

RESPONSES TO QUESTIONS FOR THE RECORD

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Committee on Education and the Workforce, U.S. House of Representatives

Field Hearing: “Protecting Workers and Powering America: The Future of Mining”

Fort Branch, Indiana

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Questions for the Record from Ranking Member Robert C. “Bobby” Scott

I thank the Ranking Member and the Committee for the opportunity to supplement my testimony. My responses to each question are set forth below.

Question 1. The Governmental Accountability Office (GAO) recently released a report addressing shortfalls in medical benefit payments by responsible operators under the Black Lung Benefits Act. You have firsthand experience litigating this exact issue. How has this problem developed, and what additional context should Congress consider as we follow up on GAO’s report?

Miners often spend years litigating to establish their eligibility for federal black lung benefits. For decades, even after those miners had prevailed on their claims, and been finally awarded federal black lung benefits, the responsible coal operators (and the U.S. Department of Labor) were declining to issue medical cards for the miners to use in accessing their hard-won benefits. Consequently, miners and their doctors struggled in order to submit medical charges to the responsible payor for the federal black lung benefits. I represented a miner seeking to remedy this problem in *Culbertson v. Office of Workers’ Compensation Programs* in the Southern District of West Virginia in 2021. To the credit of the Biden Administration, they recognized the problem and collaborated to develop a solution in response to the *Culbertson* case, ensuring the issuance of medical cards to all federal black lung beneficiaries.

A miner who is found totally disabled by black lung is entitled under the Black Lung Benefits Act to lifetime medical benefits (with no co-pays and no deductibles) covering all treatment for his breathing-related condition. That coverage can be worth a million dollars over a beneficiary’s lifetime, encompassing everything from inhalers and oxygen to pulmonary rehabilitation and lung transplants. Yet for one large group of beneficiaries, the U.S. Department of Labor’s Office of Workers’ Compensation Programs’ Division of Coal Mine Workers’ Compensation (DCMWC) historically did not issue a medical card or any meaningful notice by which the miners could access those medical benefits.

The group of miners to whom DCMWC did not issue medical cards was a very large group of miners who had previously received a state workers’ compensation award for black lung. The Department adopted a practice of withholding the federal medical card from any

beneficiary with a prior state award based on the erroneous assumption that the state program would cover their pulmonary care. But that assumption was wrong in a great many cases. No state program has ever been found to provide benefits equivalent to the federal program. Many state awards provide no medical benefits at all, or only a narrow benefit such as a single annual pulmonary exam, leaving the remainder of the miner's care to be paid by the federal benefits. Because the vast majority of federal beneficiaries live in states that offer some offsetting state award, this practice apparently resulted in the vast majority of federal black lung beneficiaries never receiving any practical method by which to access the affordable medical treatment to which they were legally entitled as federal black lung beneficiaries.

The consequences fell hardest on the sickest miners. While DCMWC has taken steps to address this problem, there are still some coal operators refusing to issue medical cards that comply with Industry Notice No. 1. That means that other payors---often Medicare or other public programs---are likely paying for extremely expensive medical care that coal companies are already legally obligated to cover. The issue deserves further oversight by Congress.

The scale of this improper cost-shifting is documented in the public health literature. A study published in the *Journal of Occupational and Environmental Medicine* examined institutional Medicare claims from 1999 to 2016 for which the Federal Black Lung Program was the designated primary payer. See Kurth L, Casey M, Schleiff P, Halldin C, Mazurek J, Blackley D, *Medicare Claims Paid by the Federal Black Lung Benefits Program: US Medicare Beneficiaries, 1999 to 2016*, 61 J. Occup. & Env't Med. e510 (2019), available at <https://pmc.ncbi.nlm.nih.gov/articles/PMC7685175/>.

The Kurth study found that, across roughly 19,700 beneficiaries and 75,690 claims, providers were paid about \$668.8 million over the study period. Of that total, the Black Lung Program paid roughly \$423 million (about 63 percent), but Medicare paid roughly \$207 million (about 31 percent) and the beneficiaries themselves paid about \$38.5 million (nearly 6 percent). This occurred on claims where the responsible coal company---or other entity securing the federal black lung benefits---was supposed to be the primary payer.

