Sunshine Act Meetings

Federal Register
Vol. 50, No. 2
Thursday, January 3, 1985

This section of the FEDERAL REGISTER contains notices of meetings published under the "Government in the Sunshine Act" (Pub. L. 94-409) 5 U.S.C. 552b(e)(3).

CONTENTS

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CONSUMER PRODUCT SAFETY COMMISSION

TIME AND DATE: 9:30 a.m., Thursday, December 27, 1984.

LOCATION: Third Floor Hearing Room, 1111—18th Street, NW., Washington, D.C.

STATUS: Open to the Public.

MATTERS TO BE CONSIDERED. Fiscal Year 1986 Budget.

The Commission will consider issues related to the Budget for Fiscal Year 1986.

Note.—The Commission voted that agency business required holding this meeting without the usual advance notice.

FOR A RECORDED MESSAGE CONTAINING THE LATEST AGENDA INFORMATION, CALL: 301–492–5709.

CONTACT PERSON FOR ADDITIONAL INFORMATION: Sheldon D. Butts, Office of the Secretary, 5401 Westbard Ave., Bethesda, Md. 20207, 301–492–6800.

Sheldon D. Butts,

Deputy Secretary.

[FR Doc. 84-34014 Filed 12-28-84; 4:36 pm]

BILLING CODE 6355-01-M

2

CONSUMER PRODUCT SAFETY COMMISSION

TIME AND DATE: 2:30 p.m., Wednesday, December 26, 1984.

LOCATION: Third Floor Hearing Room, 1111—18th Street, NW., Washington, D.C.

STATUS: Open to the Public.

MATTERS TO BE CONSIDERED: Fiscal Year 1986 Budget.

The Commission will consider issues related to the Budget for Fiscal Year 1986.

Note.—The Commission voted that agency business required holding this meeting without the usual advance notice.

FOR A RECORDED MESSAGE CONTAINING THE LATEST AGENDA INFORMATION, CALL: 301–492–5709.

CONTACT PERSON FOR ADDITIONAL INFORMATION: Sheldon D. Butts, Office of the Secretary, 5401 Westbard Ave., Bethesda, Md. 20207 301–492–6800.

Sheldon D. Butts,

Deputy Secretary.

[FR Doc. 84-34015 Filed 12-28-84; 4:36 pm]

BILLING CODE 6355-01-M

3

FEDERAL DEPOSIT INSURANCE CORPORATION

[38796]

Agency Meeting.

Pursuant to the provisions of the "Government in the Sunshine Act" (5 U.S.C. 552b), notice is hereby given that at 11:25 a.m. on Friday, December 28, 1984, the Board of Directors of the Federal Deposit Insurance Corporation met in closed session, by telephone conference call, to consider a recommendation with respect to administrative enforcement actions against an insured bank (name and location of bank authorized to be exempt from disclosure pursuant to the provisions of subsections (c)(6), (c)(8), and (c)(9)(A)(ii) of the "Government in the Sunshine Act" (5 U.S.C. 552b (c)(6), (c)(8), and (c)(9)(A)(ii)).

In calling the meeting, the Board determined, on motion of Chairman William M. Isaac, seconded by Director Irvine H. Sprague (Appointive), concurred in by Mr. David L. Chew, acting in the place and stead of Director C.T. Conover (Comptroller of the Currency), that Corporation business required its consideration of the matters on less than seven days' notice to the public; that no earlier notice of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting pursuant to subsections (c)(6), (c)(8), and (c)(9)(A)(ii) of the "Government in the Sunshine Act" (5 U.S.C. 552b (c)(6), (c)(8), and (c)(9)(A)(ii)).

Dated: December 28, 1984.

Federal Deposit Insurance Corporation.

Margaret M. Olsen,

Deputy Executive Secretary.

[FR Doc. 84-34017 Filed 12-31-84; 10:53 am]

BILLING CODE 6714-01-M

4

FEDERAL ELECTION COMMISSION

DATE & TIME: Tuesday, January 8, 1985, 10:00 a.m.

PLACE: 1325 K Street, NW., Washington, D.C.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED: Compliance. Litigation. Audits. Personnel.

* * * * *

DATE & TIME: Thursday, January 10, 1985 10:00 a.m.

PLACE: 1325 K Street, NW., Washington, D.C. (fifth floor).

STATUS: This meeting will be closed to the public.

MATTERS TO BE CONSIDERED:

Setting of dates of future meetings
Correction and approval of minutes
Eligibility for candidtates to receive presidential primary matching funds
Draft advisory opinion #1984-60, W. Patrick Mulloy, II
Draft advisory opinion #1984-61, Elaine Acevedo, Government Affairs Director
Proposed revisions to the testing the waters regulations [11 CFR 100.7(b)(1), 100.8(b)(1), and 101.3]
Routine administrative matters

PERSON TO CONTACT FOR INFORMATION: Mr. Fred Eiland, Information Officer, 202–523–4065.

Majorie W. Emmons,

Secretary of the Commission.

[FR Doc. 84-34023 Filed 12-31-84; 2:47 pm]

BILLING CODE 6715-01-M

5

NATIONAL TRANSPORTATION SAFETY BOARD

[NM-85-1]

TIME AND PLACE: 9 a.m., Tuesday, January 8, 1985.

PLACE: NTSB Board Room, Eighth Floor, 800 Independence Ave., SW., Washington, D.C. 20594.

STATUS: The first two items will be open to the public; the remainder will be

closed under Exemption 10 of the Government in the Sunshine Act.

MATTERS TO BE CONSIDERED:

1. Railroad Accident Report—Derailment of Amtrak Train No. 21 (The Eagle) on the Missouri Pacific Railroad, Woodlawn, Texas, November 12, 1983.
2. Railroad Accident Report—Rear-End Collision between Conrail Trains OIPI–6 and ENPJ–6X, near Saltsburg, Pennsylvania, February 26, 1984.
3. Opinion and Order—Administrator v. Beguin; disposition of the Administrator's appeal.
4. Order—Dismissing petition for rehearing; Administrator v. Brehany, Dkt. SE–5806.
5. Opinion and Order—Petition of Nelson, Dkt. SM–3178.

CONTACT PERSON FOR MORE INFORMATION: Sharon Flemming (202) 382–6525.

Ray Smith,

Federal Register Liaison Officer.

December 28, 1984.

[FR Doc. 84–34016 Filed 12–28–84; 5:05 pm]

BILLING CODE 7533–01–M

federal register

Thursday
January 3, 1985

Part II

Department of Labor

Employment Standards Administration

20 CFR Parts 701, 702, and 703
Longshore and Habor Workers' Compensation Act and Related Statutes; Interim Final Rule With Request for Comments

DEPARTMENT OF LABOR

Employment Standards Administration

20 CFR Parts 701, 702 and 703

Longshore and Harbor Workers' Compensation Act and Related Statutes

AGENCY: Employment Standards Administration, Labor.

ACTION: Interim final rule with request for comments.

SUMMARY: Congress passed and on September 28, 1984, President Reagan signed into law, the Longshore and Harbor Workers' Compensation Act Amendments of 1984, Pub. L. 98-426, 98 Stat. 1639. This legislation made many substantive changes to the Longshore Act (33 U.S.C. 901 *et seq.*), including adding an exemption from the Act's jurisdiction for certain specified categories of employees, a certification procedure provision for exempting from the Act's coverage facilities engaged in the business of building, repairing or dismantling exclusively small vessels, and provisions granting to the Secretary or the Secretary's designee authority to exclude persons found to have commited certain specified fraudulent practices from participation in the program as physicians or health care providers, or as representatives of persons seeking benefits under the Act.

These interim final rules implement these changes and the other amendments made by the enactment of Pub. L. 98-426, and make certain technical corrections in the implementing regulations as previously promulgated in 1973 and 1977. The promulgation of these rules as interim final is authorized under the Administrative Procedure Act 5 U.S.C. 553(b)(3)(B) and 553(d)(3). It is necessary because the Longshore Act provides that most of the statutory changes will become effective on the date of enactment, or within ninety days after enactment (December 27, 1984) and that the amendments will apply to all pending as well as new claims filed under the Act.

DATES: These interim final regulations become effective on December 27, 1984, and will remain in effect no later than October 1, 1985, unless extended or superseded by another issuance. Written comments must be received on or before March 4, 1985.

ADDRESS: Written comments should be sent to Richard A. Staufenberger, Deputy Director, Office of Workers' Compensation Programs, Employment Standards Administration, U.S. Department of Labor, 200 Constitution Avenue, NW., Room S-3524, Washington, D.C., 20210, Telephone (202) 523-7503. Written comments received may be inspected at Room S-3524 between 8:15 a.m. and 4:45 p.m., Monday through Friday, except holidays.

FOR FURTHER INFORMATION CONTACT: Richard A. Staufenberger, Tel. (202) 523-7503. This is not a toll free telephone call.

SUPPLEMENTARY INFORMATION: The Longshore and Harbor Workers' Compensation Act, originally enacted in 1927 (Pub. L. 803, 44 Stat. 1424), is designed to provide a statutory basis pursuant to which certain employees injured during the course of their work for a covered employer might receive compensation benefits and medical care for such injury. The Act also provides for the payment of benefits to the survivors of such employees under certain circumstances.

In 1972, the Congress amended the Longshore Act (Pub. L. 92-576, 86 Stat. 1251) to, among other things, expand the coverage of the Act to certain employees engaged in maritime employment on land, amend the level of benefits payable to the survivors of certain permanently disabled employees who died from causes unrelated to the compensable injury, and revise the procedure for the adjudication of contested claims by requiring that hearings be conducted by administrative law judges and by establishing, in the Department of Labor, the Benefits Review Board to review such decisions, subject to further appeal to the appropriate United States court of appeals and ultimately the Supreme Court of the United States.

Beginning in 1977, the respective labor committees of the Senate and of the House have conducted a series of oversight hearings on the LHCWA and on the impact of the 1972 amendments. During this review, Congress considered many proposals to amend the law to eliminate difficulties which had arisen in its implementation, while at the same time assuring that all of those deserving of compensation received adequate and timely benefits. This review process culminated with the enactment of Pub. L. 98-426. These interim final rules implement Pub. L. 98-426.

Set forth below is a summary of the more substantive changes to the regulations governing the administration of the Act which are required by the 1984 amendments. To help the reader, these sections first describe the Act before the 1984 amendments; this is always referred to as the "Act". The provisions of the 1984 amendments ("the statute" or "the amendments") are then described. Finally, the regulations ("the rules" or "regulations") are explained.

Coverage

Sections 2 and 3 of the Act define its terms and delineate the Act's coverage. Coverage concerns which employers are subject to the Act and which employers are entitled to its benefits.

Section 2(3) of the Act defines the term "employee." That definition in the Act specifically excluded two categories of workers: a master or member of any vessel, and any person engaged by the master to load or unload or repair any small vessel under eighteen tons net.

The 1984 amendments affect the coverage of the Act in two ways. First, the amendments add several categories to those specific categories of workers expressly excluded from the definition of "employee". Second, the amendments allow certain small vessel facilities to seek from the Secretary of Labor a certificate of exemption from coverage.

Section 2(a) of the amendments revised the definition of employee set forth in section 2(3) of the Act to expressly exclude specified categories of workers from coverage under the Act. The law now expressly excludes:

—Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work;
—Individuals employed by a club, camp, recreational operation, restaurant, museum, or retail outlet;
—Individuals employed by a marina and who are not engaged in construction, replacement, or expansion of such marina (except for routine maintenance);
—Individuals who (1) are employed by suppliers, transporters, vendors, (2) are temporarily doing business on the premises of a covered employer, and (3) are not performing work normally performed by employees of that employer;
—Aquaculture workers; and
—Individuals employed to build, repair, or dismantle any recreational vessel under sixty-five feet in length.

The legislative history of the amendments indicates that these exclusions from coverage must be narrowly construed and, further, that such exclusions apply only where the individual(s) is covered under a State workers' compensation law. See 130 Cong. Rec. H2465 et seq. (Daily Ed. April 9, 1984); 130 Cong. Rec. H9597-8 (Daily Ed. September 14, 1984); 130 Cong. Rec. H9731, H9733-4 (Daily Ed. September 18,

1984), 130 Cong. Rec. S11622-3 (Daily Ed. September 20, 1984).

To effectuate this amendment, the definitional section of these regulations (§ 701.301) is revised to define those persons who will qualify as "employees" and to expressly exclude those workers not covered by the Longshore Act. The regulations repeat the statutory language in listing these categories of workers in the definition in § 701.301(12). The regulations do not define the terms except where the legislative history provides guidance. Some general comments on these revisions are set forth below.

First, the 1984 amendments expressly excluded "individuals employed exclusively to perform office clerical, secretarial, security, or data processing work." Section 2(3)(A), Longshore Act as amended. Consistent with the express direction of the Conference Report, employees classified as longshore cargo checkers and clerks and other individuals performing tasks necessary to the documentation and other work related to cargo movement are not excluded from the Act's coverage.

Next, the regulations define club ("a social or fraternal organization, whether profit or nonprofit") based on the guidance provided in the House report (Committee on Education and Labor, H. Rept. No. 98-570, 98th Congress 1st Sess. (November 18, 1983)) and in the Conference Managers Statement (H. Rept. 98-1027, *Supra*). The regulations describe the activities which may constitute "routine maintenance" by marina workers (cleaning, painting, trash removal, housekeeping and small repairs) based on clarification provided in H. Rept. 98-570, *Supra*. The term "aquaculture" is defined by the regulations as a commercial enterprise involved in the controlled cultivation and harvest of aquatic plants and animals, consistent with the definition in the Senate Report; the Manager's Report emphasized that the term also included the cleaning, processing or canning of fish (H. Rept. 98-1027, *Supra*) and that language has been used in the regulations.

The Department is particularly interested in receiving comments concerning the interim final definition of "recreational operation" and "recreational vessel", as used in amended subparagraphs (B) and (F) of section 2(3) of the Act. The regulations define "recreational operation" to include recreational scuba diving and commercial rafting and canoeing expeditions. The legislative history states that the term was added to exclude boatworkers engaged in "the most popular tourists activities [such as] a float trip down many of our beautiful rivers and streams." Statement of Senator James McClure, 129 Cong. Rec. S8660 (Daily Ed. June 16, 1983). See also Statement of Senator Orin Hatch, 129 Cong. Rec. S8662 (Daily Ed. June 16, 1983), wherein he indicates that the purpose of the amendment is intended to exclude professional boatworkers or guides, e.g., professional river trip outfitters. Congressman John Erlenborn stated that "recreation operations" also included recreational scuba diving. 130 Cong. Rec. H. 9733.

The new section 2(3)(F) of the Act excludes from the definition of employee "individuals employed to build, repair, or dismantle any recreational vessel under sixty-five feet in length."

The statute does not, however, define what is meant by the term "recreational vessel" other than providing a way to determine the length of the craft in question. The regulations define how a vessel shall be measured, following the method set forth by the Coast Guard in determining the length of vessels (that is, the length is to be measured from the foremost part of the stem to the aftermost part of the stern). They do not, however, define the term further and specific comments are requested as to whether and/or what changes should be made to the interim final definition of "recreational vessel."

The second change made by the amendments which affect coverage of the Act is a new section 3(d), which authorizes the Secretary of Labor to certify that an employer's "facility is engaged in the business of building, repairing, or dismantling exclusively small vessels" and thereby to exclude such land-based facility and persons employed at that facility from the Act's coverage. The amendments define the term small vessel to mean: (1) A commercial barge under 900 lightship displacement tons; (2) a commercial tugboat, towboat, crew boat, supply boat, fishing vessel or other work vessel under 1,600 tons gross.

