#!docketDetail;D=NOAA-NOS-2015-0028, click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.

• *Mail:* Public comments may be mailed to Hawaiian Islands Humpback Whale National Marine Sanctuary, NOAA/DKIRC, 1845 Wasp Blvd., Bldg. 176, Honolulu, HI 96818, Attn: Malia Chow, Superintendent.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NOAA. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NOAA will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

FOR FURTHER INFORMATION CONTACT: Malia Chow, Superintendent, Hawaiian Islands Humpback Whale National Marine Sanctuary at 808–725–5901 or *hihwmanagementplan@noaa.gov.*

Copies of the draft environmental impact statement and proposed rule can be downloaded or viewed on the Internet at *www.regulations.gov* (search for docket # NOAA–NOS–2015–0028) or at *http://hawaiihumpbackwhale.noaa.gov.* Copies can also be obtained by contacting the person identified under **FOR FURTHER INFORMATION CONTACT**.

SUPPLEMENTARY INFORMATION: In addition to the ten hearings listed in the proposed rule (80 FR 16224) published on March 26, 2015, two public hearings will be held in the following locations at the locales and times indicated:

(1) Waimea, HI (Kaua'i)

Date: May 5, 2015

Location: Waimea Canyon Middle School Cafeteria

Address: 9555 Huakai Road, Waimea, Hawaii 96796

Time: 5:30 p.m.—8 p.m.

(2) Hilo, HI (Hawai'i)

Date: May 11, 2015

Location: Mokupāpapa Discovery Center

Address: 76 Kamehameha Avenue, Hilo, HI 96720

Time: 4:30 p.m.—7 p.m.

Authority: 16 U.S.C. 1431 *et seq.*

Dated: April 21, 2015.

Daniel J. Basta,

Director, Office of National Marine Sanctuaries.

[FR Doc. 2015–10015 Filed 4–28–15; 8:45 am]

BILLING CODE 3510–NK–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: Notice of proposed rulemaking; request for comments.

SUMMARY: The Department is proposing revisions to the Black Lung Benefits Act (BLBA) regulations to address several procedural issues that have arisen in claims processing and adjudications. To protect a miner's health and promote accurate benefit determinations, the proposed rule would require parties to disclose all medical information developed in connection with a claim for benefits. The proposed rule also would clarify that a liable coal mine operator is obligated to pay benefits during post-award modification proceedings and that a supplemental report from a physician is considered merely a continuation of the physician's earlier report for purposes of the evidence-limiting rules.

DATES: The Department invites written comments on the proposed regulations from interested parties. Written comments must be received by June 29, 2015.

ADDRESSES: You may submit written comments, identified by RIN number 1240–AA10, by any of the following methods. To facilitate receipt and processing of comments, OWCP encourages interested parties to submit their comments electronically.

• *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions on the Web site for submitting comments.

• *Facsimile:* (202) 693–1395 (this is not a toll-free number). Only comments of ten or fewer pages, including a Fax cover sheet and attachments, if any, will be accepted by Fax.

• *Regular Mail:* Submit comments on paper, disk, or CD–ROM to the Division of Coal Mine Workers' Compensation Programs, Office of Workers' Compensation Programs, U.S. Department of Labor, Room C–3520, 200 Constitution Avenue NW., Washington, DC 20210. The Department's receipt of U.S. mail may be significantly delayed due to security procedures. You must take this into consideration when preparing to meet the deadline for submitting comments.

• *Hand Delivery/Courier:* Submit comments on paper, disk, or CD–ROM to Division of Coal Mine Workers' Compensation Programs, Office of Workers' Compensation Programs, U.S. Department of Labor, Room C–3520, 200 Constitution Avenue NW., Washington, DC 20210.

Instructions: All submissions received must include the agency name and the Regulatory Information Number (RIN) for this rulemaking. All comments received will be posted without change to *http://www.regulations.gov,* including any personal information provided.

Docket: For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: 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–3520, Washington, DC 20210. Telephone: 1–800–347–2502. This is a toll-free number. TTY/TDD callers may dial toll-free 1–800–877–8339 for further information.

SUPPLEMENTARY INFORMATION:

I. Background of This Rulemaking

The 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, 5 (1976). Benefits are paid by either an individual coal mine operator that employed the coal miner (or its insurance carrier), or the Black Lung Disability Trust Fund. *Director, OWCP* v. *Bivens,* 757 F.2d 781, 783 (6th Cir. 1985). The Department has undertaken this rulemaking primarily to resolve several procedural issues that have arisen in claims administration and adjudication. Each of these issues is fully explained in the Section-By-Section Explanation below.

II. Summary of the Proposed Rule

A. General Provisions

The Department is proposing several general revisions to advance the goals

set forth in Executive Order 13563. 76 FR 3821 (Jan. 18, 2011). That Order states that regulations must be ''accessible, consistent, written in plain language, and easy to understand.'' *Id.; see also* E.O. 12866, 58 FR 51735 (Sept. 30, 1993) (Agencies must draft regulations that are ''simple and easy to understand, with the goal of minimizing the potential for uncertainty and litigation arising from such uncertainty.''). Accordingly, the Department proposes to remove the imprecise term ''shall'' throughout those sections it is amending and substitute ''must,'' ''must not,'' ''will,'' or other situation-appropriate terms. These changes are designed to make the regulations clearer and more user-friendly. *See generally* Federal Plain Language Guidelines, *http://www.plainlanguage.gov/howto/guidelines.* In some instances, the Department has also made minor technical revisions to these sections to comply with the Office of the Federal Register's current formatting requirements. *See, e.g.,* proposed § 725.414(a)(2)(ii) (inserting ''of this chapter'' after reference to § 718.107). No change in meaning is intended.

B. Section-by-Section Explanation

20 CFR 725.310 Modification of awards and denials.

Section 725.310 implements section 22 of the Longshore and Harbor Workers' Compensation Act (Longshore Act or LHWCA), 33 U.S.C. 922, as incorporated into the BLBA by section 422(a) of the Act, 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 proposes several revisions to this regulation to ensure that responsible operators (and their insurance carriers) fully discharge their payment obligations while pursuing modification.