In other words, more than \$245 million in costs that the law assigns to the coal industry (i.e. coal operators and the Black Lung Disability Trust Fund funded by severance taxes) were instead absorbed by Medicare and by sick miners themselves. Those figures likely understate the true gap, because the study counted only claims where the federal program was already identified as primary payer; the notice failures at the heart of *Culbertson* mean that many federal beneficiaries are never flagged at all, so their care is silently paid by Medicare, by other insurers, or out of the miner's own pocket.

The additional context I would urge the Committee to consider is this: GAO's findings are not the product of a flaw in the statute. They are the product of administrative practices

(inadequate notice to miners and providers, and inadequate enforcement of operators' payment duties) that the Department can and should fix. The Mine Act and the BLBA already place a duty on the Secretary of Labor to actively supervise the medical care rendered to miners and to report periodically on that care. As Congress follows up on GAO's report, the central question should be whether the Department is discharging that supervisory duty: issuing medical cards uniformly to every eligible beneficiary, instructing its own claims examiners on how medical-benefit offsets are supposed to work, and holding responsible operators to their statutory payment obligations.

Question 2. The Labor Department's Office of Workers' Compensation Programs addressed medical benefit obligations in 2022 with Industry Notice No. 1.

a. What did Industry Notice No. 1 do?

Industry Notice No. 1, issued by OWCP's Division of Coal Mine Workers' Compensation on August 22, 2022, reminded responsible coal operators and their insurance carriers of their existing obligations under the BLBA and 20 C.F.R. § 725.704 to make medical benefits actually usable by the miners who have won them. Under that regulation, once an operator is determined liable, it must do three things: (1) notify the miner and his providers that the operator or carrier is responsible for the cost of treating the miner's totally disabling pneumoconiosis; (2) designate a person with decision-making authority whom OWCP, the miner, and providers can contact about medical benefits; and (3) make arrangements for direct reimbursement of providers.

The Notice translated those duties into concrete expectations. It instructed operators to give miners proof of coverage (setting forth a prototypical medical card modeled on the Trust Fund's own black lung medical card) and to tell miners to present that card to providers when they seek treatment for their lung condition. It told operators they must inform providers how to submit bills and obtain reimbursement, and provide the name and contact information of the person responsible for treatment and payment decisions, as well as whom to contact for a replacement card. Critically, for the very population at the center of the *Culbertson* case (miners with both state and federal awards) the Notice required operators to give providers and claimants clear information on how benefits will be coordinated between the state and federal awards, including whether providers must bill the state system first.

b. What accounts for the persistent gap, and what should the Committee do about it?

Industry Notice No. 1 clarified the right standard under the Act and regulations, but a reminder is only as good as its enforcement. The persistent shortfalls GAO identified reflect the gap between what the regulation and the Notice require and what operators actually do in practice. Issuing a notice does not, by itself, make any operator issue a card, designate a contact, instruct a provider on billing, or coordinate a state offset. Where OWCP does not verify compliance and follow up on noncompliance, operators have every financial incentive

to let the duty lapse because every claim that a confused provider bills to Medicare, to another insurer, or simply writes off is a costly claim the operator never pays.

This is why it is essential for OWCP to ensure operators actually comply with Industry Notice No. 1, rather than treating the Notice as a one-time mailing. The federal black lung regulations prohibit balance billing. *See* 20 CFR § 725.713. A beneficiary is not supposed to receive a bill for covered black lung treatment. But, in reality, balance billing can readily occur in the absence of the transparent billing practices set forth in the Notice. When a provider does not know that the federal benefits (i.e. the coal operator) is the primary payer, does not know whom to bill, and does not know how the state award is coordinated, the provider often bills the miner directly. The result is exactly the harm documented in the NIOSH analysis and in the *Culbertson* complaint: miners who fought for years to establish their entitlement to federal benefits end up holding costly medical bills, or going without care, even though they have already nominally won access to their benefits.

Accordingly, I would urge the Committee to press OWCP-DCMWC to: (1) require and verify that every responsible operator issues a medical card and a designated billing contact to every entitled miner, and document that compliance in the claim file; (2) audit operator and carrier billing practices for balance-billing violations and act on them, since the prohibition is meaningless without enforcement; (3) issue and maintain up-to-date internal guidance to OWCP's own claims examiners on how medical-benefit offsets operate for miners with state awards; and (4) report publicly and periodically on medical benefits paid, as 33 U.S.C. § 907(b) already requires, so that gaps like those GAO found are visible and correctable rather than hidden. Containing and resolving these problems depends on creating a consistent enforcement program behind Industry Notice No. 1.