The regulations repeat this definition and explain the terms "displacement tons" and "gross tons" using guidance provided in the legislative history. Moreover, the term "commercial", as used in conjunction with vessel, is defined to exclude from the definition types of vessels (military supply boats, patrol boats, utility vessels, ferries, corps of engineers dredges, pressure barges or Coast Guard vessels) consistent with the description provided in the legislative history. Since the amendments require the Secretary to certify that such facilities are exempt, a procedure for the filing, processing and granting or denying a certificate of exemption are set forth in §§ 702.171-702.175 of these regulations.

As defined in these regulations, a "facility" includes an employer's business operation so long as it is located at a particular contiguous geographic location. While this term will generally apply to the entire operation of an employer, these rules would not prohibit an employer from applying for and receiving a certificate of exemption for only part of its operation, so long as the area for which the exemption is sought and the work engaged in is clearly segregated from the rest of the employer's premises and/or activities. The exemption does not apply to injuries sustained upon the navigable waters of the United States, or upon any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels, since those areas continue to be subject to the Act's coverage; the exemption is also inapplicable if the employee is not covered by a State compensation act.

The certification process set out in the regulations is designed to be initiated by the facility and is self-enforcing. The first step in the certification process is for the owner or manager of the facility seeking an exemption to provide to the Associate Director for Longshore the information described in § 702.174, which includes: The name of the facility, its location and the nature of its business, and an affidavit affirming that the facility is engaged in building, repairing or dismantling exclusively small vessels and has secured appropriate compensation liability under the State act. The applicant is also required to acknowledge the duty to inform the Associate Director, of circumstances which would void any exemption and that an exemption procured under false information would be invalid retroactively. The information required is considered by the Department to be the minimum required to ensure that the facility meets the criteria for exemption established by the amendments. In addition, it makes clear to the applicant its future duties in regard to work on other than small vessels. The regulations also require that, once the certification of exemption is effective, the employer must notify its workers through a simple posting procedure. The posted notice must state that injuries at the facility are no longer covered by the Act, the basis of the exemption and its effective date, as well as grounds for termination. Awareness by all parties of when coverage ceased will help ensure better administration of the Act. Employers are reminded that States may require posting regarding

employee rights under State workers compensation programs.

Section 702.175 states that the certificate of exemption will automatically terminate if the facility works on a vessel not included within the definition of "small vessel" as set forth in section 3(d) of the amendments and § 702.172 of the rules, or if the facility receives Federal maritime subsidies. This requirement follows the guidance provided in the legislative history. The regulations provide for automatic termination of the exemption, then set forth the procedure whereby an employer may apply for reinstatement of the certificate of exemption. Although there are some statements in the legislative history suggesting that the exemption might automatically be reinstated once the facility is again engaged in exclusively small vessel operations, the Department believes that proper administration of this statute requires that the Secretary and other persons whose rights under the Act may be affected should know exactly when exempted operations ceased and that the employer in fact qualifies anew for the exemption. A streamlined reapplication process is instituted to ensure this certainty. Comments are particularly requested on the provisions for reinstatement of the exemption.

The regulations also provide that the decision granting or denying a certificate of exemption is not subject to review in proceedings conducted pursuant to section 19 (ALJ hearings) or 21 (Benefits Review Board) of the Act. Consistent with the implementation of section 32 of the Act and with the Department's existing procedures regarding authorization of self insurors, the Department believes it is appropriate to provide that this decision is a matter vested exclusively within the authority of the Secretary. A denial of certification or of authorization is therefore not subject to ALJ or BRB review.

An individual excluded from the definition of "employee" under the definitions in section 2(3) (A) through (F) of the Act as amended or through the exemption from coverage under section 3(a), must, for any injury sustained after September 28, 1984, first apply under a State workers' compensation act before seeking benefits under the Longshore Act. This procedure is required as a matter of Federal law and therefore supercedes any provisions of State law which are inconsistent therewith. The legislative history makes it clear that the time for filing a claim under the Longshore Act does not begin to run until "the State tribunal authoritatively interprets its law to deny coverage." Statement of Senator Hatch, 130 Cong. Rec. S11623. The denial of a State claim on procedural grounds, however, would not entitle the otherwise excluded worker to proceed with the Longshore Act claim. Statement of Congressman Erlenborn, 130 Cong. Rec. H9733.

Exclusion of Physicians, Health Care Providers, and Representatives of Claimants

Prior to the 1984 amendments, the Secretary could order a change of physicians or hospitals when it was desirable or necessary in the interest of the injured employee. There was no provision to exclude health care providers or claims representatives from involvement in claims filed under the Act. However, the Secretary could remove authority to render medical care under the Act. Pub. L. 98-426 amended the Longshore Act to add the authority to order a change of physicians or hospitals if charges for treatment are excessive. Debarment of health care providers and claims representatives is also authorized under the amendments.

Section 7(c) of the Longshore Act was amended to require for the first time that the Secretary annually publish a list of physicians and health care providers, such as hospitals, clinics, etc., which are not authorized to render medical care or provide services under the Act. That section sets forth the grounds upon which the Secretary may exclude a person from participation in the program (including the denial of the right to seek reimbursement for any care or service provided to injured workers) and establishes the procedure to be followed before a physician may be excluded. The amendments provide that these procedures include the opportunity for a hearing conducted in accordance with the Administrative Procedure Act and the right to appeal an adverse decision to the United States Court of Appeals for the judicial circuit in which the person resides or has his or her principal place of business, or the Court of Appeals for the District of Columbia. The filing of such an appeal will not, however, stay the effect of the decision excluding the physician or health care provider. Longshore Act, section 7(j)(4).

The regulations implementing this amendment are set forth at §§ 702.431-702.436. These regulations repeat the grounds for debarment listed in the statute. The debarment procedures are then described. The Longshore Act is administered by the Office of Workers' Compensation Programs (OWCP) which also administers the Federal Employees Compensation Act (FECA). The debarment procedures described in these regulations were derived, where appropriate, from the FECA debarment procedures (see 20 CFR 10.137). This was done to maximize consistency in administration of the two workers' compensation programs.

The regulations recite the appeal process provisions for excluded persons set out in the statute. The regulations also describe the procedure for the publication of the list of debarred persons.

The procedures provide for an investigation by the appropriate OWCP deputy commissioner, the opportunity for a hearing before an administrative law judge who will issue a recommended decision based on the evidence produced during the hearing, and a final administrative decision by the Deputy Under Secretary for Employment Standards. The statute authorizes the Department to issue subpoenas, as necessary, to carry out its responsibilities under these provisions. Longshore Act section 7(j)(3). Judicial review of the decision to disqualify may be obtained by appeal to the appropriate United States Court of Appeals. An appeal must be filed within 60 days after the Deputy Under Secretary's final decision is mailed to the disqualified person and/or that person's attorney.

The Secretary is also required to publish a list of individuals who have been disqualified from representing claimants under the Act. The grounds for disqualification are set forth in section 31(b)(2)(B) of the Longshore Act, as amended. The procedures to be followed are the same as those applicable to physicians and health care providers.

The regulations governing the disqualification of claimant representatives are set forth at §§ 702.131 (b) and (c). These regulations repeat the grounds for debarment provided for in the statute.

In administering these provisions, the Department will be guided by the legislative history which noted that

> * * * disqualification is an extraordinarily drastic step, which should only be taken in circumstances where the physician or health care provider involved has been found to have engaged in truly egregious conduct which threatens the integrity of this or any other worker's compensation program * * *. Committee on Education and Labor, H. Rept. No. 98-570, 98th Cong. 1st Sess. (November 18, 1983) p. 13.

A similar statement was made concerning the disqualification of claimants' representatives. H. Rept. 98-570, *supra*, pp. 15-17.

Therefore, before a person may be disqualified it must be established that the person involved knowingly and willingly engaged in the fraudulent conduct proscribed by section 7(c)(1)(B) or section 31(b)(2)(B) of the Longshore Act, as amended. In all cases, the evidence must be sufficient to establish each factor required by the amendments to justify disqualification. Authenticated copies of judgments of conviction or orders excluding a person from participation in any Federal or State program will, however, be considered adequate evidence to justify disqualification under sections 7(c)(1)(B)(iv) or (v) and 31(b)(2)(B) (ii) or (iii), respectively.

Settlements

Settlements under the Act prior to the 1984 amendments took three forms: (1) Settlements of compensation benefits, (2) settlements of medical benefits and (3) commutations of compensation benefits. Settlements were to be evaluated according to the best interests of the injured employee, settlement of death claims was not permitted, and commutations were to be evaluated according to the "interest of justice".

Pub. L. 98–426 amended section 8(i) of the Longshore Act to authorize administrative law judges, as well as OWCP deputy commissioners, to approve (or reject) proposed settlements of claims filed under the Longshore Act. The commutation provision under section 14(j) has been eliminated, and death benefits can now be settled by the beneficiaries. The amended statute provides that settlement agreements shall be approved within 30 days after submission and, further, that where both the employer and claimant are represented by an attorney, a settlement shall be deemed approved unless specifically disapproved within 30 days after submission. Under the amendments, a proposed settlement may be disapproved only if it is found to be inadequate or procured by duress. This amendment is effective on December 27, 1984 and applies to pending claims as well as to claims filed after that date.

The rules governing these amendments are set forth beginning at § 702.241. The regulations specify: the information that must be submitted in support of the proposed settlement (§ 702.241); the criteria to be used in evaluating the proposed settlement (§ 702.243); and procedures to be followed in the event that a proposed settlement is not approved by the deputy commissioner, e.g., a hearing before an Administrative Law Judge who may approve or reject the settlement based on the evidence submitted at the hearing. In addition, the regulations provide that when a claim is pending before the Office of Administrative Law Judges, the application for approval of a settlement shall not be submitted less than five (5) days before the hearing is scheduled. This limitation is essential to ensure that the application is reviewed by an administrative law judge who has the opportunity to question the parties to the settlement in person and thereby to evaluate the proposal and render a reasoned judgment on whether the proposal should be rejected as "inadequate or procured by duress." Ordinarily, mail regarding a formal hearing is not reviewed until the case is assigned to be heard. This may take longer than 30 days. Therefore, without this limitation, a settlement could be approved within the meaning of the amendments without appropriate review. If the parties agree to settle the claim before a hearing is scheduled they may request that the matter be remanded to the deputy commissioner which will result in an early resolution of the case.

Although, as noted above, Congress has retained the requirement that settlements must be approved to be effective, it has established a time limit within which that review must be completed in order "to eliminate complaints of administrative delays". S. Rept. No. 98–81, 98th Cong. 1st Session (1983) p.37. The penalty provisions of section 14(f) of the Act do not apply to a settlement until it has been specifically approved or at the end of the thirty days when the parties are represented by counsel. To ensure uniformity in the review of settlement agreements § 702.243(f) of the regulations specifies the criteria to be considered in determining whether the settlement should be approved. Many of these criteria were being utilized prior to the amendments and were required to be considered by administrative law judges pursuant to the decision of the Benefits Review Board in *Clefstad* v. *Perini North River Associates*, 9 BRBS 217, BRB No. (1978).

In those cases where basic factual issues are in dispute and no compensation order has been issued, the adequacy of an agreement depends on all the circumstances and must be decided on a case-by-case basis. Therefore, no attempt has been made in the regulations to define the term "inadequate" other than to provide criteria for evaluating the proposed settlement.

In cases where a final compensation order exists and there are no issues as to continuing entitlement or the amount of benefits payable, a definition of what settlements should be deemed inadequate is possible and is set forth at § 702.243(g) of the regulations. Although Congress repealed section 14(j) of the Act, which provided a formula for the commutation of benefits being paid pursuant to an award, the Senate Report stated that "lump sum settlements are still permitted under section 8(i)." S. Rept. No. 97–498, 97th Cong. 2d Sess. (1982) p. 36; S. Rept. No. 98–81, 98th Cong. 1st Sess. (1983) p. 37. These statements reflect a recognition of the fact, as stated by Professor Larson in his treatise on workers' compensation, that

> [1] lump-sum settlements, when they are authorized by statute, are not compromises in the usual sense; that is, they do not assume concessions and adjustments in the amount of payment because of the existence of a disputed issue. Rather, they are essentially commutations, and should be calculated on a sound annuity basis in accordance with any statutory rules provided. Larson, *The Law of Workmen's Compensation*, Vol. 3, § 82.71, p. 15–590–1. (Footnotes omitted).

Section 702.243(g) does provide a sound annuity basis for determining the adequacy of these settlements.

Under the regulations, in cases where there is a final decision and no substantive issues are in dispute, the Department will determine whether the amount of the proposed settlement is equal to the present value of the future compensation payments which the claimant or beneficiary would receive under the award, computed at a 5 per centum true discount compounded annually. The Department has adopted the 5 per centum true discount figure since it is the discount figure most frequently used by States, as revealed in a survey of State compensation programs. In determining the life expectancy of the person receiving benefits, the Department will apply the most current United States Life Tables as developed by the Department of Health and Human Services.

Interested parties are requested to submit comments on the discount rate established by these rules.

Under the amendments, the parties may settle any claim for compensation, including future medical benefits, or a claim for survivor benefits. Under no circumstances, however, may a person seeking benefits under section 7 or 8 of the Longshore Act settle a claim for survivor benefits which may be filed under section 9 of the Act only after the death of the injured worker. Thus, even though the injured worker may have

settled his or her claim for compensation, such agreement would not prevent a survivor from pursuing a claim for benefits under section 9.

The enactment of Pub. L. 98–426 also addressed the issue of whether an employer could seek to limit its liability under section 8(f) of the Act after having settled the employee's claim and whether a party may seek to modify a settlement approved under section 8(i). The Congress determined that once a claim is approved (1) the employer could not subsequently seek relief or reimbursement for amounts it paid from the special fund, and (2) settlements are not subject to modification under section 22 of the Longshore Act. See sections 8(i)(4) and 22 of the Longshore Act as amended (Pub. L. 98–426, sections 9(g) and 16, 98 Stat. 1646, 1650); Conference Report pp. 32–33 (H. Rept. 98–1027). The regulations change the prior language of the rules to reflect these statutory changes.

Special Fund, Second Injury Cases

Section 8(f) of the Act was designed to remove the incentive for employers to discriminate against the hiring or retention of handicapped employees. An employer's liability was limited (in cases of a job-related injury that combined with a manifest existing permanent partial disability to result in a greater degree of permanent disability) to the payment of a specified number of weeks of compensation. The remaining liability was shifted to an industry (authorized self-insured employers and carriers) financed special fund.

Prior to the 1984 amendments the Act did not require that requests for section 8(f) relief be presented to the deputy commissioner or the Director, OWCP (the administrator of the special fund). The Act did not specifically provide the right of the Director, OWCP to recover, through third party actions, benefits paid from the special fund. Access to the special fund by unauthorized employers or insurance carriers was not prohibited. The contributions to the industry financed special fund were based upon the amount of compensation and medical benefits paid by each employer or insurance carrier in the prior calendar year.

To ensure that the OWCP deputy commissioner and Director—as administrator of the special fund—have an opportunity to consider the merits of the employer/carrier's request for a limitation of its liability (and thereby to prevent the practice of presenting such requests in the first instance to an administrative law judge), Pub. L. 98–426 requires that all requests for relief under section 8(f) must first be presented to the deputy commissioner together with a statement documenting the employer's entitlement to relief. The law also grants the legal authority for the Director to assert the lien of the special fund in third party proceedings.

Two additional amendments brought about by the enactment of Pub. L. 98–426 are intended to insure the financial integrity of the Special Fund. First, section 8(f) of the amended Act expressly states that the special fund is not available to pay for the liability of an uninsured employer. Thus, an employer which has not complied with the provisions of section 32 is not entitled to limit its liability under section 8(f) of the Act. This amendment (Pub. L. 98–426 section 8(e), 98 Stat. 1645) was effective on the date of enactment (September 28, 1984) and applies to pending claims as well as to claims filed after the effective date.