While modification is a broad remedy available to responsible operators as well as claimants, a mere request for modification does not terminate an operator's obligation to comply with the terms of a prior award, or otherwise undermine the effectiveness, finality, or enforceability of a prior award. *See Vincent* v. *Consolidated Operating Co.,* 17 F.3d 782, 785–86 (5th Cir. 1994) (enforcing award despite employer's modification request); *Williams* v. *Jones,* 11 F.3d 247, 259 (1st Cir. 1993) (same); *Hudson* v. *Pine Ridge Coal Co.,* No. 11–00248, 2012 WL 386736, *5 (S.D. W.Va. Feb. 6, 2012) (same); *see also National Mines Corp.* v. *Carroll,* 64 F.3d 135, 141 (3d Cir. 1995) (''[A]s the DOL points out in its brief, 'as a general rule, the mere existence of modification proceedings does not affect the finality of an existing award of compensation.' ''); *Crowe ex rel. Crowe* v. *Zeigler Coal Co.,* 646 F.3d 435, 445 (7th Cir. 2011) (Hamilton, J., concurring) (''If Zeigler Coal believed the June 2001 award of benefits was wrong, it was entitled to seek modification. But Zeigler Coal was not legally entitled simply to ignore the final order of payment.''). Thus, an operator must continue to pay any benefits due under an effective award even when seeking to overturn that award through a section 22 modification proceeding.

The plain language of the Act and its implementing regulations support this conclusion. An operator is required to pay benefits ''after an effective order requiring the payment of benefits''—generally an uncontested award by a district director or any award by an administrative law judge, the Benefits Review Board, or a reviewing court—even if the operator timely appeals the effective award. 20 CFR 725.502(a)(1); *see also* 33 U.S.C. 921(a), as incorporated by 30 U.S.C. 932(a). There is only one exception to an operator's obligation to pay benefits owed under an effective award: The Board or a reviewing court may issue a stay pending its resolution of an appeal based on a finding that ''irreparable injury would otherwise ensue to the employer or carrier.'' 30 U.S.C. 921(a)(3), (c); *see also* 20 CFR 725.482(a), 725.502(a)(1). Otherwise, an effective award requires payment until it is (1) ''vacated by an administrative law judge on reconsideration,'' (2) ''vacated . . . upon review under section 21 of the LHWCA, by the Benefits Review Board or an appropriate court,'' or (3) ''superseded by an effective order issued pursuant to § 725.310.'' 20 CFR 725.502. Notably absent from this list is a request for modification pursuant to § 725.310. Thus, only an administrative or judicial order relieves the operator of the obligation to pay benefits, even if the operator continues to contest the award. The operator may not terminate the obligation unilaterally.

Despite this clear authority, some operators obligated to pay benefits to claimants (and to repay the Black Lung Disability Trust Fund for interim benefit payments) by the terms of effective or final awards have refused to comply with those obligations, claiming that a subsequent modification request excuses their non-compliance. *See, e.g., Crowe,* 646 F.3d at 447 (Hamilton, J., concurring); *Hudson,* 2012 WL 386736, *3. In addition to being contrary to the unanimous weight of the courts of appeals and the plain text of the controlling statutory and regulatory provisions, the practice has a number of negative consequences.

First, it prevents claimants from timely receiving all the benefits to which they are entitled. If an operator fails to comply with the terms of an effective award, the Black Lung Disability Trust Fund pays benefits to the claimant in the operator's stead. *See* 20 CFR 725.522(a). But, in any claim filed after 1981, the Trust Fund is statutorily prohibited from paying retroactive benefits, *i.e.,* benefits owed for the period of time between the entitlement date specified in the order (typically the date the miner filed his or her claim or the date of the miner's death) and the initial determination that the claimant is entitled to benefits. 26 U.S.C. 9501(d)(1)(A)(ii). These retroactive benefits are sometimes substantial, and an operator's failure to pay them while pursuing modification imposes a similarly substantial burden on the claimant. *See Crowe,* 646 F.3d at 446 (''[T]he effect of Zeigler Coal's decision to disobey the final payment order [while it pursued modification for ten years] was to deny Mr. Crowe the $168,000 in back benefits to which he had been found entitled.'')

The Act currently provides two mechanisms for claimants to enforce these liabilities. Section 21(d) of the Longshore Act, 33 U.S.C. 921(d), as incorporated into the BLBA by section 422(a) of the Act, 30 U.S.C. 932(a), and implemented by 20 CFR 725.604, provides for the enforcement of final awards. And section 18(a) of the Longshore Act, 33 U.S.C. 918(a), as incorporated into the BLBA by section 422(a) of the Act, 30 U.S.C. 932(a), and implemented by 20 CFR 725.605, does the same for effective awards. These remedies are, however, imperfect. Even if the previous award is final, section 21(d) still requires the claimant to file an enforcement action in federal district court to secure compliance with the award, a substantial barrier for unrepresented claimants. And even for represented claimants, the process can be a source of substantial delay. For example, the district court's order enforcing a final award under section 21(d) in *Nowlin* v. *Eastern Associated Coal Corp.,* 266 F. Supp. 2d 502 (N.D. W.Va. 2003), was issued more than two years after the complaint was filed, and the consequent attorney's fee dispute took another seven months to resolve. Such delays should be minimized where possible to ensure prompt

compensation for claimants. A claimant seeking to enforce an effective but non-final award faces the same barriers, plus the additional hurdles of section 18(a)'s one-year limitations period and its requirement to obtain a supplemental order of default from the district director.

Second, the practice improperly shifts financial burdens from the responsible operator to the Trust Fund contrary to Congress's intent. Congress created the Trust Fund in 1978 to assume responsibility for claims for which no operator was liable or in which the responsible operator defaulted on its payment obligations. But Congress intended to ''ensure that individual coal operators rather than the trust fund bear the liability for claims arising out of such operator's mines, to the maximum extent feasible.'' S. Rep. No. 95–209 at 9 (1977), reprinted in Committee on Education and Labor, House of Representatives, 96th Cong., Black Lung Benefits Reform Act and Black Lung Benefits Revenue Act of 1977 at 612 (Comm. Print) (1979). Thus, operators are required to reimburse the Trust Fund for all benefits it paid to a claimant on the operator's behalf under an effective or final order. *See* 30 U.S.C. 934(b); 20 CFR 725.522(a), 725.601–603.

