Asthma and Allergy Foundation of America

December 16, 2020

President-elect Joseph Biden
Vice President-elect Kamala Harris
1401 Constitution Ave., NW
Washington, DC 20230

Dear President-Elect Biden and Vice President-Elect Harris:

On behalf of the Asthma and Allergy Foundation of America (AAFA), I am writing to recommend priority policy areas on which the next administration should focus to address asthma and, in particular, the unacceptable racial and ethnic disparities in the burden of asthma in the United States. AAFA is the leading patient organization advocating for people with asthma and allergies, and the oldest asthma and allergy patient group in the world. We believe that the ongoing disparities in asthma and other chronic health conditions in our country combined with the current COVID-19 pandemic have made the need to act for health equity even more urgent.

We are heartened by the incoming administration's focuses on racial equity[1] and on broadening access to healthcare.[2] In the U.S., asthma sits squarely at the intersection of profound structural racial inequities and ongoing inequities in healthcare access and health outcomes. As we detail in our *Asthma Disparities in America: A Roadmap to Reducing the Burden on Racial and Ethnic Minorities* report,[3] among the 25 million Americans living with asthma,[4] there are serious and persistent racial and ethnic disparities in the burden of illness:

- In 2015, Black children under age 15 had a death rate from asthma ten times that of non-Hispanic white children.[5]
- In 2014, non-Hispanic Black Americans were almost three times more likely to die from asthma-related causes than non-Hispanic whites.[6]
- In 2015, Black women were 20% more likely to have asthma than non-Hispanic white women.[7] In fact, when sex is factored in, Black women have the highest rates of death due to asthma.[8]

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[1] https://joebiden.com/racial-economic-equity/
[2] https://joebiden.com/healthcare/
[3] Asthma and Allergy Foundation of America, "Asthma Disparities in America" (2020). Available at https://www.aafa.org/asthma-disparities-burden-on-minorities.aspx#pdf
[4] National Center for Health Statistics. Asthma. Centers for Disease Control and Prevention. Page last reviewed: October 30, 2020.Available at: https://www.cdc.gov/nchs/fastats/asthma.htm
[5] Office of Minority Health. Asthma and African Americans. U.S. Department of Health and Human Services. Available at: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=15
[6] *Id.*
[7] *Id.*
[8] National Center for Health Statistics, National Vital Statistics System: Mortality (2018). Centers for Disease Control and Prevention.

- Puerto Ricans living in the continental U.S. are particularly vulnerable within Hispanic subgroups, with an asthma rate of 14.0 percent, compared to 6.4 percent for Mexican-Americans, 5.3 percent for South and Central Americans, and 4.4 percent for Mexican Americans.[9]
- Children with asthma who belong to racial or ethnic minority communities have higher rates of hospitalization, more visits to emergency rooms, and higher mortality rates from asthma than white children.[10]

While our recent report focuses on asthma disparities, it is also important to note disparities in the impact of food allergies, which are a common comorbidity for people living with asthma. Black children with food allergies are more likely than white children to have comorbid asthma (58.6% v. 35.3%) and more likely to have had a food allergy-related emergency department visit (39.7% v. 18.2%).[11] Both Black and Hispanic children with food allergy are far more likely than white children to experience food-induced anaphylaxis (odds ratio 2.44 and 2.38), an acute reaction that can result in death.[12]

Our report describes the range of ways in which factors beyond the clinical setting contribute to racial and ethnic disparities in asthma as well as other health issues. Structural factors, including racism and discrimination, contribute "upstream" to asthma risk and access to care. Meanwhile, social determinants that negatively impact health and wellbeing include poverty, lack of access to quality education or employment, unhealthy housing, unfavorable work or neighborhood conditions, and the clustering of poverty in particular groups of people and in particular places. Addressing social determinants of health is important for improving health and reducing longstanding disparities in asthma and all facets of health and health care.

Because of the broad roots of asthma disparities, achieving health equity will require approaches that include but extend far beyond the health care and public health systems. Many of the changes needed will also bolster our response to COVID-19, and the disparities that the epidemic has both reflected and exacerbated.

AAFA would therefore like to highlight the following multisectoral strategies that are key to addressing disparities in asthma and in promoting health equity. Outlined below are policy proposals detailed in our report, as well as specific examples to address asthma disparities. We would appreciate it if you would share and consider these policy proposals with the relevant agency review teams and with the COVID-19 task force.