Second, Congress amended the formula by which the Secretary is to determine how much each authorized self-insured employer and insurance carrier will be required to pay into the special fund. Under the new formula set forth in section 44(c)(2) of the Act as amended, the employer/carrier's assessment will be based not only on the amount of benefits it directly paid as compensation during the preceding calendar year but also on the payments made by the special fund under section 8(f) which are attributable to that employer/carrier. This change was made, according to Congressman Miller, because

> * * * some employers have taken steps to assign hundreds, even thousands, of cases to the fund, knowing that no matter how many cases they assigned, their proportion of payments to the fund would not grow. In effect, they knew that they could pass along their costs to all other participants in the program.
>
> The new formula in S. 38 bases an employer's assessment in part on his overall program participation, and half on his past utilization of the fund. This formula will, at once, dissuade the dumping of cases into the fund, and will more equitably apportion the responsibility. 130 Cong. Rec. H9732

Senator Nickles described the effect of the new formula, stating:

> The House and Senate committees attempted to rectify the problems as described in the two committee reports. (H. Rept. 98–570, pp. 20–21 and S. Rept. 98–81, pgs. 34–35.) While considering the differences, an alternative approach in the form of a new assessment formula was devised and agreed to by most concerned employers/carriers. The new formula takes into account the amount of fund cases each employer/carrier has and strikes an average between the actual payouts of the old formula and use of the fund. Under this formula, abuse of the Fund will be discouraged and assessments to all concerned will be equitable. There will be changes up or down in every industry, but all will be treated equally. The new formula is section 24(a) of the conference reported S. 38. 130 Cong. Rec. S11621.

The rules governing the contents of the application for section 8(f) relief, the limited grounds permissible for excusing the failure to submit such application, and the time periods specified for the filing of the application are set forth at § 702.321. This section incorporates the three criteria necessary for special fund relief: (1) A pre-existing permanent partial disability, (2) which was manifest to the employer prior to the second injury and (3) which contributes to the subsequent disability.

Upon receipt of the request for section 8(f) relief, the deputy commissioner will afford the employer up to 90 days to develop and/or obtain evidence to support its request. This period will be extended upon a showing of good cause but not beyond the date of the informal conference. The deputy commissioner will investigate the application, to the extent appropriate, and will, upon request, issue subpoenas *duces tecum* where necessary to compel the production of documentary evidence. The Benefits Review Board has upheld the right of the deputy commissioner to issue such subpoenas. *Rabb* v. *Marine Terminals Corp.*, 11 BRBS 498, BRB No. 78–628 (1979). If the employer fails to properly raise the section 8(f) issue with the deputy commissioner, that failure will constitute an absolute defense to the special fund's alleged liability to pay any benefits in connection with that claim.

The amendments to section 8(f) were effective September 28, 1984, and apply to claims then pending as well as to claims filed on or after that date. Pub. L. 98–426, section 28(a), 98 Stat. 1655. Thus, unless the employer has presented the issue of potential special fund liability to the deputy commissioner before a claim was referred to the Office of Administrative Law Judges (OALJ) for a hearing, that employer may not be entitled to an award limiting its compensation liability by virtue of section 8(f) of the Act. To ensure compliance with this particular amendment, employers may request, or the administrative law judge may order, that the claim be remanded to the deputy commissioner for consideration of the section 8(f) issue. Under these regulations, the deputy commissioner will transfer to the OALJ not only the request for a hearing and statement of contested and uncontested issues (LS

18), but also the application for relief under section 8(f) submitted by the employer/carrier and the deputy commissioner's informal decision. Where no application for 8(f) relief was presented to the deputy commissioner, that fact will be reflected in the documents sent to the OALJ. To ensure compliance with the Congressional directive that all requests for relief under section 8(f) must first be considered by the administrators of the special fund, the Director or his/her representative—the Associate Solicitor for Employee Benefits—must be given the opportunity to review any additional evidence or argument submitted by the employer before an administrative law judge may rule on the employer's request for relief under section 8(f).

The regulations incorporate the statutory language granting the special fund a lien in third party settlements. The regulations also incorporate the new formula, provided by the statute, to assess contributions to the special fund. The regulations also prohibit access to the special fund by unauthorized employers or insurance carriers, as provided for in the amendments.

Occupational Disease

Occupational disease claims, prior to the 1984 amendments, frequently involved very complex legal issues, such as when did the "injury" occur for purposes of determining the claimants' average weekly wage or wage-earning capacity.

Another issue concerned the timeliness of claims for benefits. The time of injury was variously interpreted to mean the date of last exposure or the date the disease becomes manifest. In *Aduddell* v. *Owens-Corning Fiberglass*, 16BRBS 131 (1984), for example, the Benefits Review Board held that employees who retired before their occupational disease became manifest were not entitled to compensation. The Board denied benefits because the claimant could not establish that the injury affected his wage earning capacity. Similarly, the widow of a deceased worker whose employment related disease manifested itself and caused death after retirement would not be entitled to receive survivor's benefits.

Pub. L. 98–426 amended the law in several significant respects with regard to the filing and adjudication of claims involving occupations diseases. First, sections 12 and 13 of the Act were amended to provide that in those cases where the job related disease does not immediately result in disability or death, the time within which the employee must notify the employer and/or file a claim does not begin to run until the employee or beneficiary is aware, or should have been aware by the exercise of reasonable diligence or by reason of medical advice, of the relationship between the employment, the disease, and the disability or death. In these cases, the amendments provide that notice must be given within one year and the claim for compensation must be filed within two years of such awareness, respectively.

Congress amended section 2(10) of the Longshore Act to define disability to mean

> permanent impairment, determined (to the extent covered thereby) under the Guides to the Evaluation of Permanent Impairment promulgated and modified from time to time by the American Medical Association. * * *

with respect to those cases where the occupational disease manifests itself subsequent to the date of retirement. It further amended the Act to provide a specific method for compensating these injured workers and their survivors. Longshore Act section 8(c)(23), 9(e)(2), and 10(d)(2) as amended. In adopting these amendments, Congress specifically rejected the decisions issued by the Benefits Review Board in *Dunn* v. *Todd Shipyards*, 13 BRBS 647 (1981), and *Aduddell* v. *Owens-Corning Fiberglass*, 16 BRBS 131 (1984). Conference Report (H. Rept. 98–1027) pp. 29–30. For these provisions to apply, it must be shown that the claimant is retired (defined as one who voluntarily withdrew from the workforce) and that there is no realistic expectation the person will return to the workforce. The legislative history makes it clear that eligibility under section 8(c)(23) does not include entitlement to a permanent total disability award but is limited to an award based on the degree of impairment. Statement of Senator Hatch, 130 Cong. Rec. at 11625. For this reason, the benefits payable are not subject to annual adjustment under section 10 of the Act.

The rules implementing these amendments are set forth at §§ 702.212–702.217; 701.224–702.221; and 702.601–702.604. These regulations incorporate statutory language.

Hearing Loss

The Act did not single out hearing loss claims from any other injuries. In special fund/second injury cases under section 8(f), for example, the employer's liability for a hearing loss where there was a pre-existing loss was the same as for any other type of injury: the *greater* of 104 weeks or the amount of loss directly attributable to that employment.

The amendments, however, distinguish hearing loss claims from other injuries in several areas. In special fund/second injury cases, the employer's liability for hearing loss is limited to the *lesser* of 104 weeks or the amount attributable to the employment. Also, the amendments afford audiograms presumptive evidentiary weight if performed according to set standards, and the amendments prescribe that the extent of hearing loss must be determined in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. Finally, the amendments specify that time limitations do not begin to run until an audiogram with a report showing a hearing loss is furnished the employee.

The regulations implement these changes by modifying § 702.145, which describes the use of the special fund, to reflect the change in the employer's liability for special fund hearing loss claims. A new § 702.441 specifies that audiograms can be administered by qualified technicians, as long as they are certified by a audiologist or otolaryngologist who, the regulations state, must be certified by an generally accepted professional hearing program. This clarification is based on the Conference Manager's Statement.

It should be noted that hearing loss claims have different notice and claims filing requirements than other occupational diseases. First, Congress amended section 8(c)(13) to provide that the time for filing a notice of injury or claim

> shall not begin to run * * * until the employee has received an audiogram, with the accompanying report thereon, which indicates that the employee has suffered a loss of hearing.

The Department has interpreted this amendment to mean that once the audiogram and report have been received, the employee is subject to the thirty (30) day and one (1) year filing requirements set forth in sections 12(a) and 13(a) of the Act, respectively, and not to the extended time requirements applicable to occupational diseases that do not immediately result in disability or death, since a hearing loss could entitle an employee immediately to a schedule award of compensation.

Employee Reports of Earnings

Under the 1984 amendments, employers are for the first time authorized to require employees receiving compensation to submit a statement of earnings semi-annually. The regulations implementing the provisions of the newly enacted section 8(j) are set forth at §§ 702.285 and 702.286. The provisions specify "earnings" which must be reported.

These include earnings from self-employment, even if the business operates at a loss. Failure to file a required report or the filing of an incomplete or inaccurate report may result in forfeiture of compensation. This statutory provision is repeated in the regulations.

The regulations also provide that the Director, OWCP, may require the filing of reports by employees receiving benefits from the special fund. This clarifies procedures which have been in effect for some time.

Micellaneous Provisions

Designated Official

Prior to the amendments, the Act required the employee to notify an employer of an injury by giving notice to a partner, an authorized agent of a corporation or the person in charge of the business. Employers were also required to keep records of all injuries and to send reports to the deputy commissioner.

The amendments require the employer to designate an official to whom notice must be given; that individual must be a first line supervisor, local plant manager or personnel office official at the place of employment. The amendments require the employer to notify the deputy commissioner of the selection.

In implementing this requirement, the regulations (at § 702.211) suggest types of first line supervisory positions (foreman, hatchboss or timekeeper) who are commonly those to whom notice is now given. The selection procedure is self implementing. It calls for a posting to ensure that all employees are aware of the designated official. That posting fulfills the requirement in the amendments that the employer notify the deputy commissioner.

Retired employees may not frequent the facility or indeed may live far away, and therefore may not be able to learn of the designated official. The regulations, therefore, provide that they may give notice to any other individuals listed in the statute (partner, officer or person in charge of a facility).

No Lost Time Cases

Prior to the 1984 amendments, the Act required that reports of all injuries be forwarded to the deputy commissioner and that the employer maintain record of injuries. The amendments eliminate the requirement for submitting notice in cases where the employee loses less than one work-shift but still require the employer to maintain a record of the injury. The regulations reflect this change (§ 702.201) and specify the type of record which must be maintained, listing the minimum information required for proper handling of any claim. The record keeping requirement in § 702.111 is changed to specify that records must be maintained for three years. This period is consistent with the Department's own retention schedule for such records as well as the retention requirements of FLSA and OSHA injury reports.

Penalties

The Act provided penalties for filing false information by an employee (section 31(c)), failure to file notices (section 30(e)), failure to secure coverage (section 38), and for discriminating against employees who make a claim under the Act (section 49). The penalties included fines for civil violations and fines and imprisonment for criminal violations.

The amendments generally increase the penalty provisions, add a "willing and knowing" requirement, and also extend the penalty for filing false or misleading information in connection with a claim to the employer/carrier. In addition, the penalty for discrimination against an employee who files a claim or testifies in a Longshore proceeding is not applicable where that employee has been found guilty of filing false information or misrepresenting a claim.

The regulations have been modified to reflect these increased penalties and other changes in the amendments. See § 702.204 (failure to furnish notice); § 702.271 (discrimination). New § 702.217, for the first time, describes the penalties for filing false or misleading statements. Also, for the first time the penalty for failure to secure coverage under the Act is described, in § 703.003.

Miscellaneous

Other changes in the rules include:

—Modifying § 703.108 (Period of authority to write insurance) to reflect procedural changes recently implemented. Reauthorization of carriers is now automatic and need not be sought every year.

—Clarifying the information which may be required of an authorized carrier (§ 703.302) or employer/carrier for purposes of the special fund assessment (§ 702.147). This is in accord with existing policy found necessary to ensure the integrity of the authorization and assessment processes.

—Altering the wording in § 702.162 (Liens on compensation) to reflect the change in the amendments directing that the Secretary shall (formerly this was discretionary) authorize a lien in favor of a union trust which pays disability benefits to an employee who is legally obligated to repay.

Publication as an Interim Regulation

The Department has determined that the public interest requires the immediate issuance of regulations in order to assure a smooth implementation of the amended Longshore Act. More specifically, Congress provided that many of the amendments would be effective as of September 28, 1984, while others would be effective ninety days later and that such amendments would apply to pending as well as new claims. The Act requires the Secretary to issue implementing regulations. It is essential, therefore, that these regulations become effective immediately in order to ensure compliance with the statute and to expedite the adjudication of claims that are subject to the 1984 amendments to the Longshore Act.

Additionally, the Act directs the Secretary, in accordance with regulations, to issue certificates of exemption to facilities qualified under section 3(d) and to publish lists of physicians, health care providers, and claimant representatives who have been disqualified from participation in the Longshore program in accordance with published rules and regulations. The failure to issue interim rules could result, for example, in the denial of the exemption to qualified employers and could lead to continued fraudulent activities now proscribed by the statute.

Accordingly, the Department finds good cause pursuant to 5 U.S.C. 553(b)(3)(B) and 553(d)(3), that prior notice and public comment are contrary to the public interest. However, interested members of the public are invited to submit written comments within sixty (60) days of publication of these interim final regulations. After the comments are evaluated, these rules will be republished with modifications found appropriate as a result of the comments received and any additional analysis undertaken by the Department.

This interim regulation will be effective only until October 1, 1985, unless extended by appropriate Federal Register notice.

Effective Date

Because immediate issuance of this interim regulation is required by the public interest in having a smooth implementation of the Longshore Act amendments, it shall become effective immediately instead of thirty days after publication. This determination is made pursuant to 5 U.S.C. 553(d)(3).

Information collection requirements contained in this regulation have been approved by the Office of Management and Budget and have been assigned OMB control number 1215–0160.

Classification—Executive Order 12291

These interim final rules only implement the amendments to the Longshore Act and make certain technical corrections to the regulations as previously promulgated. They do not, in themselves, impose any additional requirements. Therefore, this is not classified as a "major rule" under Executive Order 12291 on Federal Regulations, because it is not likely to result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in cost or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets. Accordingly, no regulatory impact analysis is required.

Regulatory Flexibility Act

The Department believes that the rule will have no "significant economic impact upon a substantial number of small entities" within the meaning of section 3(a) of the Regulatory Flexibility Act, Pub. L. 96–354, 91 Stat. 1164 (5 U.S.C. 605(b)). The Secretary has certified to the Chief Counsel for Advocacy of the Small Business Administration to this effect. This conclusion is reached because the amendments are only implementing the 1984 amendments to the Longshore Act and they do not, in themselves, impose any additional requirements upon small entities.

On the contrary, these regulations implement those amendments which exclude many small entities from coverage under the Longshore Act, establish procedures whereby some small entities may seek an exemption from the statute, and eliminate the reporting requirements for all employers in cases of no lost time injuries. Accordingly, no regulatory impact analysis is required.

List of Subjects

20 CFR Part 701

Longshoremen, Workers' compensation.

20 CFR Part 702

Administrative practice and procedure, Claims, Insurance, Longshoremen, Vocational rehabilitation, and Workers' compensation.

20 CFR Part 703

Insurance, Longshoremen, Workers' compensation.