This intent is undermined if an operator does not pay benefits or reimburse the Trust Fund while seeking to modify an effective award. One of the few events that terminates an effective order is being ''superseded by an effective order issued pursuant to § 725.310.'' 20 CFR 725.502(a)(1). Thus, if an operator evades its obligation to pay benefits under the terms of an effective or final order until it successfully modifies that order under § 725.310, the operator may entirely evade its obligation to pay benefits (or to reimburse the Trust Fund for paying benefits on the operator's behalf) under the initial order. Moreover, because § 725.310(d) allows only certain benefits paid under a previously effective order to be recovered (generally only benefits for periods after modification was requested), the Trust Fund will be unable to recoup benefits paid prior to that date from the claimant. And the Trust Fund's right to recover the remaining overpayment is of little practical value in many cases given that claimants may be entitled to waiver of overpayments by operation of §§ 725.540–548.

Section 725.502's requirement that operators pay benefits owed under the terms of effective (as well as final) awards is designed to place these overpayment recovery risks where they properly belong: On the operator who, if successful, has the same overpayment recoupment rights as the Trust Fund. *See* 65 FR 80009–80011 (explaining rationale for § 725.502); 20 CFR 725.547 (extending overpayment provisions to operators and their insurance carriers). The tactic of refusing to pay benefits owed while seeking modification threatens to transfer this risk to the Trust Fund, essentially rewarding operators that behave lawlessly and encouraging others to do the same. *See Crowe,* 646 F.3d at 446–47.

To deal with this recurring problem, the Department proposes adding new paragraph (e) to § 725.310. Proposed paragraphs (e)(1) and (2) provide that an operator's request to modify any effective award will be denied unless the operator proves that it has complied with all of its obligations under that award, and any other currently effective award (such as an attorney fee award) in the claim, unless payment has been stayed. By incorporating § 725.502(a)'s definition of effective award, the proposed regulation clarifies that an operator is not required to prove compliance with formerly effective awards that have been vacated either on reconsideration by an administrative law judge, or on appeal by the Board or a court of appeals, or that have been superseded by an effective modification order.

Proposed paragraph (e)(3) integrates the requirements of paragraph (e)(1) into the overall modification procedures outlined by § 725.310(b)–(c). The Department anticipates that compliance with the requirements of outstanding effective awards will be readily apparent from the documentary evidence in most cases and that any non-compliance with those obligations will be easily correctable by the operator based on that evidence. Accordingly, paragraph (e)(3) encourages the parties to submit all documentary evidence at the earliest stage of the modification process (*i.e.,* during proceedings before the district director) by forbidding the admission of any new documentary evidence addressing the operator's compliance with paragraph (e)(1) at any subsequent stage of the litigation absent extraordinary circumstances. The Department intends that the term ''extraordinary circumstances'' in this context be understood the same way that the identical term has been applied in cases governed by § 725.456(b)(1). *See, e.g., Marfork Coal Co.* v. *Weis,* 251 F. App'x 229, 236 (4th Cir. 2007) (operator failed to demonstrate ''extraordinary circumstances'' justifying late submission of evidence under § 725.456(b)(1) where evidence was not ''hidden or could not have been located'' earlier).

Proposed paragraph (e)(4) clarifies that an operator has a continuing obligation to comply with the requirements of effective awards during all stages of a modification proceeding. The Department believes that imposing an affirmative obligation on operators to continually update the administrative law judge, Board, or court currently adjudicating its modification request about every continuing payment required by previous awards would be unduly burdensome on both operators and adjudicators. When an operator's non-compliance is brought to an adjudication officer's attention, however, the adjudicator must issue an order to show cause why the operator's modification petition should not be denied. Because the issue will be the operator's compliance with paragraph (e)(1) at the time of the order rather than at the time it requested modification, evidence relevant to this issue will be admissible even in the absence of extraordinary circumstances. In addition, to avoid the burden of a minor default resulting in the denial of modification, paragraph (e)(4) gives the operator an opportunity to cure any default identified by the Director or claimant before the modification petition is denied.

Proposed paragraph (e)(5) clarifies that the denial of a modification request on the ground that the operator has not complied with its obligations under previous effective awards will not prejudice the operator's right to make additional modification requests in that same claim in the future. At the time of that future request, of course, the operator must satisfy all modification requirements, including § 725.310(e).

Finally, proposed paragraph (e)(6) makes these requirements applicable only to modification requests filed on or after the effective date of the final rule. Making the rule applicable prospectively avoids any administrative difficulties that could arise from applying the rule's requirements to pending modification requests.

20 CFR 725.413 Disclosure of Medical Information

The Department proposes a new provision that requires the parties to disclose all medical information developed in connection with a claim. Currently, parties to a claim are free to develop medical information to the extent their resources allow and then select from that information those pieces they wish to submit into evidence, subject to the evidentiary limitations set out in § 725.414. *See* 20

CFR 725.414. Medical information developed but not submitted into evidence generally remains in the sole custody of the party who developed it unless an opposing party obtains the information through a formal discovery process.

Experience has demonstrated that miners may be harmed if they do not have access to all information about their health, including information that is not submitted for the record. Claimants who do not have legal representation are particularly disadvantaged because generally they are unfamiliar with the formal discovery process and thus rarely obtain undisclosed information. Moreover, benefit decisions based on incomplete medical information are less accurate. These results are contrary to the clear intent of the statute.

One recent case, *Fox* v. *Elk Run Coal Co.,* 739 F.3d 131 (4th Cir. 2014), aptly demonstrates these problems. Mr. Fox worked in coal mines for more than thirty years. In 1997, a chest X-ray disclosed a mass in his right lung. A pathologist who reviewed tissue collected from the mass during a 1998 biopsy diagnosed an inflammatory pseudotumor. Acting without legal representation, Mr. Fox filed a claim for black lung benefits in 1999. The responsible operator submitted radiologists' reports and opinions from four pulmonologists, all concluding that Mr. Fox did not have coal workers' pneumoconiosis. The operator had developed additional medical information, however—opinions from two pathologists who reviewed the 1998 biopsy tissue and other records and then authored opinions supporting the conclusion that Mr. Fox had complicated pneumoconiosis, an advanced form of the disease. But the operator did not submit the pathologists' reports into the record, provide them to Mr. Fox, or share them with the pulmonologists it hired. An administrative law judge denied Mr. Fox's claim in 2001. To support his family, Mr. Fox continued to work in the mines, where he was exposed to additional coal-mine dust.