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[9] American Lung Association. Current Asthma Demographics [website]. Page last updated July 6, 2020. Available at: https://www.lung.org/research/trends-in-lung-disease/asthma-trends-brief/current-demographics

[10] Anna Volerman, Marshall H. Chin and Valerie G. Press. Solutions for Asthma Disparities. Pediatrics March 2017, 139 (3) e20162546; DOI: https://doi.org/10.1542/peds.2016-2546

[11] Mahdavinia, M., Fox, S. R., Smith, B. M., James, C., Palmisano, E. L., Mohammed, A., . . . Gupta, R. S. (2017). Racial Differences in Food Allergy Phenotype and Health Care Utilization among US Children. The Journal of Allergy and Clinical Immunology: In Practice, 5(2). doi:10.1016/j.jaip.2016.10.006

[12] *Id.*

1. **Health Care**
    a. Expand health insurance access and coverage for socioeconomically disadvantaged adults and children.
    b. Improve coverage of asthma guidelines-based care and treatment in federal programs by expanding specialist care coverage, lowering co-pays, expanding eligibility criteria and removing prior authorization and step therapy barriers.
    c. Increase diversity in the primary and specialty health care workforce.
    d. Increase the percentage of minority patients with a usual source of care by addressing provider shortage areas, removing financial barriers to office-based primary care services, and expanding the primary care infrastructure to integrate better care coordination.
    e. Develop sustainable models for care coordination and case management that do not place financial burdens on patients.
    f. Encourage and incentivize state and local health departments to adopt comprehensive community asthma programs.
    g. Develop policies and programs to address the ongoing underrepresentation and exclusion of minorities from NIH-funded studies on respiratory diseases.

2. **Education**
    a. Increase access to quality early childhood education and care.
    b. Create more equitable school finance systems, including allocation of federal funds to schools that serve low-income and minority students.
    c. Use federal policies and funding to reduce exposure to environmental triggers by improving school building conditions and improving air quality in and around schools.
    d. Support federal legislation, the School-Based Allergies and Asthma Management Program Act (HR 2468 in the 116th Congress), to encourage important asthma management programs in schools.

3. **Physical Environment**
    a. Improve housing quality for rental units (including assisted rental units such as public housing) through "healthy home" policies and green building practices.
    b. Directly finance or support reimbursement models for programs that align asthma clinical interventions with home assessments, indoor environmental improvements and remediation to reduce asthma triggers.
    c. Increase access to affordable, quality housing through expanded rental assistance programs, tax credits, inclusionary zoning programs, and policies that address major racial disparities in homeownership rates.

d. Address major racial disparities in homeownership rates through policies that desegregate residential neighborhoods through mobility programs and neighborhood revitalization efforts.
e. Combat environmental injustice and the disproportionate impact of pollution and climate change on communities of color and low-income populations by strengthening clean air policies, reducing transportation-related emissions, restricting zoning of polluting sources and transitioning to a clean energy economy.

4. Economic Stability

a. Increase the federal minimum wage.
b. Reduce the racial wage gap in the US labor market.
c. Implement tax policies that help low-income families accumulate more wealth.

We stand ready to provide any additional information that would be useful, and to communicate with the broader asthma and food allergy community about any endeavors that your administration undertakes. Thank you for your time and attention.

Sincerely,

Kenneth Mendez

Kenneth Mendez
President and Chief Executive Officer
Asthma and Allergy Foundation of America

Cc: The Honorable Ted Kaufman, The Honorable Michelle Lujan-Grisham, The Honorable Cedric Richmond, The Honorable Jeff Zients, The Honorable Anita Dunn, Biden-Harris Transition Team Co-Chairs

Dr. David Kessler, Dr. Vivek Murthy, and Dr. Marcella Nunez-Smith, COVID-19 Advisory Board Co-Chairs
Dr. Linda Darling-Hammond, Team Lead, U.S. Department of Education Review Team
Ms. Chiquita Brooks-LaSure, Team Lead, U.S. Department of Health and Human Services Review Team
Ms. Erika Poethig, Team Lead, U.S. Department of Housing and Urban Development Review Team
Mr. Patrice Simms, Team Lead, U.S. Environmental Protection Agency Review Team