Accordingly, 20 CFR parts 701, 702 and 703 are amended as set forth below.

1. The citation of authorities for Parts 701, 702 and 703, are revised to read as follows:

Authority: 5 U.S.C. 301; Reorg. Plan No. 6 of 1950, 15 FR 3174, 64 Stat. 1263; 83 U.S.C. 939; 36 D.C. Code 501 et seq.; 42 U.S.C. 1651 et seq.; 43 U.S.C. 1331; 5 U.S.C. 8171, et seq.; Secretary's Order 6–84, 49 FR 32473; Employment Standards Order 78–1, 43 FR 51469.

PART 701—GENERAL; ADMINISTERING AGENCY DEFINITIONS AND USE OF TERMS

2. Section 701.101 is revised to read as follows:

Rules in This Subchapter

§ 701.101 Scope of this subchapter and Subchapter B.

(a) This subchapter contains the regulations governing the administration of the Longshore and Harbor Workers' Compensation Act (LHWCA) and its direct extensions, the Defense Base Act (DBA), the Outer Continental Shelf Lands Act (OCSLA), and the Nonappropriated Fund Instrumentalities Act (NFLA), and such other amendments and extensions as may hereinafter be enacted.

(b) The regulations also apply to claims filed under the District of Columbia Workmen's Compensation Act (DCCA). That law applies to injuries or deaths sustained prior to July 26, 1982, the effective date of the District of Columbia Workers' Compensation Act.

(c) The regulations governing administration of the Black Lung Benefits Program are in Subchapter B of this chapter.

3. Section 701.201 and the center heading preceding it are revised to read as follows:

Office of Workers' Compensation Programs

§701.201 Establishment of Office of Workers' Compensation Programs.

The Assistant Secretary of Labor for Employment Standards, by authority vested in him or her by the Secretary of Labor in Secretary's Order No 6–84, 49 FR 32473, established in the Employment Standards Administration (ESA) an Office of Workers' Compensation Programs (OWCP). The Assistant Secretary further designated as the head thereof a Director, who shall administer the programs assigned to that office by the Assistant Secretary. By Secretary's order 81–1, the position of Deputy Under Secretary for Employment Standards was established to replace the position of Assistant Secretary for Employment Standards and all authority previously transferred to that position was transferred to the Deputy Under Secretary.

4. The introductory text and paragraphs (a) and (f) of § 701.202 are revised to read as follows:

§ 701.202 Transfer of functions.

Pursuant to the authority vested in him or her by the Secretary of Labor (which was by Secretary's order 81–1 transferred to the position of Deputy Under Secretary for Employment Standards), the Assistant Secretary for Employment Standards transferred from the Bureau of Employees' Compensation to the Office of Workers' Compensation Programs all functions of the Department of Labor with respect to the administration of benefits programs under the following statutes:

(a) The Longshore and Harbor Workers' Compensation Act, as amended and extended, 33 U.S.C. 901 et seq.;

* * * * *

(f) Title IV of the Federal Mine Safety and Health Act of 1977, as amended, 30 U.S.C. 901 et seq.

§ 701.301 [Amended]

5. In § 701.301, paragraph (a)(4) is removed and reserved.

6. Section 701.301(a)(12) is revised to read as follows:

Terms Used in This Subchapter

§ 701.301 Definitions and use of terms.

(a) * * *

(12)(i) "Employee" means any person engaged in maritime employment, including:

(A) Any longshore worker or other person engaged in longshoring operations;

(B) Any harbor worker, including a ship repairer, shipbuilder and shipbreaker;

(C) Any other individual to whom an injury may be the basis for a compensation claim under the LHWCA as amended, or any of its extensions;

(ii) The term does not include:

(A) A master or member of a crew of any vessel;

(B) Any person engaged by a master to load or unload or repair any small vessel under eighteen tons net.

(iii) Nor does this term include the following individuals where it is first determined that they are covered by a state workers' compensation act:

(A) Individuals employed exclusively to perform office clerical, secretarial, security, or data processing work (but not longshore cargo checkers and cargo clerks);

(B) Individuals employed by a club (meaning a social or fraternal organization whether profit or nonprofit), camp, recreational operation (including recreational scuba diving and any commerical rafting or canoeing expeditions upon the navigable waters of the United States), restaurant, museum or retail outlet, whether or not over the navigable waters of the United States;

(C) Individuals employed by a marina, provided they are not engaged in its construction, replacement or expansion, except for routine maintenance such as cleaning, painting, trash removal, housekeeping and small repairs;

(D) Employees of suppliers, vendors and transporters temporarily doing business on the premises of a covered employer, provided they are not performing work normally performed by employees of the covered employer;

(E) Aquaculture workers, meaning those employed by commercial enterprises involved in the controlled cultivation and harvest of aquatic plants and animals, including the cleaning, processing or canning of fish and fish products, the cultivation and harvesting of shellfish, and the controlled growing and harvesting of other acquatic species;

(F) Individuals engaged in the building, repairing or dismantling of recreational vessels under 65 feet in length. For purposes of this subparagraph "length" means a straight line measurement of the overall length from the foremost part of the vessel to the aftmost part of the vessel, measured parallel to the center line. The measurement shall be from end to end over the deck, excluding sheer.

7. In Part 701, a new center heading and § 701.401 are added to read as follows:

Coverage Under State Compensation Programs

§ 701.401 Coverage under state compensation programs.

(a) Exclusions from the definition of "employee" under § 701.301(a)(12), and the employees of small vessel facilities otherwise covered which are exempted from coverage under § 702.171, are dependent upon coverage under a state workers' compensation program. For these purposes, a worker or dependent must first claim compensation under the appropriate state program and receive a final decision on the merits of the claim, denying coverage, before any claim may be filed under this Act.

(b) The intent of the Act is that state law will apply to those categories of employees if it otherwise would. Accordingly, not withstanding any contrary state law, claims by any of the categories of workers excluded under § 701.301 or 702.171 must be made to and processed by the state and a merit decision denying coverage on jurisdictional grounds must be made before coverage or benefits under the Act may be sought.

(c) The time for filing notice and claim under the Act (see Subpart B of Part 702) does not begin to run for purposes of claims by those workers or dependents described in § 701.301(a)(12) and § 702.171, until a final adverse decision denying coverage under a state compensation act is received.

PART 702—ADMINISTRATION AND PROCEDURE

7a. The table of contents for Part 702 is revised to read as follows:

8. In § 702.111 a new sentence and OMB control number are added after the last sentence to read as follows:

§ 702.111 Employer's records.

* * * * *

Records required by this section shall be retained by the employer for three years following the date of injury; this applies to records for lost-time and no-lost-time injuries.

(Approved by the Office of Management and Budget under control number 1215-0160.)

9. In § 702.131, designate the existing paragraph as paragraph (a) and add the following paragraphs (b) and (c):

§ 702.131 Representation of parties in interest.

* * * * *

(b) The Secretary shall annually publish a list of individuals who are disqualified from representing claimants under the Act. Individuals on this list are not authorized to represent claimants under the Act subject to the provision of section 31(b)(2)(C) of the Act, 33 U.S.C. 931(b)(2)(C), and they shall not have their representation fee approved as provided in section 28(e), 33 U.S.C. 928(e).

(c) Individuals shall be included on the list mentioned in (b) if the Secretary determines, after proceedings under §§ 702.432(b) through 702.434, that such individual:

(1) Has been convicted (without regard to pending appeal) of any crime in connection with the representation of a claimant under this Act or any workers' compensation statute;

(2) Has engaged in fraud in connection with the presentation of a claim under this or any workers' compensation statute, including, but not limited to, knowingly making false representations, concealing or attempting to conceal material facts with respect to a claim, or soliciting or otherwise procuring false testimony;

(3) Has been prohibited from representing claimants before any other workers' compensation agency for reasons of professional misconduct which are similar in nature to those which would be grounds for disqualification under this section; or

(4) Has accepted fees for representing claimants under the Act which were not approved, or which were in excess of the amount approved pursuant to section 28 of the Act, 33 U.S.C. 928.

10. § 702.132 is revised to read as follows:

§ 702.132 Fees for services.

(a) Any person seeking a fee for services performed on behalf of a claimant with respect to claims filed under the Act shall make application therefor to the deputy commissioner, administrative law judge, Board, or court, as the case may be, before whom the services were performed (See 33 U.S.C. 928(c)). The application shall be filed and serviced upon the other parties within the time limits specified by such deputy commissioner, administrative law judge, Board, or court. The application shall be supported by a complete statement of the extent and character of the necessary work done, described with particularity as to the professional status (e.g., attorney, paralegal, law clerk, or other person assisting an attorney) of each person performing such work, the normal billing rate for each such person, and the hours devoted by each such person to each category of work. Any fee approved shall be reasonably commensurate with the necessary work done and shall take into account the quality of the representation, the complexity of the legal issues involved, and the amount of benefits awarded, and when the fee is to be assessed against the claimant, shall also take into account the financial circumstances of the claimant. No contract pertaining to the amount of a fee shall be recognized.

(b) No fee shall be approved for a representative whose name appears on the Secretary's list of disqualified representatives under § 702.131(b).

(c) Where fees are included in a settlement agreement submitted under § 702.241, et seq. approval of that agreement shall be deemed approval of attorney fees for purposes of this subsection for work performed before the Administrative Law Judge or deputy commissioner approving the settlement.

§ 702.141 [Removed]

11. § 702.141 is removed.

§ 702.142 [Amended]

12. 20 CFR § 702.142 is amended by removing the word "wife" wherever it appears and inserting in its place the word "spouse".

13. § 702.145(b) is revised to read as follows:

§ 702.145 Use of the special fund.

* * * * *

(b) Under section 8(f) of the Act (Second Injuries), In any case in which an employee having an existing permanent partial disability suffers injury, the employer shall provide compensation for such disability as is found to be attributable to that injury based upon the average weekly wages of the employee at the time of injury. If, following an injury falling within the provisions of section 8(c)(1)–(20), the employee with the pre-existing permanent partial disability becomes permanently and totally disabled after the second injury, but such total disability is found not to be due solely to his second injury, the employer (or carrier) shall be liable for compensation as provided by the provisions of section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20) or for 104 weeks, whichever is greater. However, if the injury is a loss of hearing covered by section 8(c)(13), 33 U.S.C. 908(c)(13), the liability shall be the lesser of these periods. In all other cases of a second injury causing permanent total disability (or death), wherein it is found that such disability (or death) is not due solely to the second injury, and wherein the employee had a pre-existing permanent partial disability, the employer (or carrier) shall first pay compensation under section 8 (b) or (e) of the Act, 33 U.S.C. 908 (b) or (e), if any is payable thereunder, and shall then pay 104 weeks compensation for such total disability or death, and none otherwise. If the second injury results in permanent partial disability, and if such disability is compensable under section 8(c)(1)–(20) of the Act, 33 U.S.C. 908(c)(1)–(20), but the disability so compensable did not result solely from such second injury, and the disability so compensable is materially and substantially greater than that which would have resulted from the second injury alone, then the employer (or carrier) shall only be liable for the amount of compensation provided for in section 8(c)(1)–(20) that is attributable to such second injury, or for 104 weeks, whichever is greater. In all other cases wherein the employee is permanently and partially disabled following a second injury, and wherein such disability is not attributable solely to that second injury, and wherein such disability is materially and substantially greater than that which would have resulted from the second injury alone, and wherein such disability following the second injury is not compensable under section 8(c)(1)–(20) of the Act, then the employer (or carrier) shall be liable for such compensation as may be appropriate under section 8 (b) or (e) of the Act, 33 U.S.C. 908 (b) or (e), if any, to be followed by a payment of compensation for 104 weeks, and none other. The term "compensation" herein means money benefits only, and does not include medical benefits. The procedure for determining the extent of the employer's (or carrier's) liability under this paragraph shall be as provided for in the adjudication of claims in Subpart C of this Part 702. Thereafter, upon cessation of payments which the employer is requred to make under this paragraph, if any additional compensation is payable in the case, the deputy commissioner shall forward such case to the Director for consideration of an award to the person or persons entitled thereto out of the special fund. Any such award from the special fund shall be by order of the Director or Acting Director.

* * * * *

14. In § 702.146 paragraph (a) and (c) are revised to read as follows:

§ 702.146 Source of the special fund.

(a) All amounts collected as fines and penalties under the several provisions of the Act shall be paid into the special fund (33 U.S.C. 44(c)(3)).

* * * * *

(c) The Director annually shall assess an amount against insurance carriers and self-insured employers authorized under the Act and Part 703 of this subchapter to replenish the fund. That total amount to be charged all carriers and self-insurers to be assessed shall be based upon an estimate of the probable expenses of the fund during the calendar year. The assessment against each carrier and self-insurer shall be based upon (1) the ratio of the amount each paid during the prior calendar year for compensation and medical benefits, in relation to the amount all such carriers of self-insurers paid during that period for compensation and medical benefits, and (2) the ratio of the amount of payments made by the special fund for all cases being paid under section 8(f) of the Act, 33 U.S.C. 908(f), during the preceding calendar year which are attributable to the carrier or self-insurer in relation to the total of such payments during such year attributable to all carriers and self-insurers. The resulting sum of the percentages from paragraphs (c) (1) and (2) of this section will be divided by two, and the resulting percentage multiplied by the probable expenses of the fund. The Director may, in his or her discretion, condition continuance or renewal of authorization under Part 703 upon prompt payment of the assessment. However, no action suspending or revoking such authorization shall be taken without affording such carrier or self-insurer a hearing before the Director or his/her designee.

15. § 702.147 is amended by revising paragraph (a) and adding a new paragraph (c) and OMB control number to read as follows:

§ 702.147 Enforcement of special fund provisions.

(a) As provided in section 44(d)(1) of the Act, 33 U.S.C. 944(d)(1), for the purpose of making rules, regulations, and determinations under the special fund provisions in section 44 and for providing enforcement thereof, the Director may investigate and gather appropriate data from each carrier and self-insured employer, and may enter and inspect such places and records (and make such transcriptions of records), question such employees, and investigate such facts, conditions, practices, or other matters as he may deem necessary or appropriate. The Director may require the employer to have audits performed of claims activity relating to this Act. The Director may also require detailed reports of payments made under the Act, and of estimated future liabilities under the Act, from any or all carriers of self-insurers. The Director may require that such reports be certified and verified in whatever manner is considered appropriate.

* * * * *

(c) Civil penalties and unpaid assessments shall be collected by civil suits brought by and in the name of the Secretary.

(Approved by the Office of Management and Budget under control number 1215-0160.)

16. In § 702.148 the existing paragraph is designated as paragraph (a) and paragraphs (b) and (c) are added to read as follows:

§ 702.148 Insurance carriers' and self-insured employers' responsibilities.

(a) * * *

(b) Consistent with their greater direct liability stemming from the amended assessment formula, employers and insurance carriers are given the authority to monitor their claims in the special fund as outlined in paragraph (c) of this section. For purposes of monitoring these claims, employers and insurance carriers remain parties in interest to the claim and are allowed access to all records relating to the claim. Similarly, employers and insurance carriers can initiate proceeding to modify an award of compensation after the special fund has assumed the liability to pay benefits. It is intended that employers and insurance carriers have neither a greater nor a lesser responsibility in this new role that they not have with regard to cases that remain their sole liability. (See § 702.373(d).)

(c) An employer or insurance carrier may conduct any reasonable investigation regarding cases placed into the special fund by the employer or insurance carrier. Such investigation may include, but shall not be limited to, a semi-annual request for earnings information pursuant to section 8(j) of the Act, 33 U.S.C. 908(j) (See § 702.285) periodic medical examinations, vocational rehabilitation evaluations, and requests for any additional information needed to effectively monitor such a case.