Mr. Fox left the mines in 2006 at the age of 56 because his pulmonary capacity had diminished to the point he could no longer work. He filed a second claim for benefits that same year. This time he was represented by counsel, who successfully obtained discovery of the medical information that the responsible operator had developed in connection with Mr. Fox's first claim but had not disclosed. This additional information included the pathologists' opinions and X-ray interpretations showing that Mr. Fox had complicated pneumoconiosis. The operator did not disclose any of these documents, despite an order from an administrative law judge, until 2008. Mr. Fox died in 2009 while awaiting a lung transplant.

Had Mr. Fox received the responsible operator's pathologists' opinions in 2000 when they were authored, he could have sought appropriate treatment for his advanced pneumoconiosis five or six years sooner than he did. He also could have made an informed decision as to whether he should continue in coal mine employment, where he was exposed to additional coal-mine dust. Or, he might have transferred to a position in a less-dusty area of the mine. *See* 30 U.S.C. 943(b). Finally, if the pathology reports the operator obtained had been available, Mr. Fox's first claim might have been awarded; indeed, the operator conceded entitlement when ordered to disclose this information.

Mr. Fox's case highlights the longstanding problem claimants face in obtaining a full picture of the miner's health from testifying and non-testifying medical experts as well as examining and non-examining physicians. *See, e.g., Lawyer Disciplinary Board* v. *Smoot,* 716 SE.2d 491 (W. Va. 2010); *Belcher* v. *Westmoreland Coal Co.,* BRB No. 06–0653, 2007 WL 7629355 (Ben. Rev. Bd. May 31, 2007) (unpublished); *Cline* v. *Westmoreland Coal Co.,* 21 Black Lung Rep. 1–69 (Ben. Rev. Bd. 1997).

Ensuring that a miner has access to information about his or her health is consistent with the primary tenet of the Mine Safety and Health Act (Mine Act). Congress expressly declared that ''the 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). This priority informs the Secretary's administration of the BLBA—including adoption of appropriate regulations—because Congress placed the BLBA in the Mine Act.

By requiring disclosure, the rule also protects parties who do not have legal representation. Virtually without exception, coal mine operators are represented by attorneys in claims heard by administrative law judges. But claimants cannot always obtain legal representation. The Department estimates that approximately 23 percent of claimants appear before administrative law judges without any representation, and some of those claimants who have representation are represented by lay persons. Unrepresented claimants and lay representatives are generally unfamiliar with technical discovery procedures and thus do not pursue any information not voluntarily disclosed by the operator. And even when represented, not all attorneys use available discovery tools. Thus, making full disclosure mandatory will put all parties on equal footing, regardless of representation and regardless of whether they request disclosure of all medical information developed in connection with a claim.

Finally, allowing parties fuller access to medical information may lead to better, more accurate decisions on claims. Elevating correctness over technical formalities is a fundamental tenant of the BLBA. Subject to regulations of the Secretary, the statute gives the Department explicit authority to depart from technical rules: adjudicators ''shall not be bound by common law or statutory rules of evidence or by technical or formal rules of procedure . . . but may make such investigation or inquiry or conduct such hearing in such manner as to best ascertain the rights of the parties.'' 33 U.S.C. 923(a), as incorporated by 30 U.S.C. 932(a). *See also* 20 CFR 725.455(b). This statutory provision evidences Congress's strong preference for ''*best ascertain[ing] the rights of the parties''*— in other words, getting to the truth of the matter—over following the technical formalities associated with regular civil litigation. Full disclosure of medical information is therefore consistent with Congressional intent. Indeed, the current regulations require the miner to provide the responsible operator authorization to access his or her medical records. *See* 20 CFR 725.414(a)(3)(i)(A).

An incorporated provision of the Social Security Act provides additional authority for proposed § 725.413. *See* 30 U.S.C. 923(b), incorporating 42 U.S.C. 405(a). As incorporated into the BLBA, section 205(a) of the Social Security Act, 42 U.S.C. 405(a), gives the Department wide latitude in regulating evidentiary matters pertaining to an individual's right to benefits. Specifically, the Department is vested with ''full power and authority to make rules and regulations and to establish procedures, not inconsistent with the provisions of this subchapter, which are necessary or appropriate to carry out such provisions, and [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.'' Section 205(a) has been construed as granting ''exceptionally broad authority to prescribe standards'' for proofs and evidence. *Heckler* v.

Campbell, 461 U.S. 458, 466 (1983) (quoting *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 43 (1981)). The proposed rule honors these tenets.

The proposed rule sets out both requirements for the disclosure of medical information and sanctions that may be imposed on parties that do not comply with the rule. Proposed § 725.413(a) defines what constitutes ''medical information'' for purposes of this regulation. The regulation casts a broad net by encompassing any medical data about the miner that a party develops in connection with a claim. Treatment records are not information developed in connection with a claim and thus do not fall within this definition. But any party may obtain and submit records pertaining to treatment for a respiratory or pulmonary or related disease under § 725.414(a)(4).

Proposed paragraph (a)(1) addresses examining physicians' opinions and includes all findings made by an examining physician in the definition of ''medical information.'' An examining physician's opinion may disclose incidental physical conditions beyond a miner's respiratory or pulmonary systems that need attention. Giving miners full access to this data is consistent with the Act's and the Department's intent to protect the miner's health. Proposed paragraphs (a)(2) through (a)(4) include all other physicians' opinions, tests, procedures and related documentation in ''medical information,'' but only to the extent they address the miner's respiratory or pulmonary condition.

Proposed § 725.413(b) sets out the duty to disclose medical information about the miner and a time frame for such disclosure. The duty to disclose arises when either a party or a party's agent receives medical information. By including a ''party's agent,'' the proposed rule requires disclosure of medical information received by any individual or business entity that develops or screens medical information for the party or the party's attorney. Thus, a party may not avoid disclosure by having medical opinions and testing results filtered through a third-party agent. The time frame for disclosure is generally 30 days after receipt of the medical information. Within that time period, the disclosing party must send a copy of the medical information obtained to all other parties of record. In the event the claim is already scheduled for hearing by an administrative law judge when the medical information is received, the proposed rule requires the disclosing party to send the information no later than 20 days prior to the hearing. This provision correlates with current § 725.456(b)(2)'s 20-day requirement for exchanging any documentary evidence a party wants to submit into the hearing record.