Question 3. During the hearing, you mentioned the Biden Administration's standard to protect miners from respirable crystalline silica.

a. How did the Biden silica standard change previous rules on silica dust?

The 2024 rule was the first independently enforceable permissible exposure limit for silica dust in America's coal mines. Before this rule, silica dust was regulated as a secondary component of overall coal-mine dust, and the nominal exposure limit was twice the level that NIOSH has known to be unsafe and unhealthful for over fifty years. In 2016, OSHA published a respirable silica dust limit economywide---for nearly all categories of American workers except for the miners who face the most acute exposures to freshly fractured silica. We have been failing our miners for a hundred years, casting them off where it's dark as a dungeon, relegating their short lives to the ravages of a brutal disease---a disease which is utterly preventable if only America could muster the political will to demand it.

The 1969 Coal Act set the interim respirable coal dust standard at 3.0 mg/m³ effective June 30, 1970, then automatically dropped it to 2.0 mg/m³ effective December 30, 1972. The Act

also directed that the standard be reduced further whenever the respirable dust contained more than five percent quartz. That reduction was implemented by a formula: the applicable dust standard equals 10 divided by the percentage of quartz. So at exactly five percent quartz the formula yields 2.0 mg/m³, and at any higher quartz percentage the dust standard drops proportionally. Whatever the quartz fraction, the respirable quartz concentration itself is held at or below 0.1 mg/m³ or 100 micrograms per cubic meter (µg/m³), reported as a full-shift time-weighted average on a dust sampling instrument. Under that arrangement, there is no reliable, fixed silica limit because it is expressed proportionally.

Moreover, in 1974, NIOSH issued a recommended exposure limit of 50 µg/m³ for silica dust. Consequently, the 100 µg proportional threshold has been set at twice the level that NIOSH has recommended as protective of human health for fifty years. Silica was regulated only derivatively, and only when quartz exceeded five percent of the respirable dust, through a reduction in the overall coal-dust standard rather than a direct limit or reduction on the silica itself. This framework obscured the independent, acute toxicity of silica dust itself, and it was triggered by a threshold (100 µg) that itself was not protective of human health even if it had been systematically attained. When MSHA was created in 1978 under the Federal Mine Safety and Health Act of 1977 (taking over from the Bureau of Mines and, from 1973, MESA), it inherited and carried this scheme forward, codified at 30 C.F.R. Section 70.101 (underground coal), 71.101 (surface coal), and 90.101 (Part 90 miners).

The 2024 rule's key features were straightforward and engineering-driven, aimed at finally directly regulating silica and limiting it to the fifty-year-old recommended level. First, the 2024 rule established a uniform permissible exposure limit (PEL) for respirable crystalline silica of 50 µg/m³ of air, measured as a full-shift, 8-hour time-weighted average, cutting the prior coal and metal/nonmetal limit of 100 µg in half. This aligned the MSHA limit with the silica dust limit OSHA had already set for the rest of American industry back in 2016. Second, and just as important, it set a corrective-action level of 25 µg/m³ which is the level that NIOSH has found to be "immediately dangerous to life and health" of workers ("IDLH"). Under this corrective-action threshold, coal operators are required to plan, sample, and intervene before exposures reach the legal limit, rather than waiting until miners are already overexposed at levels between 25 and 50 µg/m³.

The structure of the 2024 rule reflected a moderate, collaborative, engineering-driven approach. By tying obligations to an action level set below the PEL, the rule encouraged operators to plan ahead and to collaborate on reducing exposure through monitoring and engineering controls (mine planning, ventilation, water suppression, sequencing, and dust collection) before anyone is exposed to silica in concentrations that are IDLH---i.e. over 25 µg/m³. It applied uniform monitoring and control requirements across coal and metal/nonmetal mines to ensure consistent public health protections for all miners, and added medical surveillance for metal/nonmetal miners modeled on the long-standing coal program. This background underscores how overdue this was: NIOSH first recommended moving to a

far more protective limit back in 1974, and for roughly fifty years the operative mining limit remained at the older, less protective level with a contingent enforcement structure that led to poor compliance and woefully inadequate protections. Ten years ago, the Nation moved to protect all other categories of workers with a 50 µg limit, yet miners remained unprotected. The 2024 rule finally sought to fix that fifty-year failure for America's miners.

b. Are there ways in which the rule needed to be more protective? If so, how?