17. Section 702.161 is revised to read as follows:

§ 702.161 Liens against assets of insurance carriers and employers.

Where payments have been made from the special fund pursuant to section 18(b) of the Act, 33 U.S.C. 918(b) and § 704.145(f) the Secretary of Labor shall, for the benefit of the fund, be subrogated to all the rights of the person receiving such payments. The Secretary may institute proceedings under either section 18 or 21(d) of the Act, 33 U.S.C. 918 or 921(d), or both, to recover the amount expended by the fund or so much as in the judgement of the Secretary is possible, or the Secretary may settle or compromise any such claim.

18. 20 CFR 702.162(a), (f), (h)–(j) are revised and an OMB control number is added to the section to read as follows:

§ 702.162 Liens on compensation authorized under special circumstances.

(a) Pursuant to section 179(b) of the Act, 33 U.S.C. 917(b), when a trust fund which complies with section 302(c) of the Labor-Management Relations Act of 1947, 29 U.S.C. 186(c) [LMRA], established pursuant to a collective bargaining agreement in effect between an employer and an employee entitled to compensation under this Act, has paid disability benefits to an employee which the employee is legally obligated to repay by reason of his entitlement to compensation under this Act, a lien shall be authorized on such compensation in favor of the trust fund for the amount of such payments.

* * * * *

(f) If the administrative law judge issues a compensation order in favor of the claimant, such order shall establish a lien in favor of the trust fund if it is determined that the trust fund has satisfied all of the requirements of the Act and regulations.

* * * * *

(h) In the event that either the deputy commissioner or the administrative law judge is not satisfied that the trust fund qualifies for a lien under section 17(b), the deputy commissioner or administrative law judge may require further evidence including but not limited to the production of the collective bargaining agreement, trust agreement or portions thereof.

(i) Before any such lien is approved, if the trust fund has provided continued disability payments after the application for a lien has been filed, the trust fund shall submit a further certified statement showing the total amount paid to the claimant as disability payments. The claimant shall likewise be given an

opportunity to contest the amount alleged in this subsequent statement.

(j) In approving a lien on compensation, the deputy commissioner or administrative law judge shall not order an initial payment to the trust fund in excess of the amount of the past due compensation. The remaining amount to which the trust fund is entitled shall thereafter be deducted from the affected employee's subsequent compensation payments and paid to the trust fund, but any such payment to the trust fund shall not exceed 10 percent of the claimant-employee's bi-weekly compensation payments.

(Approved by the Office of Management and Budget under control number 1215-0160.)

19. In Part 702, new center heading and §§ 702.171 through 702.175 are added to subpart A to read as follows:

Certification of Exemption

§ 702.171 Certification of exemption, general.

An employer may apply to the Director or his/her designee to certify a particular facility as one engaged in the building, repairing or dismantling of exclusively small vessels, as defined. Once certified, injuries sustained at that facility would not be covered under the Act except for injuries which occur over the navigable waters of the United States including any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels. A facility otherwise covered under the Act remains covered until certification of exemption is issued; a certification will be granted only upon submission of a complete application (described in § 702.174), and only for as long as a facility meets the requirements detailed in section 3(d) of the Act, 33 U.S.C. 903(d). This exemption from coverage is not intended to be used by employers whose facilities from time to time may temporarily meet the criteria for qualification but only for facilities which work on exclusively small vessels, as defined.

§ 702.172 Certification; definitions.

For purposes of §§ 702.171 through 702.175 dealing with certification of small vessel facilities, the following definitions are applicable.

(a)(1) "Small vessel" means only those vessels described in section 3(d)(3) of the Act, 33 U.S.C. 903(d)(3), that is:

(i) A commercial barge which is under 900 lightship displacement tons (long); or

(ii) A commercial tugboat, towboat, crewboat, supply boat, fishing vessel or other work vessel which is under 1,600 tons gross.

(2) For these purposes: (i) One gross ton equals 100 cubic feet, as measured by the current formula contained in the Act of May 6, 1984 as amended through 1974 (46 U.S.C. 77); (ii) one long ton equals 2,240 lbs; and (iii) "Commercial" as it applies to "vessel" means any vessel engaged in commerce but does not include among other types military supply boats, patrol boats, utility vessels, ferries, Corps of Engineers dredges, pressure barges or Coast Guard vessels.

(b) "Federal Maritime Subsidy" means the construction differential subsidy (CDS) or operating differential subsidy under the Merchant Marine Act of 1936 (46 U.S.C. 1101 et seq.).

(c) "facility" means an operation of an employer at a particular contiguous geographic location.

§ 702.173 Exemptions; requirements, limitations.

(a) Injuries at a facility otherwise covered by the Act are exempted only upon certification that the facility is: (1) Engaged in the building, repairing or dismantling of exclusively small commercial vessels; and (2) does not receive a Federal maritime subsidy.

(b) The exemption does not apply to: (1) Injuries at any facility which occur over the navigable waters of the United States or upon any adjoining pier, wharf, dock, facility over land for launching vessels or for hauling, lifting or drydocking vessels; or (2) where the employee at such facility is not subject to a state workers' compensation law.

§ 702.174 Exemptions; necessary information.

(a) *Application.* Before any facility is exempt from coverage under the Act, the facility must apply for and receive a certificate of exemption from the Director or his/her designee. The application must be made by the owner of the facility; where the owner is a partnership it shall be made by a partner and where a corporation by an officer of the corporation or the manager in charge of the facility for which an exemption is sought. The information submitted shall include the following:

(1) Name, location, physical description of the facility for which an exemption is sought.

(2) Description of the nature of the business.

(3) An affidavit (signed by a partner if the facility is owned by a partnership or an officer if owned by a corporation) verifying and/or acknowledging that:

(i) the facility is, as of the date of the application, engaged in the business of building, repairing or dismantling exclusively small commercial vessels and that it does not then nor foreseeably will it engage in the building, repairing or dismantling of other than small vessels.

(ii) The facility does not receive any Federal maritime subsidy.

(iii) The signator has the duty to immediately inform the deputy commissioner of any change in these or other conditions likely to result in a termination of an exemption.

(iv) the employer has secured appropriate compensation liability under a state workers' compensation law.

(v) Any false, relevant statements relating to the application or the failure to notify the deputy commissioner of any changes in circumstances likely to result in termination of the exemption will be grounds for revocation of the exemption certificate and will subject the employer to all provisions of the Act, including all duties, responsibilities and penalties, retroactive to the date of application or date of change in circumstances, as appropriate.

(b) *Action by the Director.* The Director or his/her designee shall review the application within thirty (30) days of its receipt.

(1) Where the application is complete and shows that all requirements under § 702.173 are met, the Director shall promptly notify the employer by certified mail, return receipt requested, that certification has been approved and will be effective on the date specified. The employer is required to post notice of the exemption at a conspicuous location.

(2) Where the application is incomplete or does not substantiate that all requirements of section 3(d) of the Act, 33 U.S.C. 903(d), have been met, or evidence shows the facility is not eligible for exemption, the Director shall issue a letter which details the reasons for the deficiency or the rejection. The employer/applicant may reapply for certification, correcting deficiencies and/or responding to the reasons for the Director's denial. The Director or his/her designee shall issue a new decision within a reasonable time of reapplication following denial. Such action will be the final administrative review and is not appealable to the Administrative Law Judge or the Benefits Review Board.

(c) The Director or another designated individual at any time has the right to enter on and inspect any facility seeking exemption for purposes of verifying information provided on the application form.

(d) *Action by the employer.* Immediately upon receipt of the

certificate of exemption from coverage under the Act the employer shall post:

(1) A general notice in a conspicuous place that the Act does not cover injuries sustained at the facility in question, the basis of the exemption, the effective date of the exemption and grounds for termination of the exemption.

(2) A notice, where applicable, along the entrances to all areas to which the exemption does not apply.

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.175 Effect of work on excluded vessels; reinstatement of certification.

(a) When a vessel other than a small commercial vessel, as defined in § 702.172, enters a facility which has been certified as exempt from coverage, the exemption shall automatically terminate as of the date such a vessel enters the facility. The exemption shall also terminate on the date a contract for a Federal maritime subsidy is entered into. All duties, obligations and requirements imposed by the Act, including the duty to secure compensation liability as required by sections 4 and 32 of the Act, 33 U.S.C. 904 and 932, and to keep records and forward reports, are effective immediately. The employer shall notify the Director or his/her designee immediately where this occurs.

(b) Where an exemption certification is terminated because of circumstances described in (a), the employer may apply for reinstatement of the exemption once the event resulting in termination of the exemption ends. The reapplication shall consist of a reaffirmation of the nature of the business, an explanation of the circumstances leading to the termination of exemption, and an affidavit by the appropriate person affirming that the circumstances prompting the termination no longer exists nor will they reoccur in the forseeable future and that the facility is engaged in building, repairing or dismantling exclusively small vessels. The Director or the Director's designee shall respond to the complete reapplication within ten working days of receipt.

20. In § 702.201, the existing paragraph is designated as paragraph (a) and the following new paragraph (b) and OMB control number are added to read as follows:

§ 702.201 Reports from employers of employee's injury or death.

* * * * *

(b) No report shall be filed unless the injury causes the employee to lose one or more shifts from work. However, the employer shall keep a record containing the information specified in § 702.202.

(Approved by the Office of Management and Budget under control number 1215-0160.)

21. Section 702.204 is revised to read as follows:

§ 702.204 Employer's report; penalty for failure to furnish and/or falsifying.

Any employer, insurance carrier, or self-insured employer who knowingly and willingly fails or refuses to send any report required by § 702.201, or who knowingly and willfully makes a false statement or misrepresentation in any report, shall be subject to a civil penalty not to exceed $10,000 for each such failure, refusal, false statement or misrepresentation.

§ 702.205 [Amended]

22. In § 702.205 is amended by deleting the reference to § 702.212 and replacing it with § 702.221.

23. The following redesignations and amendments are made to §§ 702.206 through 702.216:

a. Sections 702.212 through 702.216 are redesignated as §§ 702.221 through 702.225 respectively; new §§ 702.221 and 702.222 are revised to read as set forth below, and new § 702.223 is amended by revising the reference to "§ 702.212" to read "§ 702.221."

b. Section 702.211 is redesignated as new § 702.216 and revised to read as set forth below.

c. Sections 702.206 through 702.210 are redesignated as §§ 702.211 through 702.215 and new §§ 702.211, 702.212, and 702.215 are revised to read as set forth below.

d. A new § 702.217 is added to read as set forth below.

The revised and added sections described above read as follows:

Notice

§ 702.211 Notice of employee's injury or death; designation of responsible official.

(a) In order to claim compensation under the Act, an employee or claimant must first give notice of the fact of an injury or death to the employer and also may give notice to the deputy commissioner for the compensation district in which the injury or death occurred. Notice to the employer must be given to that individual whom the employer has designated to receive such notices. If no individual has been so designated notice may be given to: (1) The first line supervisor (including foreman, hatchboss or timekeeper), local plant manager or personnel office official; (2) to any partner if the employer is a partnership; or (3) if the employer is a corporation, to any authorized agent, to an officer or to the person in charge of the business at the place where the injury occurred. In the case of a retired employee, the employee/claimant may submit the notice to any of the above persons, whether or not the employer has designated an official to receive such notice.

(b) In order to facilitate the filing of notices, each employer shall designate an individual responsible for receiving notices of injury or death; this requirement applies to all employers. The designation shall be by position and the employer shall provide the name and/or position, exact location and telephone number of the individual to all employees by the appropriate method described below.

(1) *Type of individual.* Designees must be a first line supervisor (including a foreman, hatchboss or timekeeper), local plant manager or personnel office official who is located full-time on the premises of the covered facility. The employer must designate one individual at each place of employment or one individual for each work crew where there is no fixed place of employment (in that case, the designation should always be the same position for all work crews).

(2) *How designated.* The name and/or title, the location and telephone number of the individual who is selected by the employer to receive all notices shall be given to the deputy commissioner for the compensation district in which the facility is located; posting on the worksite in a conspicuous place shall fulfill this requirement. A redesignation shall be effected by a change in posting.

(3) *Publication.* Every employer shall post the name and/or position, the exact location and telephone number of the designated official. The posting shall be part of the general posting requirement, done on a form prescribed by the Director, and placed in a conspicuous location. Posting must be done at each worksite.

(4) *Effect of failure to designate.* Where an employer fails to properly designate and to properly publish the name and/or position of the individual authorized to receive notices of injury or death, failure of any employee/claimant to give timely notice shall not bar any claim for compensation.

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.212 Notice; when given; when given for certain occupational diseases.

(a) For other than occupational diseases described in (b), the employee must give notice within thirty (30) days

of the date of the injury or death. For this purpose the date of injury or death is:

(1) The day on which a traumatic injury occurs;

(2) The date on which the employee or claimant is or by the exercise of reasonable diligence or by reason of medical advice, should have been aware of a relationship between the injury or death and the employment; or

(3) In the case of claims for loss of hearing under section 8(c)(13) of the Act, 33 U.S.C. 908(c)(13), the date the employee receives an audiogram, with the accompanying report which indicates the employee has suffered a loss of hearing. (See § 702.441).

(b) In the case of an occupational disease which does not immediately result in disability or death, notice must be given within one year after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware, of the relationship between the employment, the disease and the death or disability. For purposes of these occupational diseases, therefore, the notice period does not begin to run until the employee is disabled, or in the case of a retired employee, until a permanent impairment exists.

(c) For purposes of workers whose coverage under this Act is dependent on denial of coverage under a state compensation program, as described in § 701.401, the time limitations set forth above do not begin to run until a final decision denying state coverage is issued under the state compensation act.

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.215 Notice; how given.

Notice shall be effected by delivering it—by hand or by mail at the address posted by the employer—to the individual designated to receive such notices. Notice when given to the deputy commissioner, may be by hand or by mail on a form supplied by the Secretary, or orally in person or by telephone.

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.216 Effect of failure to give notice.

Failure to give timely notice to the employer's designated official shall not bar any claim for compensation if: (a) The employer, carrier, or designated official had actual knowledge of the injury or death; and (b) the deputy commissioner or ALJ determines the employer or carrier has not been prejudiced; or (c) the deputy commissioner excuses failure to file notice. For purposes of this subsection, actual knowledge shall be deemed to exist if the employee's immediate supervisor was aware of the injury and/or in the case of a hearing loss, where the employer has furnished to the employee an audiogram and report which indicates a loss of hearing. Failure to give notice shall be excused by the deputy commissioner if: a) notice, while not given to the designated official, was given to an official of the employer or carrier, and no prejudice resulted; or b) for some other satisfactory reason, notice could not be given. Failure to properly designate and post the individual so designated shall be considered a satisfactory reason. In any event, such defense to a claim must be raised by the employer/carrier at the first hearing on the claim.

§ 702.217 Penalty for false statement, misrepresentation.

(a) Any claimant or representative of a claimant who knowingly and willfully makes a false statement or representation for the purpose of obtaining a benefit or payment under this Act shall be guilty of a felony, and on conviction thereof shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or by both.

(b) Any person including, but not limited to, an employer, its duly authorized agent or an employee of an insurance carrier, who knowingly and willingly makes a false statement or representation for the purpose of reducing, denying or terminating benefits to an injured employee, or his dependents pursuant to section 9, 33 U.S.C. 909, if the injury results in death, shall be punished by a fine not to exceed $10,000, by imprisonment not to exceed five years, or both.

Claims

§ 702.221 Claims for compensation; time limitations.

(a) Claims for compensation for disability or death shall be in writing and filed with the deputy commissioner for the compensation district in which the injury or death occurred. Claims may be filed anytime after the seventh day of disability or anytime following the death of the employee. Except as provided below, the right to compensation is barred unless a claim is filed within one year of the injury or death, or (where payment is made without an award) within one year of the date on which the last compensation payment was made.