Proposed § 725.413(c) provides sanctions that an adjudication officer may impose on a party that does not comply with its obligation to disclose the medical information described in proposed § 725.413(a). In determining an appropriate sanction, the proposed rule requires the adjudication officer to consider whether the party who violated the disclosure rule was represented by counsel when the violation occurred. The proposed rule also requires the adjudication officer to protect represented parties when the violation was attributable solely to their attorney's errors. The sanctions listed are not exclusive, and an adjudication officer may impose a different sanction, so long as it is appropriate to the circumstances presented in the particular case. Two of the listed sanctions are unique to the BLBA claims context. First, the proposed rule allows the adjudication officer to disqualify the non-disclosing party's attorney from further participation in the claim proceedings. The Department believes this is an appropriate sanction when the party's attorney is solely at fault for the non-disclosure and the failure to disclose resulted from more than an administrative error. Second, the proposed rule empowers an adjudication officer to relieve a claimant from the impact of a prior claim denial (*see* 20 CFR 725.309(c)(6)) if the medical information was not disclosed in accordance with the regulation in the prior claim proceeding. This sanction removes an incentive for responsible operators to withhold medical information and, by encouraging operators to comply, helps protect miners like Mr. Fox.

Finally, proposed § 725.413(d) sets out when the rule is applicable. Significantly, proposed paragraph (d)(2) specifies that the rule applies to claims pending on the rule's effective date if an administrative law judge has not yet entered a decision on the merits. To provide adequate time for disclosure in pending cases, the proposed rule allows the parties 60 days to disclose evidence received prior to the rule's adoption. Evidence received after the rule's effective date remains subject to proposed § 725.413(b)'s 30-day time limit. After an administrative law judge issues a merits decision, proposed paragraph (d)(3) imposes the obligation to disclose medical information only when further evidentiary development is permitted on reconsideration, remand from an appellate body, or after a party files a modification request. Applying this rule to pending claims will further one of the rule's primary purposes: protecting the health of the nation's miners.

20 CFR 725.414 Development of Evidence

(a) Section 725.414 imposes limitations on the quantity of medical evidence that each party may submit in a black lung claim. The Department proposed the limitations, in part, to ensure that eligibility determinations are based on the quality, not the quantity, of evidence submitted and to reduce litigation costs. 62 FR 3338 (Jan. 22, 1997). Under the evidence limiting rule, each side in a living miner's claim—both the claimant and the responsible operator (or Director, when appropriate)—may submit two chest X-ray interpretations, the results of two pulmonary function tests, two arterial blood gas studies and two medical reports as its affirmative case. Current § 725.414(a)(1) 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). Because additional medical evidence may become available after a physician has prepared a medical report, physicians often update their initial reports in supplemental reports addressing the new evidence. This practice has, at times, caused confusion regarding whether the supplemental report must be deemed a second medical report for purposes of the evidentiary limitations. The Department proposes to amend § 725.414(a)(1) to reflect the Director's longstanding position that these supplemental reports are merely a continuation of the physician's original medical report for purposes of the evidence-limiting rules and do not count against the party as a second medical report. The revised rule would apply to all claims filed after January 19, 2001. *See* 20 CFR 725.2(c).

The Director's position flows from the language of the current rules, which constrains the evidence a physician may review in a written report based only on its admissibility. Current § 725.414(a)(1) makes clear that a physician who provides a written opinion on the miner's pulmonary condition may consider all ''admissible medical evidence.'' Significantly, a physician who prepares a written medical report may also provide oral testimony in a claim, either at the formal hearing or through a deposition, and may ''testify as to any other medical evidence of

record.'' 20 CFR 725.414(c), 725.457(d). Thus, so long as a piece of medical evidence is admissible, a physician may consider it when addressing the miner's condition in either a written report or oral testimony. The Benefits Review Board has long accepted the Director's position that the medical opinion of a physician may be submitted in more than one document and still be considered one medical report for purposes of § 725.414. *See, e.g., Akers* v. *TBK Coal Co.,* BRB No. 06–894 BLA, 2007 WL 7629772 (Ben. Rev. Bd. Nov. 30, 2007).

Supplemental reports are a reasonable and cost-effective means of providing medical opinion evidence given the practical realities of federal black lung litigation. Even with the evidence-limiting rules, a miner who files a black lung claim may undergo up to five sets of examinations and testing ''spread . . . out over time.'' 65 FR 79992 (Dec. 20, 2000). A physician who examines the miner early in the claim process will obviously not at that time have access to all the medical evidence that ultimately will be admitted into the record. Given that the rules allow the physician to review all admissible medical evidence when evaluating the miner's condition, it makes sense to allow the physician to supplement his or her original report as new evidence becomes available. Indeed, a contrary rule would increase litigation costs because the party would be forced to have the physician review new evidence during a deposition or in-court testimony, both of which are much more costly means of providing evidence. There is therefore no practical or logical reason to consider a physician's supplemental written report a second medical report under the evidence limiting rules.

(b) For cases in which the Trust Fund is liable for benefits, current § 725.414(a)(3)(iii) authorizes the Director to exercise the rights of a responsible operator for purposes of the evidentiary limitations. 20 CFR 725.414(a)(3)(iii). The current rule does not, however, allow the Director to submit medical evidence, except for the medical evidence developed under § 725.406, in cases in which a coal mine operator is deemed the liable party. The rule thus leaves the Trust Fund potentially unprotected in cases in which the identified responsible operator has ceased to defend a claim during the course of litigation because of adverse financial developments, such as bankruptcy or insolvency. The Department proposes to amend § 725.414(a)(3)(iii) to allow the Director to submit medical evidence, up to the limits allowed an identified responsible operator, in such cases. The revised rule would apply to all claims filed after January 19, 2001. *See* 20 CFR 725.2(c).

The Trust Fund is liable for the payment of benefits if no operator can be identified as liable or if the operator identified as liable fails to pay benefits owed. *See* 26 U.S.C. 9501(d)(1); 20 CFR 725.522. As a result, the Director's inability to develop medical evidence in responsible operator cases imperils the Trust Fund if the operator ceases to defend the claim. In such cases, the Director currently has only two choices: (1) Dismiss the operator and have the Trust Fund assume liability so that medical evidence can be developed; or (2) keep the operator as the liable party and, if an award is issued, attempt to enforce the award against the operator or related entities (*e.g.,* insurance carrier, surety-bond companies, successor operator, *etc.*).

