



January 20, 2026

Dear Chairman Mackenzie and Ranking Member Omar:

We thank you and the Members of the Subcommittee on Workforce Protection for the opportunity to provide this letter related to the scheduled hearing “Examining the Policies and Priorities of the Mine Safety and Health Administration.” For over 40 years, the National Coalition of Black Lung and Respiratory Disease Clinics (NCBLRDC) has been educating coal miners about early diagnosis, treatment, and prevention of black lung disease along with conducting research to better understand the disease and its impact on miners’ lives. We are a coalition of nearly 60 black lung clinic sites in 15 states, serving 13,000 current and former coal miners along with many metal/nonmetal miners annually. Our members are on the front lines of the trends and developments in black lung disease.

Since the late 1990s, we have witnessed firsthand the progressively worsening toll that black lung disease has taken on our patients, their families, and our communities. It is well-documented that coal workers’ pneumoconiosis (CWP) is on the rise in the United States, particularly in the Central Appalachian states of Kentucky, Virginia, and West Virginia. Rates of disease among long-tenured coal miners have trended upward since the late 1990s despite an absence of changes to permissible exposure limits for coal mine dust, particularly in Central Appalachia, as seen in Figure 1.

Disturbingly, rates of progressive massive fibrosis (PMF), the most severe form of black lung disease, in Central Appalachia today are as high among long-tenured coal miners as they were when regulation of respirable coal mine dust levels were first instituted in the US in 1972 (Figure 2). Certainly, when it comes to severe black lung disease, *we are right back at square*

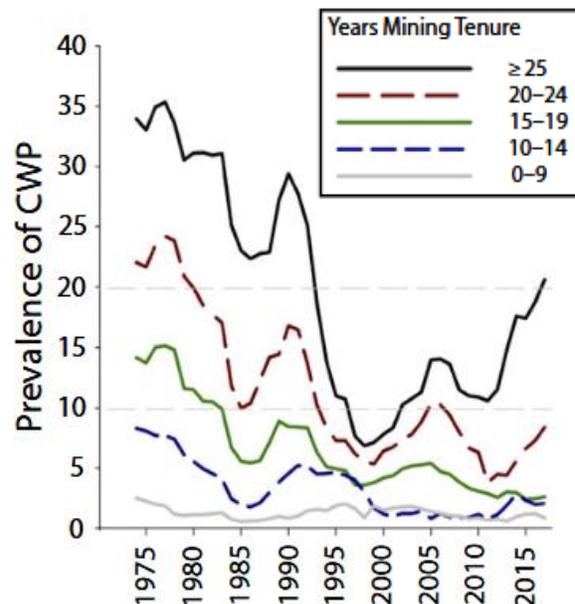


Figure 1. Prevalence of coal workers’ pneumoconiosis among those working in Central Appalachia: Coal Workers’ Health Surveillance Program, 1970-2017. From Blackley, et al. Am J Pub Health 2018.

one. Miners as young as 31 years old are receiving diagnoses of PMF, and miners in their 30s and 40s are undergoing lung transplants due to end-stage black lung disease.

Studies comparing differences in characteristics of severe black lung disease between contemporary and historical coal miners in the United States (Figure 3) show, convincingly, the central role of respirable crystalline silica in causing the observed rise in disease. This is highly important, as respirable crystalline silica is not as tightly regulated in the mining industry as it is in other industries, where it is regulated by the Occupational Safety and Health Administration. The 1969 Federal Coal Mine Health and Safety Act, signed by President Richard Nixon, was instrumental in reducing rates of black lung disease in the United States.

However, we now know that it had a weakness: there was no direct regulation of respirable crystalline silica. MSHA's respirable dust rule, lowering the permissible exposure limit for respirable coal mine dust, went into effect in 2014, but did not address the absence of direct regulation of respirable crystalline silica. With this knowledge, NCBLRDC has deep concerns about further delays in the enforcement of MSHA's final silica rule, intended to reduce miners' exposure to respirable crystalline silica dust, entitled *Lowering Miners' Exposure to Respirable Crystalline Silica and Improving Respiratory Protection*. This rule went into effect in June 2024, with coal mine operators mandated to come into compliance with the rule by April 14, 2025 and metal/non-metal mine operators by April 8, 2026. However, legal challenges brought by large industry trade associations covering various commodities has resulted in delays in enforcement and, to date, miners have not benefitted from necessary improvements in protection from respirable crystalline silica, a highly toxic exposure. **It is disturbing to consider that, absent enforcement of the MSHA Silica Rule as written, cases of severe black lung disease and silicosis will continue to occur well into the future.**

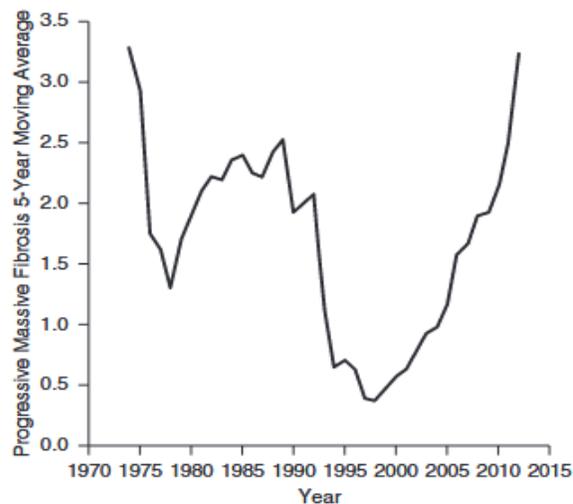


Figure 2. Prevalence of progressive massive fibrosis among working underground coal miners with 25 or more years of underground mining tenure (1974-2012) in Kentucky, Virginia, and West Virginia. Data from the Coal Workers' Health Surveillance Program. From Blackley, et al. *Am J Respr Crit Care Med* 2014.

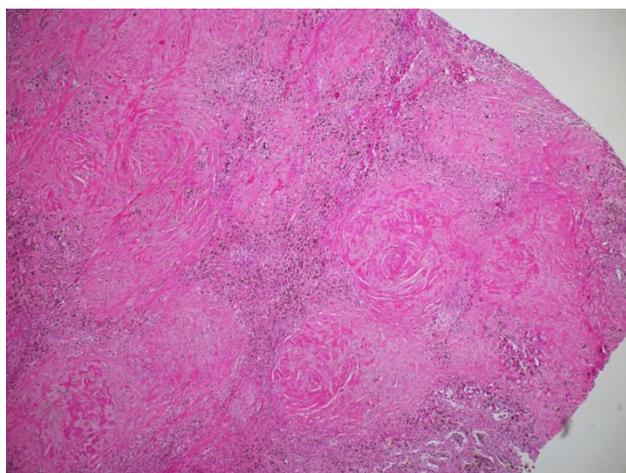


Figure 3. Representative microscopic image of lung tissue from a former underground coal miner who worked in the 1990s-2000s. Lung tissue demonstrates silicotic nodules, with pink whorled appearance, with notable lack of black coal dust pigment. Silicotic nodules have scarred over gas exchange units of the lung.

Congress made its priorities for MSHA clear when they created the agency in 1978. The Mine Safety and Health Administration exists for one core reason: to prioritize and protect the lives and health of our nation's miners. It is imperative that MSHA resist attempts and calls to weaken the silica rule and focus on enforcing the rule instead, lest they consign miners to more unnecessary suffering and death.

Sincerely,

On behalf of the Executive Board of the National Coalition of Black Lung and Respiratory Disease Clinics