on the defunct operator's behalf may be impossible. And, even assuming the operator continues

to exist in some form, an operator lacking financial capacity to pay benefits has little incentive to respond to a certification request. The rule, and the protection it affords the Trust Fund, would be rendered useless if an operator either failed or simply refused to supply any required certification.

(c) No other significant comments were received concerning this section, and the Department has promulgated § 725.414 as proposed.

20 CFR 725.601 Enforcement generally.

(a) Currently, § 725.601(b) refers to "payments in addition to compensation" and cross references § 725.607. The proposed rule replaced this phrase with "payments of additional compensation." 80 FR 23753. The Department intended this to be a technical change, unifying this language with a simultaneously proposed change to § 725.607. 80 FR 23748.

(b) One commenter objected, contending that the wording change is substantive and would impose unauthorized penalties on operators. The Department disagrees with this comment. The change to this rule is technical in nature and, as stated in the NPRM, no substantive change is intended. Id. For this reason, as well as the reasons set forth in the discussion under § 725.607, the Department is promulgating this rule as proposed.

20 CFR 725.607 Payments in addition to compensation.

(a) Section 725.607 implements section 14(f) of the Longshore Act, an incorporated provision. 33 U.S.C. 914(f), as incorporated by 30 U.S.C. 932(a). Section 14(f) generally provides that claimants are entitled to receive from a liable coal mine operator 20 percent of any compensation owed under the terms of an award that is not paid within ten days of the date payment is due. By regulation, payment is due "on the

fifteenth day of the month following the month for which the benefits are payable." 20 CFR 725.502(b)(1); see also 20 CFR 725.502(a). The operator is liable for the 20 percent amount even if the Trust Fund pays ongoing benefits to the claimant on an interim basis. 20 CFR 725.607(b).

The Department proposed revising both the title of § 725.607 and the text of paragraph (c) by replacing the phrase "payments in addition to compensation" with the phrase "payments of additional compensation." 80 FR 23853-54. As explained in the NPRM, 80 FR 23748-49, section 725.607(b) uses the phrase "additional compensation," and conforming the title and paragraph (c) to that language adds clarity to the regulation and "eliminate[s] any possibility that the regulation's phrasing could confuse readers." 80 FR 23749; see also 20 CFR 725.530(a) (cross-referencing § 725.607 and describing potential operator liabilities as including "additional compensation"). The phrase "additional compensation" reflects the Director's view, as well as the view of the majority of courts that have considered the issue, that payments made under Longshore Act section 14(f) are compensation rather than penalties. 80 FR 23748.

(b) Four commenters contend that the proposed revisions to the title and paragraph (c) impose new and unauthorized penalties on operators. Although these commenters concede that section 14(f) is incorporated into the BLBA, they challenge application of the provision to the BLBA program.

Using the phrase "additional compensation" consistently throughout the regulations does not impose any new or unauthorized penalties on operators. The Department has had a regulation interpreting and applying section 14(f)'s 20 percent additional compensation provision to unpaid black lung benefits since 1978. See 43 FR

36814-15 (Aug. 18, 1978). Clarifying the language neither adds a new provision nor alters the character of the 20 percent additional compensation payment to a penalty. The Department is therefore promulgating the rule as proposed.

IV. Information Collection Requirements (Subject to the Paperwork Reduction Act) Imposed under the Proposed Rule

The Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 et seq., and its implementing regulations, 5 CFR part 1320, require that the Department consider the impact of paperwork and other information collection burdens imposed on the public. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by the Office of Management and Budget (OMB) under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person may generally be subject to penalty for failing to comply with a collection of information that does not display a valid Control Number. See 5 CFR 1320.5(a) and 1320.6.

In the NPRM, the Department noted that proposed § 725.413, which, as discussed above, requires parties to exchange certain medical information, could be considered a collection of information within the meaning of the PRA. 80 FR 23749. Accordingly, the Department submitted an Information Collection Request (ICR) to OMB for approval. See ICR Reference Number 201504-1240-002. The NPRM specifically invited comments regarding the information collection and notified the public of their opportunity to file such comments with both OMB and the Department. 80 FR 23749. On July 24, 2015, OMB concluded its review of the ICR by asking the Department to

submit another ICR at the final rule stage and after considering any public comments regarding the information collection requirements in the rule.