The first choice forecloses any possibility of recovery from the operator in the case of an award because the award would run against the Trust Fund. To be enforceable against an operator, the order awarding benefits must identify the operator as the liable party. *See* 20 CFR 725.522(a), 725.601-.609. The second choice restricts the Trust Fund's ability to defend against an unmeritorious claim without providing any certainty as to the recovery of any benefits awarded. In both cases, the Trust Fund is unnecessarily put at risk. This risk can be ameliorated by the simple expedient of allowing the Director, at his or her discretion, to develop evidence in cases in which the identified responsible operator has ceased to defend the claim.

Proposed § 725.414(a)(3)(iii) allows the Director the option of developing evidence in such cases. This revision would not prejudice claimants because the Director would be bound by the same evidence-limiting rules as the operator. In a miner's claim, the medical evidence developed under § 725.406 counts as one medical report and one set of tests submitted by the Director, 20 CFR 725.414(a)(3)(iii), and the Director would be able to submit only one additional medical report and set of tests, along with appropriate rebuttal evidence. And in a survivor's claim, the Director, like an operator, is limited to two complete reports and rebuttal evidence. Moreover, in appropriate cases, the Director may determine that an award of benefits is justified, and decline to submit additional evidence. In sum, the proposed rule reasonably allows the Director to defend the Trust Fund against unwarranted liability in appropriate circumstances without unjustifiably burdening claimants.

20 CFR 725.601 Enforcement Generally

Current § 725.601 sets out the Department's policy regarding enforcing the liabilities imposed by Part 725. The last sentence of current paragraph (b) refers to ''payments in addition to compensation (see § 725.607)[.]'' For the reasons explained in the discussion under § 725.607, the Department proposes to replace the phrase ''payments in addition to compensation'' with the phrase ''payments of additional compensation.'' No substantive change is intended.

20 CFR 725.607 Payments in Addition to Compensation

The Department proposes two revisions to current § 725.607, which implements section 14(f) of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. 914(f), as incorporated into the BLBA by section 422(a) of the Act, 30 U.S.C. 932(a), to clarify that amounts paid under section 14(f) are compensation. Section 14(f) generally provides that claimants are entitled to an additional 20% of any compensation owed under the terms of an award that is not paid within ten days after it becomes due.

The majority of courts to consider the question have agreed with the Director's view that the 20% payment required by section 14(f) is itself ''compensation'' rather than a penalty. *See Newport News Shipbuilding and Dry Dock Co.* v. *Brown,* 376 F.3d 245, 251 (4th Cir. 2004) (''[I]t is plain that an award for late payment under [section] 14(f) is compensation.''); *Tahara* v. *Matson Terminals, Inc.,* 511 F.3d 950, 953–54 (9th Cir. 2007) (same); *but see Burgo* v. *General Dynamics Corp.,* 122 F.3d 140, 145–46 (2d Cir. 1997). Part 725 reflects this view by generally referring to 14(f) payments as ''additional compensation.'' *See* 20 CFR 725.530(a), 725.607(b), 725.608(a)(3); *see also* 65 FR 80014 (Dec. 20, 2000) (''Section 14(f) provides that additional compensation, in the amount of twenty percent of unpaid benefits, shall be paid if an employer fails to pay within ten days after the benefits become due.'').

Current § 725.607 does not consistently reflect the majority rule or the Director's position. Paragraph (b) describes section 14(f) payments as ''additional compensation.'' But both the title of the section and paragraph (c) describe them as payments ''in addition to compensation.'' The latter formulation could be read to suggest

that 14(f) payments are something other than compensation. While the ''in addition to compensation'' formulation has not caused any problems in the administration of § 725.607 thus far, the Department wishes to eliminate any possibility that the regulation's phrasing could confuse readers. Accordingly, the Department proposes to replace ''in addition to compensation'' with ''additional compensation'' in the title of § 725.607 and paragraph (c). To maintain consistency within part 725, the Department also proposes the same change to § 725.601(b).

III. Statutory Authority

Section 426(a) of the BLBA, 30 U.S.C. 936(a), authorizes the Secretary of Labor to prescribe rules and regulations necessary for the administration and enforcement of the Act.

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.

As discussed earlier in the preamble, proposed § 725.413 would require each party in a black lung benefits claim to disclose certain medical information about the miner that the party or the party's agent receives by sending a complete copy of the information to all other parties in the claim. The Department does not believe this rule will have a broad impact because in many (and perhaps the majority) of cases, the parties already exchange all of the medical information in their possession as part of their evidentiary submissions. But requiring an exchange of additional medical information could be considered a collection of information within the meaning of the PRA. Thus, consistent with the requirements codified at 44 U.S.C. 3506(c)(2)(B) and 3507(d), and at 5 CFR 1320.11, the Department has submitted a new Information Collection Request to OMB for approval under the PRA and is providing an opportunity for public comment. A copy of this request (including supporting documentation) may be obtained free of charge 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.

The Department has estimated the number of responses and burdens as follows for this information collection:

Title of Collection: Disclosure of Medical Information

OMB Control Number: 1240–0NEW [OWCP will supply before publication]

Total Estimated Number of Responses: 4,074

Total Estimated Annual Time Burden: 679 hours

Total Estimated Annual Cost Burden: $21,537.88

In addition to having an opportunity to file comments with the Department, the PRA provides that an interested party may file comments on the information collection requirements in a proposed rule directly with OMB at the Office of Information and Regulatory Affairs, Attn: OMB Desk Officer for DOL–OWCP, Office of Management and Budget, Room 10235, 725 17th Street, NW., Washington, DC 20503; by Fax: 202–395–5806 (this is not a toll-free number); or by email: *OIRA_submission@omb.eop.gov*. Commenters are encouraged, but not required, to send a courtesy copy of any comments to the Department by one of the methods set forth in the **ADDRESSES** section above. OMB will consider all written comments that the agency receives within 30 days of publication of this NPRM in the **Federal Register**. In order to help ensure appropriate consideration, comments should mention the OMB control number listed above.

OMB and the Department are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses.