Yes. The rule should set forth a minimum frequency and sampling methodology for the dust monitoring conducted by MSHA itself as part of its regular inspections, and should not rely on respirators as a primary method of compliance with the PEL at any time.

First, MSHA must conduct respirable dust sampling as part of all of its regular inspections (quarterly at underground mines and semiannually at surface mines) just as it always has for coal and silica dust. Sampling under the supervision of federal inspectors is an essential means of developing best practices and ensuring compliance with dust controls.

Second, the 2024 rule (§§ 60.13, 14) required all miners to wear respirators in certain ill-defined situations, creating several significant problems. This is in direct conflict with the directives of the Mine Act, Section 202(h), 30 U.S.C. § 842(h): "Use of respirators shall not be substituted for environmental control measures in the active workings." The Act requires that each operator "shall continuously maintain the average concentration of respirable dust in the mine atmosphere during each shift to which each miner in the active workings of such mine is exposed" at or below the standard. (*Id.*) The statute controls the amount respirable dust in the mine atmosphere, not the amount of dust inhaled by the miner---respirators cannot rationally relate to fulfilling that atmospheric requirement.

Many miners already experience significant, partially-disabling respiratory conditions that make respirators unsafe, raising concerns that a respirator mandate could place those miners in the untenable position of having to undergo medical examinations, due to the presence of their disabilities, simply in order to perform their job. Such disability-based medical examinations are generally disfavored under the Americans with Disabilities Act.

Additionally, MSHA itself admits respirators are a problematic means of protection. Even during short-term abatement periods, allowing miners to work in areas with atmospheric levels known to exceed the protective limit while they are wearing respirators---rather than requiring the operator to remotely adjust the ambient respirable dust concentration through environmental controls (i.e. ventilation controls)---invites high risks of overexposures that will be very hard to detect or prevent. Personal protective equipment (PPE) is the least reliable rung of the occupational hazard-control hierarchy. In real mining conditions, MSHA has found respirators can fail to fulfill their intended function through fit challenges and other vulnerabilities. A device that performs perfectly in a carefully orchestrated fit-test may

nonetheless perform very differently in a narrow, confined space performing heavy labor miles underground. Rather than allowing miners to work in dusty conditions, the regulation should require operators to use ventilation controls to reduce the dust levels before sending miners to the section to apply additional abatement measures.

That is precisely why the Mine Act has always relied on environmental controls (i.e. reducing the actual concentration of dust in the air the miner breathes) rather than on PPE as the primary line of defense. Environmental and engineering controls protect every miner in the affected area continuously and do not depend on the perfect performance of a device strapped to one person's face or other technology that is susceptible to latent, undetected failures. A more protective rule---and one that is consistent with the dictates of the Mine Act---would require the withdrawal of miners from areas where the atmospheric silica dust concentrations exceeded the PEL until sampling indicated the respirable dust level had become compliant.

c. How would you respond to the mining industry's arguments against the standard?

The industry's principal arguments were that the rule is technologically or economically infeasible, that sampling and recordkeeping are too operationally burdensome, and that existing protections suffice. Those arguments do not withstand scrutiny. Indeed, advanced industrialized economies have reportedly established even lower exposure limits of 25 µg/m³ for respirable crystalline silica, including the Canadian provinces of Nova Scotia and Manitoba. Many more have established 50 µg limits for silica. These are all places with thriving mining industries.

On feasibility, the 50-µg limit is not novel or untested---quite the opposite, as it is now outmoded by more recent science indicating 25 µg is IDLH, and it has been in place for decade economy-wide under OSHA, and other nations as noted above. OSHA has enforced the identical 50 µg limit across our industries and construction sites since 2016. Many mining companies operate facilities under the jurisdiction of both agencies, and so have already been complying with a 50 µg limit for ten years. It strains logic to assert that a limit that is feasible for the workers processing silica-bearing material a few hundred yards away under OSHA rules cannot be feasible for the nearby miners extracting it---especially when the mining industry complies with *even lower limits* in other nations.