The Department received comments on the substance of proposed § 725.413; these comments are fully addressed in the Section-by-Section Explanation above. The Department received no comments about the information collection burdens. The Department has submitted an ICR to OMB for the information collection in this final rule. See ICR Reference Number 201511-1240-003. A copy of this request (including supporting documentation) may be obtained free of charge from the Reginfo.gov website at http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201511-1240-003, or by contacting Michael Chance, Director, Division of Coal Mine Workers' Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor, 200 Constitution Avenue, NW., Suite N–3464, Washington, DC 20210. Telephone: (202) 693–0978 (this is not a toll-free number). TTY/TDD callers may dial toll-free 1–800–877–8339. OMB is currently reviewing the ICR. The Department will publish a notice in the FEDERAL REGISTER when OMB concludes its review of the ICR.

The information collection and its burdens are summarized as follows:

Agency: DOL-OWCP

Title of Collection: Disclosure of Medical Information

OMB Control Number: 1240-0054

Affected Public: Private Sector: Businesses and other for-profits

Total Estimated Number of Respondents: 4,074

Total Estimated Number of Responses: 4,074

Total Estimated Annual Time Burden: 679 hours

Total Estimated Annual Other Costs Burden: $6,681

V. Executive Orders 12866 and 13563 (Regulatory Planning and Review)

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. The Department has considered the final rule with these principles in mind and has determined that the regulated community will benefit from these new and revised regulations.

The Department addressed these issues in the NPRM. 80 FR 23749-50. With regard to § 725.310(e), which requires operators to pay effective awards of benefits while seeking to modify them, the Department stated that the proposed rule was "cost neutral" because it merely enforced operators' existing legal obligations under the Act. 80 FR 23749. The Department also noted that even if § 725.310(e) were construed as imposing a new obligation, any additional costs would not be burdensome because operators must reimburse the Trust Fund (with interest) when unsuccessful on modification, operators are not often successful on modification, and if successful, operators may seek reimbursement from the claimant for at least some of the benefits paid. 80 FR 23750. Apart from the potential monetary impact, the Department determined that § 725.310(e) struck an appropriate balance between claimants, who are made whole under the rule, and operators, who may seek a stay of payments if they would be irreparably harmed by making them. 80 FR 23750.

The Department similarly concluded that the benefits of § 725.413, which requires the parties to exchange all medical information they develop in connection with a claim, far outweighed any minimal administrative burden the rule might place on parties. 80 FR 23750. These benefits include protecting miners' health and reaching more accurate claims determinations. The Department also noted that the rule may not have broad impact because parties often already exchanged all of the medical information in their possession. Id.

The Department has considered the final rule with these principles in mind and has determined that the regulated community will benefit from these new and revised regulations. One comment, in which four entities joined, generally criticized the Department for not demonstrating why these rule revisions were necessary. The comment states that the Department provided no empirical data to support them and instead cited only unrepresentative anecdotes documenting mostly non-existent problems that do not accurately characterize how black lung claims are handled. The comment also alludes generally to significant expenses imposed on coal mine operators and their insurers by the Department but provides no specific information regarding how these rules in particular impose increased costs. In addition to these general allegations, this comment states that the Department did not conduct an empirical review of the impact of § 725.310 and did not adequately consider the actual impact § 725.413 would have on miners' health.

The Department does not believe this comment compels a different conclusion regarding the benefits of this rulemaking. The Department has administered the black lung program for more than three decades and been a party in hundreds of thousands of

claims. As a result, the Department is intimately familiar with how black lung claims are litigated by all parties. To further illustrate that §§ 725.310(e) and 725.413 respond to non-illusory problems, the Department has added additional representative case examples in the Section-by-Section Explanation above (see Section III, supra). While these modification and discovery issues do not arise in every case, they arise frequently enough—and can have sufficiently important consequences when they do arise—that resolution by regulatory action is appropriate.