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 proposed rule with these principles in mind and has determined that the regulated community will benefit from this regulation. The discussion below sets out the rule's anticipated economic impact and discusses non-economic factors favoring adoption of the proposal. OMB has reviewed this rule prior to publication in accordance with these Executive Orders.

A. Economic Considerations

The proposed rule includes only one provision that arguably could have an economic impact on parties to black lung claims or others: proposed § 725.310(e), which requires a responsible operator to pay effective awards of benefits while seeking to modify those awards. As set forth above in the Section-by-Section Explanation, within one year of an award of benefits or of the last payment of benefits, a liable coal mine operator may request modification of an award (*i.e.,* may seek to have the award converted to a denial) based on a change in conditions or because of a mistake in a determination of fact in the award. 20 CFR 725.310(a). Operators are legally obligated to make benefit payments during such modification proceedings. But few do, and the Trust Fund pays monthly benefits in their stead. To avoid this result, proposed § 725.310(e) would prohibit a responsible operator from seeking modification until it meets the

payment obligations imposed by effective awards in a claim. Because the proposed rule merely enforces operators' existing obligations, it imposes no additional costs and is thus cost neutral.

Even if the proposed rule were construed to impose a new obligation on operators, the Department believes any additional costs involved would not be burdensome for several reasons. First, if an operator's modification request is denied, the operator must reimburse the Trust Fund with interest for all benefits paid to the claimant during the proceeding. In such cases, whether the responsible operator starts paying benefits after the award is made initially or does so after the modification process has ended, the operator must pay all benefits owed. Second, in those instances where the operator's modification petition is successful, the operator can pursue reimbursement from the claimant for at least some of the benefits paid, including those paid during the modification proceeding itself. *See* 20 CFR 725.310(d). The potential economic impact on responsible operators in this instance is the amount that they cannot recoup from the claimant. In this regard, when an operator successfully modifies an award, the operator can seek only to recover cash benefits paid to the claimant and not medical benefits paid to hospitals and other health care providers. The Department believes, based on its experience in administering the program, that there are very few claims in which an operator is successful on modification. Thus, even if recoupment is unavailable, the cost impact would not be large.

B. Other Considerations

The Department has also considered other benefits and burdens that would result from the proposed rules apart from any potential monetary impact. As discussed in the Section-by-Section analysis, proposed § 725.310(e) requires responsible operators to meet their payment obligations on effective awards before modifying those awards. This rule strikes an appropriate balance between the parties' competing interests: claimants are made whole while operators who would be irreparably harmed by making such payments can seek a stay in payments. While there is some risk that the operator will not recover payments made after a successful modification petition, placing that risk on the operator, rather than the Trust Fund, is consistent with the Act's intent.

Proposed § 725.413, which requires the parties to disclose all medical information they develop, will help protect miners' health and assist in reaching more accurate benefits determinations. These concerns far outweigh any minimal additional administrative burden this rule would place on the parties as a result of the mandatory exchange of this information. Moreover, the Department does not believe this rule will have an extremely broad impact. In many (and perhaps the majority) of cases, the Department believes, and has been informed by the public, that the parties already exchange all of the medical information in their possession as part of their evidentiary submissions.

Finally, the proposed revisions to § 725.414 and § 725.607 will benefit all regulated parties simply by adding clarity to the rules.

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 prepare a regulatory flexibility analysis when it proposes regulations that will have ''a significant economic impact on a substantial number of small entities,'' or to certify that the proposed regulations will have no such impact, and to make the analysis or certification available for public comment. 5 U.S.C. 605.

The Department has determined that a regulatory flexibility analysis under the RFA is not required for this rulemaking. While many coal mine operators are small entities within the meaning of the RFA, *see* 77 FR 19471–72 (Mar. 30, 2012), this proposed rule, if adopted in final, would not have a significant economic impact on them. As discussed above, the proposed rule addresses procedural issues that have arisen in claims administration and adjudication, and does not change the substantive standards under which claims are adjudicated. As such, the Department anticipates that the proposed rule would have little, if any, financial consequences for operators. Moreover, to the extent proposed § 725.310(e) requires that operators make benefit payments on effective awards while pursuing modification, the regulation merely reflects an existing payment obligation rather than imposing a new one on operators.

Based on these facts, the Department certifies that this rule will not have a significant economic impact on a substantial number of small entities. Thus, a regulatory flexibility analysis is not required. The Department invites comments from members of the public who believe the regulations will have a significant economic impact on a substantial number of small coal mine operators. The Department has provided the Chief Counsel for Advocacy of the Small Business Administration with a copy of this certification. *See* 5 U.S.C. 605.

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 proposed rule in accordance with Executive Order 13132 regarding federalism, and has determined that it does not have ''federalism implications.'' E.O. 13132, 64 FR 43255 (Aug. 4, 1999). The proposed 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'' if promulgated as a final rule. *Id.*

IX. Executive Order 12988 (Civil Justice Reform)

The proposed rule meets the applicable standards in Sections 3(a) and 3(b)(2) of Executive Order 12988, Civil Justice Reform, to minimize litigation, eliminate ambiguity, and reduce burden. *See* 61 FR 4729 (Feb. 5, 1996).

X. Congressional Review Act

The proposed rule is not a ''major rule'' as defined in the Congressional Review Act, 5 U.S.C. 801 *et seq.* If promulgated as a final rule, this rule will not result in an annual effect on the economy of $100,000,000 or more; a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the

ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

List of Subjects in 20 CFR Part 725

Administrative practice and procedure, Black lung benefits, Claims, Health care, Reporting and recordkeeping requirements, Vocational rehabilitation, Workers' compensation.

For the reasons set forth in the preamble, the Department of Labor proposes to amend 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) Any modification request by an operator must be denied unless the operator proves that at the time of the request, the operator has complied with all of the obligations imposed by all awards in the claim that are currently effective as defined by § 725.502(a). These include the obligations to—

(i) Pay all benefits owed to the claimant (including retroactive benefits under § 725.502(b)(2), additional compensation under § 725.607, and medical benefits under §§ 725.701 *through 725.708*). If the prior award is final, these obligations also include the payment of approved attorney's fees and expenses under § 725.367 and witness fees under § 725.459; and

(ii) Reimburse the Black Lung Disability Trust Fund for all benefits paid (including payments prior to final adjudication under § 725.522, costs for the medical examination under § 725.406, and other benefits paid on behalf of the operator) with such penalties and interest as are appropriate.