(b) In the case of a hearing loss claim, the time for filing a claim does not begin to run until the employee receives an audiogram with the accompanying report which indicates the employee has sustained a hearing loss. (See § 702.441).

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.222 Claims; exceptions to time limitations.

(a) Where a person entitled to compensation under the Act is mentally incompetent or a minor, the time limitation provision of § 702.221 shall not apply to a mentally incompetent person so long as such person has no guardian or other authorized representative, but § 702.221 shall be applicable from the date of appointment of such guardian or other representative. In the case of minor who has no guardian before he or she becomes of age, time begins to run from the date he or she becomes of age.

(b) Where a person brings a suit at law or in admiralty to recover damages in respect of an injury or death, or files a claim under a state workers' compensation act because such person is excluded from this Act's coverage by reason of section 2(3) or 3(d) of the Act (33 U.S.C. 902(3) or 903(d)), and recovery is denied because the person was an employee and defendant was an employer within the meaning of the Act, and such employer had secured compensation to such employee under the Act, the time limitation in § 702.221 shall not begin to run until the date of termination of such suit or proceeding.

(c) Notwithstanding the provisions in paragraph (a) of this section, where the claim is one based on disability or death due to an occupational disease which does not immediately result in death or disability, it must be filed within two years after the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice, should have been aware of the relationship between the employment, the disease and the death or disability, or within one year of the date of last payment of compensation, whichever is later. For purposes of occupational disease, therefore, the time limitation for filing a claim does not begin to run until the employee is disabled, or in the case of a retired employee, where a permanent impairment exists.

(d) The time limitations set forth above do not apply to claims filed under section 49 of the Act, 33 U.S.C. 949.

(Approved by the Office of Management and Budget under control number 1215-0160.)

24. Section 702.231 is revised to read as follows:

§ 702.231 Noncontroverted claims; payment of compensation without an award.

Unless the employer controverts its liability to pay compensation under this Act, the employer or insurance carrier shall pay periodically, promptly and directly to the person entitled thereto benefits prescribed by the Act. For this purpose, where the employer furnishes to an employee a copy of an audiogram with a report thereon, which indicates the employee has sustained a hearing loss causally related to factors of that employment, the employer or insurance carrier shall pay appropriate compensation or at that time controvert the liability to pay compensation under this Act.

25. Section 702.232 is revised to read as follows:

§ 702.232 Payments without an award; when; how paid.

The first installment of compensation shall become due by the fourteenth (14th) day after the employer has been notified, through the designated official or by any other means described in § 702.211 et seq., or has actual knowledge of the injury or death. All compensation due on that fourteenth (14th) day shall be paid then and appropriate compensation due thereafter must be paid in semi-monthly installments, unless the deputy commissioner determines otherwise.

§ 702.235 [Amended]

26. In § 702.235, paragraph (b)(3) is removed and paragraphs (4) and (5) are redesignated as (3) and (4), respectively.

27. By revising § 702.241 and § 702.242 to read as follows:

§ 702.241 Definitions and supplementary information.

(a) As used hereinafter, the term "adjudicator" shall mean deputy commissioner or administrative law judge (ALJ).

(b) If a settlement application is submitted to an adjudicator and the case is pending at the Office of Administrative Law Judges, the Benefits Review Board, or any Federal circuit court of appeals, the parties may request that the case be remanded to the adjudicator for consideration of the application. The thirty day period as described in paragraph (f) of this section begins when the remanded case is received by the adjudicator.

(c) If a settlement application is first submitted to an ALJ, the thirty day period mentioned in paragraph (f) of this section does not begin until five days before the date the formal hearing is set. Where a case is pending before the ALJ but not set for a hearing, the parties may request the case be remanded to the deputy commissioner for consideration of the settlement.

(d) A settlement agreement between parties represented by counsel, which is deemed approved when not disapproved within thirty days, as described in paragraph (f) of this section, shall be considered to have been filed in the office of the deputy commissioner on the thirtieth day for purposes of sections 14 and 21 of the Act, 33 U.S.C. 914 and 921.

(e) A fee for representation which is included in an agreement that is approved in the manner described in paragraph (d) of this section, shall also be considered approved within the meaning of section 28(e) of the Act, 33 U.S.C. 928(e).

(f) The thirty day period for consideration of a settlement agreement shall be calculated from the day after receipt unless the parties are advised otherwise by the adjudicator. (See § 702.243(b)). If the last day of this period is a holiday or occurs during a weekend, the next business day shall be considered the thirtieth day.

(g) An agreement among the parties to settle a claim is limited to the rights of the parties and to claims then in existence; settlement of disability compensation or medical benefits shall not be a settlement of survivor benefits nor shall the settlement affect, in any way, the right of survivors to file a claim for survivor's benefits.

(h) For purposes of this section and § 702.243 the term "counsel" means any attorney admitted to the bar of any state, territory or the District of Columbia.

§ 702.242 Information necessary for a complete settlement application.

(a) The settlement application shall be a self-sufficient document which can be evaluated without further reference to the administrative file. The application shall be in the form of a stipulation signed by all parties and shall contain a brief summary of the facts of the case to include: a description of the incident, a description of the nature of the injury to include the degree of impairment and/or disability, a description of the medical care rendered to date of settlement, and a summary of compensation paid and the compensation rate or, where benefits have not been paid, the claimant's average weekly wage.

(b) The settlement application shall contain the following:

(1) A full description of the terms of the settlement which clearly indicates, where appropriate, the amounts to be paid for compensation, medical benefits, survivor benefits and representative's fees which shall be itemized as required by § 702.132.

(2) The reason for the settlement, and the issues which are in dispute, if any.

(3) The claimant's date of birth and, in death claims, the names and birth dates of all dependents.

(4) Information on whether or not the claimant is working or is capable of working. This should include, but not be limited to, a description of the claimant's educational background and work history, as well as other factors which could impact, either favorably or unfavorably, on future employability.

(5) A current medical report which fully describes any injury related impairment as well as any unrelated conditions. This report shall indicate whether maximum medical improvement has been reached and whether further disability or medical treatment is anticipated. If the settlement is for medical benefits the medical report shall include an estimate of the claimant's need for future medical treatment. A medical report need not be submitted with agreements to settle survivor benefits unless the circumstances warrant it.

(6) A statement explaining how the settlement amount is considered adequate.

(7) If the settlement application covers medical benefits, an itemization of the amount paid for medical expenses by year for the three years prior to the date of the application. An estimate of the cost of future medical treatment shall also be submitted which indicates the inflation factor and/or the discount rate used, if any.

(8) Information on any collateral source available for the payment of medical expenses.

(Approved by the Office of Management and Budget under control number 1215–0160.)

28. In part 702, a new § 702.243 is added to read as follows:

§ 702.243 Settlement application; how submitted, how approved, how disapproved, criteria.

(a) When the parties to a claim for compensation, including survivor benefits and medical benefits, agree to a settlement they shall submit a complete application to the adjudicator. The application shall contain all the information outlined in § 702.242 and shall be sent by certified mail, return receipt requested, to the adjudicator. Failure to submit a complete application shall toll the thirty day period mentioned in section 8(i) of the Act, 33 U.S.C. 908(i), until a complete application is received by certified mail.

(b) The adjudicator shall consider the settlement application within thirty days and either approve or disapprove the application. The liability of an employer/insurance carrier is not discharged until the settlement is specifically approved by a compensation order issued by the adjudicator. However, if the parties are represented by counsel, the settlement shall be deemed approved unless specifically disapproved within thirty days after receipt of a complete application. This thirty day period does not begin until all the information described in § 702.242 has been submitted. The adjudicator shall examine the settlement application within thirty days and shall immediately serve by certified mail on all parties notice of any deficiency. This notice shall also indicate that the thirty day period will not commence until the deficiency is corrected.

(c) If the adjudicator disapproves a settlement application, the adjudicator shall serve on all parties a written statement or compensation order containing the reasons for disapproval. This statement shall be served by certified mail within thirty days of receipt of a complete application (as described in § 702.242) if the parties are represented by counsel. This disapproval may be appealed pursuant to sections 19 and 21 of the Act, 33 U.S.C. 919 and 921, or an amended application may be submitted to the adjudicator for reconsideration.

(d) The parties may submit a settlement application solely for compensation, or solely for medical benefits or for compensation and medical benefits combined.

(e) If either portion of a combined compensation and medical benefits settlement application is disapproved the entire application is disapproved unless the parties indicate on the face of the application that they agree to settle either portion independently.

(f) When presented with a settlement, the adjudicator shall review the application and determine whether, considering all of the circumstances, the amount is adequate. The criteria for determining the adequacy of the settlement application shall include, but not be limited to:

(1) The claimant's age, education and work history;

(2) The degree of the claimant's disability or impairment;

(3) The availability of the type of work the claimant can do;

(4) The probability of success if the case were to be formally litigated; and

(5) The cost and necessity of future medical treatment (where the settlement includes medical benefits).

(g) In cases being paid pursuant to a final compensation order, where no substantive issues are in dispute, a settlement amount which does not equal the present value of future compensation payments commuted, computed at five percent true discount compounded annually shall be considered inadequate unless the parties to the settlement show that the amount is adequate. The probability of the death of the beneficiary before the expiration of the period during which he or she is entitled to compensation shall be determined according to the most current United States Life Table, as developed by the United States Department of Health and Human Services, which shall be updated from time to time.

29. In § 702.271, paragraph (a) is revised to read as follows:

§ 702.271 Discrimination; against employees who bring proceedings, prohibition and penalty.

(a) No employer or its duly authorized agent may discharge or in any manner discriminate against an employee as to his/her employment because that employee: (1) has claimed or attempted to claim compensation under this Act; or (2) has testified or is about to testify in a proceeding under this Act; except that to discharge or refuse to employ a person who has been adjudicated to have filed a fraudulent claim for compensation or otherwise made a false statement or misrepresentation under section 31(a)(1) of the Act, 33 U.S.C. 931(a)(1) is not a violation of this section. Any employer who violates this section shall be liable to a penalty of not less than $1,000 or more than $5,000 to be paid (by the employer alone, and not by a carrier) to the deputy commissioner for deposit in the special fund described in section 44 of the Act, 33 U.S.C. 944; and shall restore that employee to his or her employment along with all wages lost due to the discrimination unless that employee has ceased to be qualified to perform the duties of the employment.

* * * * *

§ 702.281 [Amended]

30. Section 702.281 is amended by removing the last sentence ("Caution: see 33 U.S.C. 933(a)") and by adding a new paragraph (b) to read as follows:

(b) Where the claim or legal action instituted against a third party results in a settlement agreement which is for an amount less than the compensation to which a person would be entitled under this Act, the person (or the person's representative) must obtain the prior, written approval of the settlement from the employer and the employer's carrier before the settlement is executed. Failure to do so relieves the employer and/or carrier of liability for compensation described in section 33 of Act, 33 U.S.C. 933(f). The approval shall be on a form provided by the Director and filed, within thirty days after the settlement is entered into, with the deputy commissioner who has jurisdiction in the district where the injury occurred.

31. In Part 702, new §§ 702.285 and .286 are added to Subpart B to read as follows:

§ 702.285 Report of earnings.

(a) An employer, carrier or the Director (for those cases being paid from the Special Fund) may require an employee to whom it is paying compensation to submit a report on earnings from employment or self-employment. This report may not be required any more frequently than semi-annually. The report shall be made on a form prescribed by the Director and shall include all earnings from employment and self-employment and the periods for which the earnings apply. The employee must return the complete report on earnings even where he or she has no earnings to report.

(b) For these purposes the term "earnings" is defined as all monies received from any employment and includes but is not limited to wages, salaries, tips, sales commissions, fees for services provided, piecework and all revenue received from self-employment even if the business or enterprise operated at a loss of if the profits were reinvested.

(Approved by the Office of Management and Budget under control number 1215-0160.)

§ 702.286 Report of earnings; forfeiture of compensation.

(a) Any employee who fails to submit the report on earnings from employment or self-employment under § 702.285 or, who knowingly and willingly omits or understates any part of such earnings, shall upon a determination by the deputy commissioner forfeit all right to compensation with respect to any period during which the employee was required to file such a report. The employee must return the completed report on earnings (even where he or she reports no earnings) within thirty (30) days of the date of receipt; this period may be extended for good cause, by the deputy commissioner, in determining whether a violation of this requirement has occurred.

(b) Any employer or carrier who believes that a violation of paragraph (a) of this section has occurred may file a charge with the deputy commissioner. The allegation shall be accompanied by evidence which includes a copy of the report, with proof of service requesting the information from the employee and clearly stating the dates for which the employee was required to report income. Where the employer/carrier is alleging an omission or understatement of earnings, it shall, in addition, present evidence of earnings by the employee during that period, including copies of checks, affidavits from employers who paid the employee earnings, receipts of income from self-employment or any other evidence showing earnings not reported or underreported for the period in question. Where the deputy commissioner finds the evidence sufficient to support the charge he or she shall convene an informal conference as described in subpart C and shall issue a compensation order affiming or denying the charge and setting forth the amount of compensation for the specified period. If there is a conflict over any issue relating to this matter any party may request a formal hearing before an Administrative Law Judge as described in subpart C.

(c) Compensation forfeited under paragraph (b) of this section, if already paid, shall be recovered by a deduction from the compensation payable to the employee if any, on such schedule as determined by the deputy commissioner. The deputy commissioner's discretion in such cases extends only to rescheduling repayment by crediting future compensation and not to whether and in what amounts compensation is forfeited. For this purpose, the deputy commissioner shall consider the employee's essential expenses for living, income from whatever source, and assets, including cash, savings and checking accounts, stocks, bonds, and other securities.

32. Section 702.321 is added to Subpart C of Part 702 to read as follows:

§ 702.321 Procedures for determining applicability of Section 8(f) of the Act.

(a) *Application: filing, service, contents.* An employer or insurance carrier which seeks to invoke the provisions of section 8(f) of the Act, must request limitation of its liability, and file, in duplicate, with the deputy commissioner a fully documented application. The application shall specify with particularity the pre-existing condition relied upon as constituting an existing permanent partial disability. The application shall also state: (1) The reasons for believing that the claimant's permanent disability after the injury would be less were it not for the pre-existing permanent partial disability or that the death would not have ensued but for that disability; and (2) the basis for the assertion that the pre-existing disability relied upon was manifest to the employer before the employment injury. Documentary medical evidence relied upon in support of the request for section 8(f) relief shall also be submitted. This medical evidence shall include, but not be limited to, a current medical report establishing the extent of all impairments and the date of maximum medical improvement. If the current disability is less than total, the medical evidence must show that the disability is materially and substantially greater than that which would have resulted from the subsequent injury alone. If the injury is loss of hearing, the pre-existing hearing loss must be documented by an audiogram which complies with the requirements under § 702.441. Any additional evidence considered necessary by the Director shall also be submitted. If the claim is being paid by the special fund and the claimant dies, an employer need not reapply for section 8(f) relief. However, survivor benefits will not be paid until it has been established that the death was due to the accepted injury and the eligible survivors have been identified. The deputy commissioner will issue a compensation order once a claim for survivor benefits is filed and entitlement of the survivors to compensation has been verified. Since the employer remains a party in interest to the claim a compensation order will not be issued without the agreement of the employer.