As to any purported burden, the monitoring and corrective-action requirements are the mechanism by which the rule actually protects miners, and by extension protects mine operators and their shareholders from facing the debilitating long-term liabilities of unchecked occupational lung disease. Allowing operators to continue overexposing miners to lethal amounts of silica dust would not be a lighter burden, but rather a latent and hidden hazard and liability.

On the claim that existing protections suffice, this is plainly refuted by ongoing NIOSH surveillance data showing occupational pneumoconiosis and silicosis are at the highest levels

in fifty years. Berkes, H., & Hicks, J. (2026, August 5). *New study: Black lung disease rate in Appalachia is the worst in nearly 50 years as coal miner protections stall*. [Public Health Watch](https://publichealthwatch.org/2026/08/05/black-lung-disease-coal-miners-appalachia). <https://publichealthwatch.org/2026/08/05/black-lung-disease-coal-miners-appalachia>

I represent far too many young miners preparing for double lung transplants from breathing sandstone in amounts the industry has known for well over fifty years are deadly. MSHA's own analysis projected that the rule would avert on the order of a thousand deaths and thousands of cases of silica-related disease.

When the choice is between a documented, fatal, and entirely preventable hazard on one side and compliance costs that the mining industry already readily absorbs in other industrialized nations on the other, the balance is not close. The strongest response to the industry's arguments is the one that follows to the next question below: where MSHA has actually sampled, it keeps finding miners overexposed at the very levels this rule was written to stop.

Question 4. A new report by the Appalachian Citizens' Law Center finds that 20 percent of mines where MSHA tested silica dust last year exceeded the silica dust cap of the Biden Administration silica standard, and 12 of them had more than double that level. What does that figure tell us, and why does it matter for the Committee's work?

The Appalachian Citizens' Law Center's recent findings remove any doubt about whether the current Administration is actively harming miners by failing to take every available step to secure immediate enforcement of the 2024 silica rule. They clearly are. When 20 percent of the mines where MSHA tested silica last year exceeded the cap set by the 2024 standard (and 12 of them exceeded it by more than double) that is not a projection or a modeling exercise. It is a direct measurement of miners being exposed, right now, to deeply dangerous amounts of a highly toxic substance.

Week in and week out, I see these young miners walk through the doors of my office in southern West Virginia. They are trusting, well-intentioned, industrious young workers, many in their thirties or forties. At these tender ages, they have already developed the kind of extremely advanced, fatal-stage disease that we thought was a relic of barbaric bygone eras. This is the kind of disease we used to see in miners only after many decades of mining, and now it's raging back into younger generations.

What that figure tells us is that, without the rule in force, miners are facing known and extreme overexposures to respirable crystalline silica. This is not a speculative or contested risk; it is a known and certain hazard, confirmed by the government's own sampling. And it matters enormously for the Committee's work because of what it implies about cause and prevention. These overexposures would have been prevented, or at minimum been subject to mandatory corrective action, if the 2024 standard's 50-microgram limit and 25-microgram action level were being enforced. They are occurring because MSHA allowed its life-saving rule to be stayed and then declined to defend it.

That is the crux of my concern. MSHA had a rule on the books that the sampling data show was directly responsive to a documented, ongoing hazard. Rather than opposing the stay and proactively defending the rule in court, the agency stepped back and told the court it would “reconsider” the standard. Every month that passes in that posture, miners at the 20 percent of sampled mines that exceeded the limit, and the unknown number of unsampled mines like them, continue breathing silica at levels the agency itself has determined are dangerous. These data convert an abstract policy debate into a concrete, preventable human harm. These data, and the lost lives they represent, make an incontrovertible case for restoring, strengthening, and aggressively, urgently enforcing a modern silica rule.

Question 5. Even without the 2024 silica rule in force, does MSHA have the legal authority today to reduce miners’ silica exposures? What should it be doing right now?

Yes. Even with the 2024 rule not in force, MSHA has clear legal authority today to reduce miners’ silica exposures, and it has a duty to use it. The Mine Act gives MSHA broad existing authority to inspect, sample, and cite operators for hazardous conditions and for violations of their approved ventilation and dust-control plans, independent of the new rule. MSHA does not have to wait for the rule’s reinstatement to act.