(2) The requirements of paragraph (e)(1) 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.

(3) Except as provided by paragraph (e)(4) of this section, the operator must submit all documentary evidence pertaining to its compliance with the requirements of paragraph (e)(1) 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)(1) at the time of the modification request will be admitted into the hearing record or otherwise considered at any later stage of the proceeding.

(4) The requirements imposed by paragraph (e)(1) of this section are continuing in nature. If at any time during the modification proceedings the operator fails to meet obligations imposed by all effective awards in the claim, 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)(1). 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.

(5) 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)(1) of this section with each future modification petition.

(6) The provisions of this paragraph (e) apply to all modification requests filed on or after the effective date of this rule.

■ 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 medical data 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) 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)).

(c) 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.

(d) This rule applies to—

(1) All claims filed after the effective date of this rule;

(2) Pending claims not yet adjudicated by an administrative law judge, except that medical information received prior to the effective date of this rule and not previously disclosed must be provided to the other parties within 60 days of the effective date of this rule; 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), (c), and (d) to read as follows:

§ 725.414 Development of evidence.

(a) *Medical evidence.* (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 (a)(2)(i) 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 (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 of this chapter, 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 (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 (a)(3)(i)

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, 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).

(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 of this chapter, 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, 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.

(4) Notwithstanding the limitations in paragraphs (a)(2) and (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. 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 20th day of April, 2015.

Leonard J. Howie III,

Director, Office of Workers' Compensation Programs.

[FR Doc. 2015–09573 Filed 4–28–15; 8:45 am]

BILLING CODE 4510–CR–P

DEPARTMENT OF STATE

22 CFR Parts 22 and 51

[Public Notice: 9111]

RIN 1400–AD76

Proposed Elimination of Visa Page Insert Service for U.S. Passport Book Holders

AGENCY: Department of State.

ACTION: Proposed rule.

SUMMARY: Currently, all U.S. passport book applicants may apply for either a 28-page or 52-page passport book at no extra charge. U.S. passport book holders may then apply for additional visa pages while the passport book is still valid. The Department of State proposes eliminating the option to add visa pages in passports beginning January 1, 2016. To help mitigate the need for visa page inserts, the Department began issuing the larger 52-page passport book in October 2014 to all overseas U.S. passport applicants at no extra cost. U.S. passport applicants applying domestically can still obtain the 52-page passport book at no extra charge by requesting it on the application form. The elimination of visa page inserts coincides with the Department's anticipated rollout of the Next Generation Passport in 2016. The Next Generation Passport incorporates new security features designed to protect the integrity of U.S. passport books against fraud and misuse. An interagency working group determined that the addition of visa page inserts could reduce the effectiveness of these new security features. If this change is implemented, the fee for this service will be removed from the Schedule of Fees for Consular Services.

DATES: Written comments must be received on or before June 29, 2015.

ADDRESSES: Interested parties may submit comments by any of the following methods:

- Visit the Regulations.gov Web site at: *http://www.regulations.gov/index.cfm* and search the RIN 1400–AD76 or docket number DOS–2015–0017.
- Mail (paper, disk, or CD–ROM): U.S. Department of State, Office of Passport Services, Bureau of Consular Affairs (CA/PPT), Attn: CA/PPT/IA, 44132 Mercure Circle, P.O. Box 1227, Sterling, Virginia 20166–1227.

FOR FURTHER INFORMATION CONTACT: Michael Holly, Office of Passport Services, Bureau of Consular Affairs; 202–485–6373: *PassportRules@state.gov.*

SUPPLEMENTARY INFORMATION:

Background

The Department proposes eliminating the visa page insert service for regular fee passport book holders beginning January 1, 2016. The expected effective date of this rule coincides with when the Department expects to begin issuing an updated version of the Next Generation Passport book. The Department routinely updates the technology used to produce U.S. passport books so that U.S. passport books use the most current anti-fraud and anti-counterfeit measures. The Next Generation Passport, which is the next update of the U.S. passport book, will contain a polycarbonate data-page and will be personalized with laser engraving. This passport will also employ conical laser perforation of the passport number through the data and visa pages; display a general artwork upgrade and new security features including watermark, security artwork, optical variable security devices, tactile features, and optically variable inks. The primary reason for eliminating visa page inserts is to protect the integrity of the Next Generation Passport books.

In 2012, an interagency working group tasked with overseeing the development and deployment of Next Generation Passport books found that visa page inserts could compromise the effectiveness of security features of the new passport books that are intended to provide greater protections against fraud and misuse. To maximize the effectiveness of the Next Generation Passport that is expected to be issued to the general public in 2016, the Department considered whether visa page inserts could be phased out at the time that the Department begins to issue the new passport books.

As part of this study, the Department considered the extent of the public's usage of visa page inserts, costs to the Department of eliminating the service, and whether any inconvenience to the public could be minimized. A study of a sample of visa page insert applications revealed that a significant majority of those applying for visa page inserts had them added to 28-page passport books, rather than to the larger 52-page books. A set of visa page inserts is 24 pages. Accordingly, a 52-page passport book is the same size as a 28-page book with a set of extra visa pages. The Department determined that the demand for additional visa pages would be substantially reduced by issuing only the larger 52-page passport books to overseas U.S. passport applicants. Accordingly, the Department has begun issuing the 52-page book to overseas applicants, who are the most likely to apply for extra visa pages, at no additional cost. This should further reduce the already limited demand for visa page inserts, thus making the rule's impact on the public very minimal. Individuals who apply for U.S. passports within the United States will continue to have the option to request a 52-page passport at no additional charge.

Each version of the Next Generation Passport book contains two fewer pages total, but the same number of visa pages as the passport books currently in circulation. Accordingly, after the Department begins issuing the Next Generation Passport book, all domestic passport book applicants will still have the option to choose between a 26-page passport book and a larger 50-page passport book, but the larger 50-page passport books will be automatically issued to people applying overseas.

The Department believes the limited demand for visa page inserts is outweighed by the importance of ensuring that the Next Generation Passport provides the maximum protection against fraud and misuse. Furthermore, the Department must monitor unused inventories of passport products, and the elimination of visa page inserts would facilitate more secure inventory controls. Accordingly,