(b) *Application: Time for filing.* A request for section 8(f) relief must be made on or before whichever of the following occurs first: (1) The date of the informal conference where the permanency of the claimant's condition is to be considered, or (2) the date when benefits are first paid for permanent disability. When the request for section 8(f) relief is made, an application for such relief, together with all the evidence described in paragraph (a), must be submitted, in duplicate, to the deputy commissioner within ninety (90) days. This period may be extended by the deputy commissioner for good cause. However, this extension may not continue beyond the date of the informal conference where section 8(f) relief or the permanency of the claimant's condition is to be considered. The failure to submit a fully documented application by the date of that informal conference shall be an absolute defense to the liability of the special fund. The failure of an employer to submit a complete and timely application in support of a request for section 8(f) relief shall not prevent the deputy commissioner, at his or her discretion, from considering the claim for compensation and transmitting the case for formal hearing. However, such failure shall be an absolute defense to the special fund's liability for the payment of benefits in connection with such claim. The failure of an employer to present a timely request for relief under section 8(f) of the Act may be excused only where the employer could not have reasonably anticipated the liability of the Special Fund prior to the issuance of a compensation order. Relief under section 8(f) is not available to an employer who fails to comply with section 32(a) of the Act, 33 U.S.C. 932(a).

(c) *Application: Approval, disapproval.* If all the evidence required by paragraph (a) was submitted with the application for section 8(f) relief and the facts warrant relief under this section, the deputy commissioner shall award such relief after concurrence by the Associate Director, DLHWC. If the deputy commissioner or the Associate Director finds that the facts do not warrant relief under section 8(f) the deputy commissioner shall advise the employer of the grounds for the denial. The application for section 8(f) relief may then be considered by an administrative law judge. When a case is transmitted to the Office of Administrative Law Judges the deputy commissioner shall indicate whether the 1984 amendment to this section of the Act applies to the case and whether the application for section 8(f) was properly presented to the deputy commissioner for consideration. The deputy commissioner shall also attach a copy of the application for section 8(f) relief submitted by the employer, and notwithstanding § 702.317(c), the deputy commissioner's denial of the application.

(Approved by the Office of Management and Budget under control number 1215-0160.)

33. In § 702.373 paragraph (a) is revised and paragraph (d) is added to read as follows:

§ 702.373 Modification of awards.

(a) Upon his/her own initiative, or upon application of any party in interest (including an employer or carrier which has been granted relief under section 8(f) of the Act, 33 U.S.C. 908(f)), the deputy commissioner may review any compensation case (including a case under which payments are made

pursuant to section 44(i) of the Act, 33 U.S.C. 944(i)) in accordance with the procedure in Subpart C of this part, and after such review of the case under § 702.315, or review at formal hearings under the regulations governing formal hearings in Subpart C of this part, file a new compensation order terminating, continuing, reinstating, increasing or decreasing such compensation, or awarding compensation. Such new order shall not affect any compensation previously paid, except that an award increasing the compensation rate may be made retroactive from the date of injury, and if any part of the compensation due or to become due is unpaid, an award decreasing the compensation rate may be made effective from the date of the injury, and any payment made prior thereto in excess of such decreased rate shall be deducted from any unpaid compensation, in such manner and by such method as may be determined by the deputy commissioner or the administrative law judge. Settlements cannot be modified.

* * * * *

(d) If the investigation, described in § 702.148(c), discloses a change in conditions and the employer or insurance carrier intends to pursue modification of the award of compensation the deputy commissioner and claimant shall be notified through an informal conference. At the conclusion of the informal conference the deputy commissioner shall issue a recommendation either for or against the modification. This recommendation shall also be sent to the Associate Director, Division of Longshoremen's and Harbor Workers' Compensation (DLHWC) for a determination on whether or not to participate in the modification proceeding on behalf of the special fund. Lack of concurrence of the Associate Director, DLHWC or lack of participation by a representative of the special fund shall not be a bar to the modification proceeding.

34. In § 702.401 the existing paragraph is designated as paragraph (a) and a new paragraph (b) is added to read as follows:

§ 702.401 Medical care defined.

* * * * *

(b) An employee may rely on treatment by prayer or spiritual means alone, in accordance with the tenets and practice of a recognized church or religious denomination, by an accredited practitioner of such recognized church or religious denomination, and nursing services rendered in accordance with such tenets and practice without loss or diminution of compensation or benefits under the Act. For purposes of this section, a recognized church or religious denomination shall be any religious organization: (1) That is recognized by the Social Security Administration for purposes of reimbursements for treatment under Medicare and Medicaid or (2) that is recognized by the Internal Revenue Service for purposes of tax exempt status.

35. Section 702.402 is revised to read as follows:

§ 702.402 Employer's duty to furnish; duration.

It is the duty of the employer to furnish appropriate medical care (as defined in § 702.401(a)) for the employee's injury, and for such period as the nature of the injury or the process of recovery may require.

36. Section 702.403 is revised to read as follows:

§ 702.403 Employee's right to choose physician; limitations.

The employee shall have the right to choose his/her attending physician from among those authorized by the Director, OWCP, to furnish such care and treatment, except those physicians included on the Secretary's list of debarred physicians. In determining the choice of a physician, consideration must be given to availability, the employee's condition and the method and means of transportation. Generally 25 miles from the place of injury, or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into consideration.

37. In § 702.405, a new sentence is added at the end of the existing paragraph to read as follows:

§ 702.405 Selection of physician; emergencies.

* * * The Director will direct reimbursement of medical claims for services rendered by physicians or health care providers who are on the list of those excluded from providing care under the Act, if such services were rendered in an emergency. (See §§ 702.417 and 702.435(b)).

38. In § 702.406, the existing paragraph is designated as paragraph (a) and a new paragraph (b) is added to read as follows:

§ 702.406 Change of physicians, non-emergencies.

* * * * *

(b) The deputy commissioner for the appropriate compensation district may order a change of physicians or hospitals when such a change is found to be necessary or desirable or where the fees charged exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges.

39. In § 702.407, paragraph (b) is revised to read as follows:

§ 702.407 Supervision of medical care.

* * * * *

(b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee, including whether the charges made by any medical care provider exceed those permitted under the Act;

* * * * *

40. In § 702.410 paragraphs (b) and (c) are revised to read as follows:

§ 702.410 Duties of employees with respect to special examinations.

* * * * *

(b) Where an employee fails to submit to an examination required by §§ 702.408 and 702.409, the deputy commissioner or administrative law judge may order that no compensation otherwise payable shall be paid for any period during which the employee refuses to submit to such examination unless circumstances justified the refusal.

(c) Where an employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the deputy commissioner may by order suspend the payment of further compensation during such time as the refusal continues. Except that refusal to submit to medical treatment because of adherence to the tenets of a recognized church or religious denomination as described in § 702.401(b) shall not cause the suspension of compensation.

41. Section 702.413 is revised to read as follows:

§ 702.413 Fees for medical services; prevailing community charges.

All fees charged by medical care providers for persons covered by this Act shall be limited to such charges for the same or similar care (including supplies) as prevails in the community in which the medical care provider is located and shall not exceed the customary charges of the medical care provider for the same or similar services. The opinion of an agency medical director that a charge by a medical care provider disputed under the provisions of § 702.414 exceeds the charge which prevails in the community in which said medical care provider is located shall constitute sufficient

evidence to warrant further proceedings pursuant to § 702.414 and to permit the Director to direct the claimant to select another medical provider for care to the claimant.

42. Section 702.414 is revised to read as follows:

§ 702.414 Fees for medical services; unresolved disputes on prevailing charges.

(a) The Director may, upon written complaint of an interested party, or upon the Director's own initiative, investigate any medical care provider or any fee for medical treatment, services, or supplies that appears to exceed prevailing, community charges for similar treatment, services or supplies or the provider's customary charges. Such investigation shall initially be conducted informally through contact of the medical care provider by the district medical director. If this informal investigation is unsuccessful further proceedings shall be undertaken. These proceedings shall include, but not be limited to: An informal conference involving all interested parties; agency interrogatories to the pertinent medical care provider; and issuance of subpoenas duces tecum for documents having a bearing on the dispute.

(b) The failure of any medical care provider to present any evidence required by the Director pursuant to this section without good cause shall not prevent the Director from making findings of fact.

(c) After any proceeding under this section the Director shall make specific findings of fact and provide notice of these findings to the affected parties.

(d) The Director may suspend any such proceedings if after receipt of the written complaint the affected parties agree to withdraw the controversy from agency consideration on the basis that such controversy has been resolved by the affected parties. Such suspension, however, shall be at the discretion of the Director.

43. Section 702.415 is revised to read as follows:

§ 702.415 Fees for medical services; unresolved disputes on charges; procedure.

After issuance of specific findings of fact and proposed action by the Director as provided in § 702.414 any affected provider has the right to seek a hearing pursuant to section 556 of Title 5, United States Code. Upon written request for such a hearing, the matter shall be referred by the Deputy Commissioner to the OALJ for formal hearing in accordance with the procedures in subpart C of this part. If no such request for a hearing is filed with the deputy commissioner within thirty (30) days the findings issued pursuant to § 702.414 shall be final.

44. Section 702.417 is revised to read as follows:

§ 702.417 Fees for medical services; disputes; effect of adverse decision.

If the final decision and order upholds the finding of the Director that the fee or charge in dispute was not in accordance with prevailing community charges or the provider's customary charges, the person claiming such fee or cost charge shall be given thirty (30) days after filing of such decision and order to make the necessary adjustment. If such person still refuses to make the required readjustment, such person shall not be authorized to conduct any further treatments or examinations (if a physician) or to provide any other services or supplies (if by other than a physician). Any fee or cost charge subsequently incurred for services performed or supplies furnished shall not be a reimbursable medical expense under this subpart. This prohibition shall apply notwithstanding the fact that the services performed or supplies furnished were in all other respects necessary and appropriate within the provision of these regulations. However, the Director may direct reimbursement of medical claims for services rendered if such services were rendered in an emergency (see § 702.435(b)). At the termination of the proceedings provided for in this section the deputy commissioner shall determine whether further proceedings under § 702.432 should be initiated.

45. In § 702.418 the existing paragraph is designated as paragraph (a) and a new paragraph (b) and OMB control number are added to read as follows:

§ 702.418 Procedure for requesting medical care; employee's duty to notify employer.

* * * * *

(b) In the case of an occupational disease which does not immediately result in a disability or death, such notice shall be given within one year after the employee becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability. Notice shall be given: (1) To the deputy commissioner in the compensation district in which the injury or death occurred, and (2) to the employer.

(Approved by the Office of Management and Budget under control number 1215-0160.)

46. Section 702.419 is revised to read as follows:

§ 702.419 Action by employer upon acquiring knowledge or being given notice of injury.

Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, said employer shall forthwith authorize, in writing, appropriate medical care. If a form is prescribed for this purpose it shall be used whenever practicable. Authorization shall also be given in cases where an employee's initial choice was not of a specialist whose services are necessary for and appropriate to the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

47. Section 702.421 is revised to read as follows:

§ 702.421 Effect of failure to obtain initial authorization.

An employee shall not be entitled to recover for medical services and supplies unless:

(a) the employer shall have refused or neglected a request to furnish such services and the employee has complied with sections 7 (b) and (c) of the Act, 33 U.S.C. 907 (b) and (c) and these regulations; or

(b) the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize same.

48. Section 702.422 is revised to read as follows:

§ 702.422 Effect of failure to report on medical care after initial authorization.

(a) Notwithstanding that medical care is properly obtained in accordance with these regulations, a finding by the Director that a medical care provider has failed to comply with the reporting requirements of the Act shall operate as a mandatory revocation of authorization of such medical care provider. The effect of a final finding to this effect operates to release the employer/carrier from liability of the expenses of such care. In addition to this, when such a finding is made by the Director, the claimant receiving treatment will be directed by the deputy commissioner to seek authorization for medical care from another source.

(b) For good cause shown, the Director may excuse the failure to comply with the reporting requirements of the Act and further, may make an

award for the reasonable value of such medical care.

49. In Part 702, new §§ 702.431—702.436 are added to Subpart D to read as follows:

Debarment of Physicians and Other Providers of Medical Services and Suppliers and Claims Representatives

§ 702.431 Grounds for debarment.

A physician or health care provider shall be debarred if it is found, after appropriate investigation as described in § 702.414 and proceedings under §§ 702.432 and 702.433, that such physician or health care provider has:

(a) Knowingly and willfully made, or caused to be made, any false statement or misrepresentation of a material fact for use in a claim for compensation or claim for reimbursement of medical expenses under this Act;

(b) Knowingly and willfully submitted, or caused to be submitted, a bill or request for payment under this Act containing a charge which the Director finds to be substantially in excess of the charge for the service, appliance, or supply prevailing within the community or in excess of the provider's customary charges, unless the Director finds there is good cause for the bill or request containing the charge;

(c) Knowingly and willfully furnished a service, appliance, or supply which is determined by the Director to be substantially in excess of the need of the recipient thereof or to be of a quality which substantially fails to meet professionally recognized standards;

(d) Been convicted under any criminal statute, without regard to pending appeal thereof, for fraudulent activities in connection with federal or state program for which payments are made to physicians or providers of similar services, appliances, or supplies; or has otherwise been excluded from participation in such program.

(e) The fact that a physician or health care provider has been convicted of a crime previously described in (d), or excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any program as described in (d), shall be a prima facie finding of fact for purposes of section 7(j)(2) of the Act, 33 U.S.C. 907(j)(2).

§ 702.432 Debarment process.

(a) *Pertaining to health care providers.* Upon receipt of information indicating that a physician or health care provider has engaged in activities enumerated in subparagraphs (a) through (c) of § 702.431, the Director, through the Director's designees, may evaluate the information (as described in § 702.414) to ascertain whether proceedings should be initiated against the physician or health care provider to remove authorization to render medical care or service under the Longshore and Harbor Workers' Compensation Act.

(b) *Pertaining to health care providers and claims representatives.* If after appropriate investigation the Director determines that proceedings should be initiated, written notice thereof sent certified mail, return receipt requested, shall be provided to the physician, health care provider or claims representative containing the following:

(1) A concise statement of the grounds upon which debarment will be based;

(2) A summary of the information upon which the director has relied in reaching an initial decision that debarment proceedings should be initiated;

(3) An invitation to the physician, health care provider or claims representative to: (i) Resign voluntarily from participation in the program without admitting or denying the allegations presented in the written notice; or (ii) request a decision on debarment to be based upon the existing agency record and any other information the physician, health care provider or claims representative may wish to provide;

(4) A notice of the physician's, health care provider's or claims representative's right, in the event of an adverse ruling by the Director, to request a formal hearing before an administrative law judge;

(5) A notice that should the physician, health care provider or claims representative fail to provide written answer to the written notice described in this section within thirty (30) days of receipt, the Director may deem the allegations made therein to be true and may order exclusion of the physician, health care provider or claims representative without conducting any further proceedings; and

(6) The name and address of the deputy commissioner who shall be responsible for receiving the answer from the physician, health care provider or claims representative.

(c) Should the physician, health care provider or claims representative fail to file a written answer to the notice described in this section within thirty (30) days of receipt thereof, the Director may deem the allegations made therein to be true and may order debarment of the physician, health care provider or claims representative.

(d) The physician, health care provider or claims representative may inspect or request copies of information in the agency records at any time prior to the Director's decision.

(e) The Director shall issue a decision in writing, and shall send a copy of the decision to the physician, health care provider or claims representative by certified mail, return receipt requested. The decision shall advise the physician, health care provider or claims representative of the right to request, within thirty (30) days of the date of an adverse decision, a formal hearing before an administrative law judge under the procedures set forth herein. The filing of such a request for hearing within the time specified shall operate to stay the effectiveness of the decision to debar.

§ 702.433 Requests for hearing.

(a) A request for hearing shall be sent to the deputy commissioner and contain a concise notice of the issues on which the physician, health care provider or claims representative desires to give evidence at the hearing with identification of witnesses and documents to be submitted at the hearing.