On the more specific comments, § 725.310(e), as discussed above (see Section III, supra), enforces an existing legal obligation imposed on operators by the statute and implementing regulations. Absent a stay of payments ordered by the Benefits Review Board or a court, operators are obligated to pay effective benefits awards, regardless of any other proceedings in the claim. The statute and regulations already mandate that any associated economic burden be borne by operators rather than the Trust Fund. The only new burden the rule places on operators is to demonstrate that they have complied with the relevant orders. For operators that are in compliance, this showing will not be difficult. This minimal burden does not outweigh the Department's duty to ensure that claimants receive all benefits when due and to protect the Trust Fund's assets.

Similarly, the benefits associated with § 725.413 far outweigh any additional minimal burden the regulation will impose on the parties. For the reasons explained above (see Section III, supra), the Department cannot quantify the actual impact of non-disclosure of medical information on miners' health with any certainty. But the rule is fully consistent with the Mine Safety and Health Act's prime directive: to protect the health and safety of the miner. Section 725.413 also affords unrepresented claimants an

even playing field when litigating their claims and increases the possibility of more accurate entitlement determinations. Balanced against these important interests is the minimal administrative burden of exchanging all medical information a party develops about the miner with the other parties, a practice several objecting commenters state the parties have routinely followed in all but a few instances. Thus, to the extent § 725.413 mandates such practice, the impact on the parties should be very small.

Finally, one comment stated that several parts of the proposed rules violated the various directions in Executive Orders 12866 and 13563 that rules be clear and written in plain language. The Department has responded to these comments in discussing the substance of each rule in the Section-by-Section Explanation above.

This rule is a significant regulatory action under section 3(f)(4) of Executive Order 12866 and has been reviewed by the Office of Information and Regulatory Affairs in the Office of Management and Budget.

VI. Regulatory Flexibility Act and Executive Order 13272 (Proper Consideration of Small Entities in Agency Rulemaking)

The Regulatory Flexibility Act of 1980, as amended, 5 U.S.C. 601 et seq. (RFA), requires an agency to evaluate the potential impacts of their proposed and final rules on small businesses, small organizations, and small governmental jurisdictions and to prepare a "regulatory flexibility analysis" describing those impacts. But if the rule is not expected to have "a significant economic impact on a substantial number of small entities," the RFA allows the agency to so certify in lieu of preparing the analysis. 5 U.S.C. 605(b).

In the NPRM, the Department determined that a complete regulatory flexibility analysis was not necessary, set forth the factual basis for this conclusion, and certified that the revised rule would not have a significant economic impact on a substantial number of small entities. 80 FR 23750. The Department provided a copy of that certification to the Chief Counsel for Advocacy of the Small Business Administration, see 5 U.S.C. 605(b), and invited public comment on the certification.

The Chief Counsel for Advocacy has not filed comments on the certification. Moreover, no public comments address any adverse economic impacts this rule will have on small coal mine operators. Because the comments do not provide a basis for departing from its prior conclusion, the Department again certifies that this rule will not have a significant economic impact on a substantial number of small entities. Thus, no regulatory flexibility analysis is required.

VII. Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1531 et seq., directs agencies to assess the effects of Federal Regulatory Actions on State, local, and tribal governments, and the private sector, "other than to the extent that such regulations incorporate requirements specifically set forth in law." 2 U.S.C. 1531. For purposes of the Unfunded Mandates Reform Act, this rule does not include any Federal mandate that may result in increased expenditures by State, local, tribal governments, or increased expenditures by the private sector of more than $100,000,000.

VIII. Executive Order 13132 (Federalism)

The Department has reviewed this rule in accordance with Executive Order 13132 regarding federalism, and has determined that it does not have "federalism implications."

Executive Order 13132, 64 FR 43255, Aug. 4, 1999. The rule will not "have substantial direct 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." Id.

IX. Executive Order 12988 (Civil Justice Reform)

This rule was drafted and reviewed in accordance with Executive Order 12988, Civil Justice Reform, and it will not unduly burden the Federal court system. The final rule was: (1) carefully reviewed to eliminate drafting errors and ambiguities; (2) written to minimize litigation; and (3) provides clear legal standards for affected conduct. The rule also specifies when its provisions apply.

X. Congressional Review Act

The Congressional Review Act, 5 U.S.C. 801 et seq., as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. OWCP will report this rule's promulgation to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States simultaneously with publication of the rule in the Federal Register. The report will state that the rule is not a "major rule" as defined by 5 U.S.C. 804(2).