We know this because MSHA has done it before. In June 2022, the agency launched its Silica Enforcement Initiative using existing authority under the Mine Act to begin reducing silica exposure in a concerted way well before the 2024 rule was published. That initiative included spot inspections at coal and metal/nonmetal mines with histories of repeated silica overexposures; increased oversight and enforcement at mines previously cited for exceeding the then-existing limit; expanded sampling targeted at the mines, commodities, and occupations known to carry the highest overexposure risk; and a deliberate focus on sampling during the highest-risk parts of the mining process, such as shaft and slope sinking and extended cuts in coal, and overburden removal in metal/nonmetal. *See* U.S. Dep’t of Labor, *US Department of Labor Takes Action to Reduce Miners’ Exposure to Silica Dust* (June 8, 2022), <https://www.dol.gov/newsroom/releases/msha/msha20220608>.

MSHA should be doing the same things right now, and it can sharpen them further using tools it already possesses. It can audit production and tonnage reports to cite operators who place miners downwind of cutting machines in violation of their ventilation plans. It can conduct sequence-sensitive sampling so that dust pumps run while crews are turning breaks and cutting sandstone, rather than during low-exposure intervals. It can audit deep cuts and reported tonnage so operators cannot game the sampling system. And it can deploy impact inspections and pattern-of-violation reviews at thin-seam mines where sandstone, and therefore silica, is most common. None of this requires the 2024 rule to be back in force; all of it is within MSHA’s present authority, and the 2022 initiative is the proof of concept.

Question 6. A fellow witness at the hearing, Arthur Wolfson, proposed that the Mine Safety and Health Administration should adopt a program similar to the Voluntary Protection Program launched by MSHA's sibling agency, the Occupational Safety and Health Administration, during the Reagan Administration. GAO, stakeholders, and investigative reporters have repeatedly documented challenges with VPP, including the failure to screen out employers responsible for killing their workers. In your judgment, is VPP suitable for mine safety and health? Why or why not?

An OSHA-like Voluntary Protection Program is not suitable as a substitute for mandatory mine safety and health enforcement. There is no substitute for regular quarterly inspections of mine sites because of the distinct engineering challenges involving dynamic and multifactorial risks in a mining environment.

A mine is not a static workplace. The hazards change shift to shift and foot by foot as the working face advances into new ground. Electrical, hydraulic, ventilation, stratigraphic, and other risks exist in a compounded fashion in mining that is totally distinct from the workplaces OSHA regulates. The roof and ribs change with the geology; ventilation must be continuously rebalanced as the mine extends; methane liberation and respirable dust shift with the seam and the cut; and electrical and hydraulic systems operate in confined, wet, dusty conditions where a single failure can cascade. These risks are not independent. They interact so that a ventilation problem becomes a dust problem and a methane problem at once. That dynamic, multifactorial character is exactly why the Mine Act requires MSHA to inspect underground mines four times a year and surface mines twice a year, and why those mandatory inspections cannot be traded away.

The VPP model compounds the problem with its track record. GAO, the DOL Inspector General, stakeholders, and investigative reporters have repeatedly documented that VPP has failed to screen out employers responsible for killing their workers, and sites have remained in the program despite fatalities. Importing a self-certification model with those documented oversight failures into the highest-hazard industry in the country, as a replacement for regular inspections, would be exactly backward. Recognition for genuinely exemplary operators might be a useful supplement, but only on top of (never in place of) the mandatory inspection regime the Mine Act requires.

Question 7. Mr. Wolfson also testified that MSHA sometimes penalizes mine operators that exceed regulatory minimums, without taking into account the additional safety benefits provided by their above-minimum efforts. How would you respond to that?

MSHA and the Federal Mine Safety and Health Review Commission together already have full authority to consider an operator's above-minimum efforts. The Mine Act (Section 110(i) confers authority on the Commission for setting penalties) and MSHA's penalty recommendation framework require those agencies to weigh the gravity of a violation and

the operator's negligence in proposing and assessing any citation or penalty. MSHA proposes and the Commission assess the penalty. Those two factors are precisely where an operator's additional, above-minimum safety measures already may be taken into account.

If an operator has gone beyond the regulatory minimum and those efforts genuinely reduce the seriousness of a hazard or show that the operator exercised a high degree of care, that may be reflected in a lower gravity assessment, a lower negligence finding, or both, and therefore a lower penalty. The system is designed to do this. What the system should not do is treat a violative condition as not being a violation categorically simply because an operator does some other things well. A standard is a floor. Exceeding the floor in one area does not cure a breach in another, but it goes to either the gravity or negligence of the violation. This is fully accounted for in how the gravity and negligence of violations are assessed. In short, the discretion the witness asked for already exists within the Act's enforcement authority.