(b) If a request for hearing is timely received by the deputy commissioner, the matter shall be referred to the Chief Administrative Law Judge who shall assign it for hearing with the assigned administrative law judge issuing a notice of hearing for the conduct of the hearing. A copy of the hearing notice shall be served on the physician, health care provider or claims representative by certified mail, return receipt requested.

(c) If a request for hearing contains identification of witnesses or documents not previously considered by the Director, the Director may make application to the assigned administrative law judge for an offer of proof from the physician, health care provider or claims representative for the purpose of discovery prior to hearing. If the offer of proof indicates injection of new issues or new material evidence not previously considered by the Director, the Director may request a remand order for purposes of reconsideration of the decision made pursuant to § 702.432 of these regulations.

(d) The parties may make application for the issuance of subpoenas upon a showing of good cause therefore to the administrative law judge.

(e) The administrative law judge shall issue a recommended decision after the termination of the hearing. The recommended decision shall contain appropriate findings, conclusions and a recommended order and be forwarded, together with the record of the hearing.

to the Deputy Under Secretary of Labor for a final decision. The recommended decision shall be served upon all parties to the proceeding.

(f) Based upon a review of the record and the recommended decision of the administrative law judge, the Deputy Under Secretary of Labor shall issue a final decision.

§ 702.434 Judicial review.

(a) Any physician, health care provider or claims representative, after any final decision of the Deputy Under Secretary made after a hearing to which such person was a party, irrespective of the amount of controversy, may obtain a review of such decision by a civil action commenced within sixty (60) days after the mailing to him or her of notice of such decision, but the pendency of such review shall not operate as a stay upon the effect of such decision. Such action shall be brought in the Court of Appeals of the United States for the judicial circuit in which the plaintiff resides or has his or her principal place of business, or the Court of Appeals for the District of Columbia pursuant to section 7(j)(4) of the Act, 33 U.S.C. 907(j)(4).

(b) As part of the Deputy Under Secretary's answer, he or she shall file a certified copy of the transcript of the record of the hearing, including all evidence submitted in connection therewith.

(c) The findings of fact of the Deputy Under Secretary, if based on substantial evidence in the record as a whole, shall be conclusive.

§ 702.435 Effects of debarment.

(a) The Director shall give notice of the debarment of a physician, hospital, or provider of medical support services or supplies to:

(1) All OWCP district offices;

(2) The Health Care Financing Administration;

(3) The State or Local authority responsible for licensing or certifying the debarred party;

(4) The employers and authorized insurers under the Act by means of an annual bulletin sent to them by the Director; and

(5) The general public by posting in the district office in the jurisdiction where the debarred party maintains a place of business.

If a claims representative is debarred, the Director shall give notice to those groups listed in paragraphs (a) (1), (3), (4), and (5) of this section.

(b) Notwithstanding any debarment under this subpart, the Director shall not refuse a claimant reimbursement for any otherwise reimbursable medical expense if the treatment, service or supply was rendered by debarred provider in an emergency situation. However, such claimant will be directed by the Director to select a duly qualified provider upon the earliest opportunity.

§ 702.436 Reinstatement.

(a) If a physician or health care provider has been debarred or pursuant to § 702.431(d) or if a claims representative has been debarred pursuant to § 702.131(c) (1) or (3) the person debarred will be automatically reinstated upon notice to the Director that the conviction or exclusion has been reversed or withdrawn. However, such reinstatement will not preclude the Director from instituting debarment proceedings based upon the subject matter involved.

(b) A physician, health care provider or claims representative otherwise debarred by the Director may apply for reinstatement to participate in the program by application to the Director after three years from the date of entry of the order of exclusion. Such application for reinstatement shall be addressed to the Associate Director for the Longshore program, and shall contain a statement of the basis of the application along with any supporting documentation.

(c) The Director may further investigate the merits of the reinstatement application by requiring special reporting procedures from the applicant for a probationary period not to exceed six months to be monitored by the district office where the provider maintains a place of business.

(d) At the end of aforesaid probationary period, the Director may order full reinstatement of the physician, health care provider or claims representative if such reinstatement is clearly consistent with the program goal to protect itself against fraud and abuse and, further, if the physician, health care provider or claims representative has given reasonable assurances that the basis for the debarment will not be repeated.

50. By adding in Subpart D of Part 702 a new § 702.441 to read as follows:

§ 702.441 Claims for loss of hearing.

(a) Claims for hearing loss pending on or filed after September 28, 1984 (the date of enactment of Pub. L. 98–426) shall be adjudicated with respect to the determination of the degree of hearing impairment in accordance with these regulations.

(b) An audiogram shall be presumptive evidence of the amount of hearing loss on the date administered if the following requirements are met:

(1) The audiogram was administered by a licensed or certified audiologist, by a physician certified by the American Board of Otolaryngology, or by a technician, under an audiologist's or physician's supervision, certified by the Council of Accreditation on Occupational Hearing Conservation, or by any other person considered qualified by a hearing conservation program authorized pursuant to 29 CFR 1910.95(g)(3) promulgated under the Occupational Safety and Health Act of 1970 (29 U.S.C. 667). Thus, either a professional or trained technician may conduct audiometric testing. However, to be acceptable under this subsection, a licensed or certified audiologist or otolaryngologist, as defined, must ultimately interpret and certify the results of the audiogram. The accompanying report must set forth the testing standards used and describe the method of evaluating the hearing loss as well as providing an evaluation of the reliability of the test results.

(2) The employee was provided the audiogram and a report thereon at the time it was administered or within thirty (30) days thereafter.

(3) No one produces a contrary audiogram of equal probative value (meaning one performed using the standards described herein) made at the same time. "Same time" means within thirty (30) days thereof where noise exposure continues or within six (6) months where exposure to excessive noise levels does not continue. Audiometric tests performed prior to the enactment of Pub. L. 98–426 will be considered presumptively valid if the employer complied with the procedures in this section for administering audiograms.

(c) In determining the amount of pre-employment hearing loss, an audiogram must be submitted which was performed prior to employment or within thirty (30) days of the date of the first employment-related noise exposure. Audiograms performed after December 27, 1984 must comply with the standards described in paragraph (d), of this section.

(d) In determining the loss of hearing under the Act, the evaluators shall use the criteria for measuring and calculating hearing impairment as published and modified from time-to-time by the American Medical Association in the *Guides to the Evaluation of Permanent Impairment*, using the most currently revised edition of this publication. In addition, the audiometer used for testing the individual's threshold of hearing must be calibrated according to current American National Standard

Specifications for Audiometers. Audiometer testing procedures required by hearing conservation programs pursuant to the Occupational Safety and Health Act of 1970 should be followed (as described at 29 CFR, Section 1910.95 and appendices).

(Approved by the Office of Management and Budget under control number 1215-0160.)

51. In Part 702, a new Subpart F (§ 702.601 through 702.604) is added to read as follows:

Subpart F—Occupational Disease Which Does Not Immediately Result in Death or Disability

§ 702.601 Definitions.

(a) *Time of injury.* For purposes of this subpart and with respect to an occupational disease which does not immediately result in death or disability, the time of injury shall be deemed to be the date on which the employee or claimant becomes aware, or in the exercise of reasonable diligence or by reason of medical advice should have been aware, of the relationship between the employment, the disease, and the death or disability.

(b) *Disability.* With regard to an occupational disease for which the time of injury, as defined in § 702.601(a), occurs after the employee was retired, disability shall mean permanent impairment as determined according to the *Guides to the Evaluation of Permanent Impairment* which is prepared and modified from time-to-time by the American Medical Association, using the most currently revised edition of this publication. If this guide does not evaluate the impairment, other professionally recognized standards may be utilized. The disability described in this paragraph shall be limited to permanent partial disability. For that reason they are not subject to adjustments under section 10(f) of the Act, 33 U.S.C. 910(f).

(c) *Retirement.* For purposes of this subpart, retirement shall mean not being employed and having no earnings with no reasonable expectation of returning to the workforce.

§ 702.602 Notice and claims.

(a) *Time for giving notice of injury or death.* Refer to § 702.207.

(b) *Time for filing of claims.* Refer to § 702.212.

§ 702.603 Determining the payrate for compensating occupational disease claims which become manifest after retirement.

(a) If the time of injury occurs within the first year after the employee has retired, the payrate for compensation purposes shall be one fifty-second part of the employee's average annual earnings during the fifty-two week period preceding retirement.

(b) If the time of injury occurs more than one year after the employee has retired the payrate for compensation purposes shall be the national average weekly wage, determined according to section 6(b)(3) of the Act, 33 U.S.C. 906(b)(3), at the time of injury.

§ 702.604 Determining the amount of compensation for occupational disease claims which become manifest after retirement.

(a) If the claim is for disability benefits and the time of injury occurs after the employee has retired, compensation shall be 66⅔ percent of the payrate, as determined under § 702.603, times the disability, as determined according to § 702.601(b).

(b) If the claim is for death benefits and the time of injury occurs after the decedent has retired, compensation shall be the percent specified in section 9 of the Act, 33 U.S.C. 909, times the payrate determined according to § 702.603. Total weekly death benefits shall not exceed one fifty-second part of the decedent's average annual earnings during the fifty-two week period preceding retirement.

PART 703—INSURANCE REGULATIONS

52. In Part 703, a new § 703.003 is added to read as follows:

§ 703.003 Failure to secure coverage; penalties.

(a) Each employer is required to secure coverage under this Act either through an authorized insurance carrier or by becoming an authoried self-insurer. An employer who fails to secure coverage by either manner described in Section 32(a), (1) or (2) of the Act, 33 U.S.C. 932(a), is subject, upon conviction, to a fine of not more than $10,000, or by imprisonment for not more than one year, or both.

(1) Where the employer is a corporation: the president, secretary and treasurer each will also be subject to this fine and/or imprisonment, in addition to the fine against the corporation and each is personally liable, jointly with the corporation, for all compensation or other benefits payable under the Act during the time failure to secure coverage continues.

(b) Any employer who willingly and knowingly transfers, sells, encumbers, assigns or in any manner disposes of, conceals, secretes, or destroys any property belonging to the employer after an employee sustains an injury covered by this Act, with the intention to avoid payment to that employee or his/her dependents of compensation under this Act shall be guilty of a misdemeanor and punished upon conviction by a fine of not more than $10,000 and/or imprisonment for one year.

(1) Where the employer is a corporation: the president, secretary and treasurer are also each liable to imprisonment and, along with the corporation, jointly liable for the fine.

§ 703.102 [Amended]

53. In § 703.102 the zip code 20211 is changed to 20210.

§ 703.107 [Removed]

54. In Part 703, § 703.107 is removed.

55. § 703.108 is revised to read as follows:

§ 703.108 Period of authority to write insurance.

Effective with the end of the authorization period July 1, 1983, through June 30, 1984, annual reauthorization of authority to write insurance coverage under the Act is no longer necessary. Beginning July 1, 1984, and thereafter, newly issued Certificates of Authority will show no expiration date. Certificates of Authority will remain in force for so long as the carrier complies with the requirements of the OWCP.

56. § 703.118 is revised to read as follows:

§ 703.118 Agreement to be bound by report.

Every applicant for authority to write insurance under the provisions of this Act, shall be deemed to have included in its application an agreement that the acceptance by the deputy commissioner of a report of the issuance of a policy of insurance, as provided for by § 703.116, shall bind the carrier to full liability for the obligations under this Act of the employer named in said report, and every certificate of authority to write insurance under this Act shall be deemed to have been issued by the Office upon consideration of the carrier's agreement to become so bound. It shall be no defense to this agreement that the carrier failed or delayed to issue the policy to the employer covered by this report.

§ 703.302 [Amended]

57. § 703.302 is amended by revising paragraph (d) and adding an OMB control number as follows:

" * * * (d) a certified financial report for each of the three years preceding the application;"

(Approved by the Office of Management and Budget under control number 1215-0160).

58. § 703.304 is revised to read as follows:

§ 703.304 Filing of agreement and undertaking.

The applicant for the privilege of self-insurance shall as a condition subsequent to receiving authorization to act as a self-insurer, execute and file with the Office and agreement and undertaking in a form prescribed and provided by the Office in whch the applicant shall agree: (a) To pay when due, as required by the provisions of said Act, all compensation payable on account of injury or death of any of its employees injured within the purview of said Act; (b) in such cases to furnish medical, surgical, hospital, and other attendence, treatment and care as required by the provisions of said Act; (c) to deposit with the Office an indemnity bond in the amount which the Office shall fix, or to deposit negotiable securities as provided for by the regulations in this part in the amount which the Office shall fix, accordingly as elected in the application; (d) to authorize the Office to sell such negotiable securities so deposited or any part thereof and from the proceeds thereof to pay such compensation, medical, and other expenses and any accrued penalties imposed by law as it may find to be due and payable; and (e) to obtain and maintain, if required by the Office, excess or catastrophic insurance, in amounts to be determined by the Office.

59. Section 703.305 is revised to read as follows:

§ 703.305 Decision upon application of employer; furnishing of indemnity bond or deposit of negotiable securities required.

The applicant for the privilege of self-insurance, as a condition subsequent to receiving authorization to act as self-insurer, shall give security for the payment of compensation and the discharge of all other obligations under the said Act, in the amount fixed by the Office, which may be in the form of an indemnity bond with sureties satisfactory to the Office, or of a deposit of negotiable securities as provided in the regulations in this part. The amount of such security so to be fixed and required by the Office shall be such as the Office shall deem to be necessary and sufficient to secure the performance by the applicant of all obligations imposed upon him as an employer by the Act. In fixing the amount of such security the Office will take into account the financial standing of the employer, the nature of the work in which he is engaged, the hazard of the work in which the employees are employed, the payroll exposure, and the accident experience as shown in the application and the Office's records, and any other facts which the Office may deem pertinent. Additional security may be required at any time in the discretion of the Office. The indemnity bond which is required by these regulations shall be in such form, and shall contain such provisions, as the Office may prescribe: *Provided*, That only surety companies approved by the United States Treasury Department under the laws of the United States and the rules and regulations governing bonding companies may act as sureties on such indemnity bonds.

60. Section 703.306 is revised to read as follows:

§ 703.306 Kinds of negotiable securities which may be deposited; conditions of deposit; acceptance of deposits.

An applicant for the privilege of self-insurance electing to deposit negotiable securities to secure his obligations under said Act in the amount fixed by the Office under the regulations in this part shall deposit any negotiable securities acceptable as security for the deposit of public monies of the United States under regulations issued by the Secretary of the Treasury. The approval, valuation, acceptance, and custody of such securities is hereby committed to the several Federal Reserve Banks and the Treasurer of the United States when authorized under the regulations in this part to receive deposits of such securities.

61. § 703.310(a) is revised to read as follows:

§ 703.310 Reports required of self-insurers; examination of accounts of self-insurer.

* * * * *

(a) A certified financial statement of the self-insurer's assets and liabilities, or a balance sheet.

* * * * *

62. § 703.311 is revised to read as follows:

§ 703.311 Period of authorization as self-insurer.

(a) Effective with the end of the authorization period July 1, 1983, through June 30, 1984, annual reauthorization of the self-insurance privilege is no longer necessary. Beginning July 1, 1984, and thereafter, newly approved and renewed self-insurance authorizations will remain in effect for so long as the self-insurer complies with the requirements of the OWCP.

(b) A self-insurer who currently has on file an indemnity bond, will receive from the office, on or about May 10 of each year, a bond form for execution in contemplation of the continuance of the self-insurance authorization, and the submission of such bond duly executed in the amount indicated by the office will be deemed and treated as a condition of the continuing authorization.

Signed at Washington, D.C., this 24th day of December 1984.

Ford B. Ford,

Under Secretary of Labor.

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