List of Subjects in 20 CFR Part 725

Total disability due to pneumoconiosis, Coal miners' entitlement to benefits, Survivors' entitlement to benefits.

For the reasons set forth in the preamble, the Department of Labor amends 20 CFR part 725 as follows:

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

1. The authority citation for part 725 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; 33 U.S.C. 901 et seq.; 42 U.S.C. 405; Secretary's Order 10-2009, 74 FR 58834.

2. In § 725.310, revise paragraphs (b), (c) and (d) and add paragraph (e) to read as follows:

§ 725.310 Modification of awards and denials.

*** * * * ***

(b) Modification proceedings must 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, are each 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 may 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 must, 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 must 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 must 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 will 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) will 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) will 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) will be subject to collection or offset under subpart H of this part.

(e)(1) In this paragraph, an order is "effective" as described in § 725.502(a) and "final" as described in §§ 725.419(d), 725.479(a) or 802.406.

(2) Any modification request by an operator must be denied unless the operator proves that at the time of the request, the operator has:

(i) Paid to the claimant all monetary benefits, including retroactive benefits and interest under § 725.502(b)(2), due under any effective order;

(ii) Paid to the claimant all additional compensation (see § 725.607) due under an effective order;

(iii) Paid all medical benefits (see § 725.701 et seq.) due under any effective award, but only if the order awards payment of specific medical expenses;

(iv) Paid all final orders awarding attorney's fees and expenses under § 725.367 and witness fees under § 725.459, but only if the underlying benefits order is final (see § 725.367(b)); and

(v) Reimbursed the Black Lung Disability Trust Fund, with interest, for all benefits paid under the orders described in paragraphs (e)(2)(i) or (iii) of this section and the costs for the medical examination under § 725.406.

(3) The requirements of paragraph (e)(2) of this section are inapplicable to any benefits owed pursuant to an effective but non-final order if the payment of such benefits has been stayed by the Benefits Review Board or appropriate court under 33 U.S.C. 921.

(4) Except as provided by paragraph (e)(5) of this section, the operator must submit all documentary evidence pertaining to its compliance with the requirements of paragraph (e)(2) of this section to the district director concurrently with its request for modification. The claimant is also entitled to submit any relevant evidence to the district director. Absent extraordinary circumstances, no documentary evidence pertaining to the operator's compliance with the requirements of paragraph (e)(2) at the time of the modification request will be admitted into the hearing record or otherwise considered at any later stage of the proceeding.

(5) The requirements imposed by paragraph (e)(2) of this section are continuing in nature. If at any time during the modification proceedings the operator fails to meet the payment obligations described, the adjudication officer must issue an order to show cause why the operator's modification request should not be denied and afford all parties time to respond to such order. Responses may include evidence pertaining to the operator's continued compliance with the requirements of paragraph (e)(2). If, after the time for response has expired, the adjudication officer determines that the operator is not meeting its obligations, the adjudication officer must deny the operator's modification request.

(6) The denial of a request for modification under this section will not bar any future modification request by the operator, so long as the operator satisfies the requirements of paragraph (e)(2) of this section with each future modification petition.

(7) The provisions of this paragraph apply to all modification requests filed on or after [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

3. Add § 725.413 to subpart E to read as follows:

§ 725.413 Disclosure of medical information.

(a) For purposes of this section, medical information is any written medical data, including data in electronic format, about the miner that a party develops in connection with a claim for benefits, including medical data developed with any prior claim that has not been disclosed previously to the other parties. Medical information includes, but is not limited to—

(1) Any examining physician's written or testimonial assessment of the miner, including the examiner's findings, diagnoses, conclusions, and the results of any tests;

(2) Any other physician's written or testimonial assessment of the miner's respiratory or pulmonary condition;

(3) The results of any test or procedure related to the miner's respiratory or pulmonary condition, including any information relevant to the test or procedure's administration; and

(4) Any physician's or other medical professional's interpretation of the results of any test or procedure related to the miner's respiratory or pulmonary condition.

(b) For purposes of this section, medical information does not include—

(1) Any record of a miner's hospitalization or other medical treatment; or

(2) Communications from a party's representative to a medical expert.