Question 8. Government analyses suggest that there is an abundance of essential minerals in Appalachia and recoverable essential minerals in mine wastes.

a. How confident are you that essential-mineral mining would be conducted safely in Appalachia today?

I am not confident, and I raised many of the reasons in my underlying testimony. The health and safety risks have catapulted in Appalachia as the reserve base dwindled. Recovering essential minerals from Appalachian mineral reserves and from legacy mine wastes would occur in the same heavily-depleted, geologically difficult basins where operating margins are already tight. Operators in these regions already face temptations to cut corners as the mineral-per-ton recovered falls. The roof-stability, highwall, methane, and respirable-dust risks do not disappear when the target mineral changes from coal to lithium or a rare earth. In many cases the same disturbed ground and the same sandstone overburden are involved.

My lack of confidence is compounded by the lack of health standards for the specific minerals involved, and the enfeebled state of MSHA under the current Administration. MSHA and NIOSH have not derived standards, exposure limits, or other protections pertinent to the health hazards encountered in essential-mineral mining (rare earths, cobalt, etc.). As I testified, MSHA has lost experienced enforcement staff, NIOSH's mining research capacity has been disrupted, and the Review Commission is approaching the loss of a quorum. Asking a diminished enforcement and research apparatus to oversee a new and rapidly expanding category of mining, in some of the most challenging geologic conditions, is not a recipe for safe and healthful operations. It can be done safely, but only with the staffing, funding, and health-surveillance capacity that are currently being cut rather than built.

b. Would the chemical processes used to separate essential minerals raise particular health concerns for miners?

Yes. Retrieving unmined essential minerals or recovering them from mine wastes would likely involve chemical processes (leaching agents, solvents, acids, and other reagents) to separate the target minerals from surrounding material. Those processes introduce chemical-exposure hazards that are different in kind from the mechanical and respirable-dust hazards that dominate conventional coal mining, and that miners and the agency have far less experience managing in the mining context.

These concerns are real and, at present, inadequately addressed. They include inhalation and dermal exposure to process chemicals, handling and storage of corrosive or toxic reagents, the generation of new waste streams, and the interaction of those chemicals with the dust and gases already present underground. Whether the relevant exposure limits, monitoring methods, ventilation requirements, and medical-surveillance protocols exist and are being applied to these processes is an open question, and one the Committee should press, because the answer today is largely “not yet.”

Question 9. Please provide any additional information or perspectives that you would like to provide the Committee that has not been covered already in the previous questions.

I would use this opportunity to flag two related gaps in how MSHA is positioned for the rare-earth and essential-mineral mining upon which the country and the world are increasingly reliant. This is a health-surveillance gap and a jurisdictional gap.

First, on surveillance: MSHA/NIOSH have essentially no health-surveillance protocols tailored to rare-earth minerals. The coal programs have a mature surveillance infrastructure built over decades (extensive epidemiology, chest screening, dust monitoring, etc.) but nothing comparable exists for the distinct exposures presented by rare-earth and similar critical-mineral extraction and processing. If the nation is going to expand this kind of mining, which it is and it must, then MSHA and NIOSH need to develop exposure monitoring and medical-surveillance protocols for these minerals and the chemicals used to process them, before the workforce is exposed at a larger scale.

Second, on jurisdiction: there are fundamental jurisdictional questions that should be revisited under the decades-old Memorandum of Understanding between MSHA and the Atomic Energy Commission (the predecessor to the Nuclear Regulatory Commission). That MOU conditionally ceded jurisdiction over in situ leaching (ISL) operations, and it has historically applied principally to uranium. As essential-mineral production expands into techniques like in situ leaching, the Committee and the agencies should clarify which sorts of rare-earth and similar essential-mineral production sites, including ISL operations, fall within MSHA’s jurisdiction under the Mine Act. If rare-earth recovery is outside the NRC’s expertise, MSHA should consider asserting jurisdiction over future ISL operations for rare earths, so that no category of miners falls into a regulatory gap between agencies.

Once again, I am humbled by the opportunity to provide testimony to the U.S. House of Representatives. I am grateful for the Committee's attention to these issues and would welcome the chance to provide any further information that would assist your work.

Respectfully submitted,
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