(c) Each party must disclose medical information the party or the party's agent receives by sending a complete copy of the information to all other parties in the claim within 30 days after receipt. If the information is received after the claim is already scheduled for hearing before an administrative law judge, the disclosure must be made at least 20 days before the scheduled hearing is held (see § 725.456(b)).

(d) Medical information disclosed under this section must not be considered in adjudicating any claim unless a party designates the information as evidence in the claim.

(e) At the request of any party or on his or her own motion, an adjudication officer may impose sanctions on any party or his or her representative who fails to timely disclose medical information in compliance with this section.

(1) Sanctions must be appropriate to the circumstances and may only be imposed after giving the party an opportunity to demonstrate good cause why disclosure was not made and sanctions are not warranted. In determining an appropriate sanction, the adjudication officer must consider—

(i) Whether the sanction should be mitigated because the party was not represented by an attorney when the information should have been disclosed; and

(ii) Whether the party should not be sanctioned because the failure to disclose was attributable solely to the party's attorney.

(2) Sanctions may include, but are not limited to—

(i) Drawing an adverse inference against the non-disclosing party on the facts relevant to the disclosure;

(ii) Limiting the non-disclosing party's claims, defenses or right to introduce evidence;

(iii) Dismissing the claim proceeding if the non-disclosing party is the claimant and no payments prior to final adjudication have been made to the claimant unless the Director agrees to the dismissal in writing (see § 725.465(d));

(iv) Rendering a default decision against the non-disclosing party;

(v) Disqualifying the non-disclosing party's attorney from further participation in the claim proceedings; and

(vi) Relieving a claimant who files a subsequent claim from the impact of § 725.309(c)(6) if the non-disclosed evidence predates the denial of the prior claim and the non-disclosing party is the operator.

(3) Sanctions must not include—

(i) Fines or

(ii) Imprisonment.

(4) Sanctions imposed by a district director are subject to review by an administrative law judge in accordance with the provisions of this part.

(f) This rule applies to—

(1) All claims filed after [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER];

(2) Pending claims not yet adjudicated by an administrative law judge, except that medical information received prior to [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER] and not previously disclosed must be provided to the other parties within 60 days of [INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]; and

(3) Pending claims already adjudicated by an administrative law judge where—

(i) The administrative law judge reopens the record for receipt of additional evidence in response to a timely reconsideration motion (see § 725.479(b)) or after remand by the Benefits Review Board or a reviewing court; or

(ii) A party requests modification of the award or denial of benefits (see § 725.310(a)).

4. In § 725.414, revise paragraphs (a)(1) through (5), (c), and (d) to read as follows:

§ 725.414 Development of evidence.

(a) *** * ***

(1) For purposes of this section, a medical report is 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. Supplemental medical reports prepared by the same physician must be considered part of the physician's original medical report. A physician's written assessment of a single objective test, such as a chest X-ray or a pulmonary function test, is not a medical report for purposes of this section.

(2)(i) The claimant is 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 is 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 is 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 is 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 is 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 is 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 is 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 is 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 is 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 is 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), or has identified a liable operator that ceases to defend the claim on grounds of an inability to provide for payment of continuing benefits, the district director is 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 must 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 is 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 must 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.

*** * * * ***

(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 will 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 must 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 will 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 apply to all proceedings conducted with respect to a claim, and no documentary evidence pertaining to liability may 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.

5. In § 725.601, revise paragraphs (b) and (c) to read as follows:

§ 725.601 Enforcement generally.

*** * * * ***

(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 may invoke and execute the lien on the property of the operator as described in § 725.603. Enforcement of this lien must 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 may 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 may declare the award in default and proceed in accordance with § 725.605. In all cases payments of additional compensation (see § 725.607) and interest (see § 725.608) will 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 may 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.

6. Revise § 725.607 to read as follows:

§ 725.607 Payments of additional 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 will be added to such unpaid benefits an amount equal to 20 percent thereof, which must 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 will nevertheless be entitled to receive such additional compensation to which he or she may be eligible under paragraph (a), with respect to all amounts paid by the fund on behalf of such operator or other employer.

(c) The fund may not be held liable for payments of additional compensation under any circumstances.

Signed at Washington, DC, this 19th day of April, 2016

Leonard J. Howie, III,

Director, Office of Workers' Compensation Programs

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