

116TH CONGRESS
1ST SESSION

H. R. 5230

To amend the Public Health Service Act with regard to research on asthma,
and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 21, 2019

Mr. ENGEL (for himself, Mr. UPTON, Mr. COX of California, and Mr. KING
of New York) introduced the following bill; which was referred to the
Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act with regard to
research on asthma, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Elijah E. Cummings
5 Family Asthma Act”.

6 **SEC. 2. FINDINGS.**

7 Congress finds the following:

8 (1) According to the Centers for Disease Con-
9 trol and Prevention, in 2017 more than 25,100,000

1 people in the United States had been diagnosed with
2 asthma, including an estimated 6,200,000 children.

3 (2) According to the Centers for Disease Con-
4 trol and Prevention, asthma usually affects racial
5 and ethnic minorities, including African Americans,
6 American Indians, Alaska Natives, Puerto Ricans,
7 and people of multiple races more than non-Hispanic
8 Whites. In 2017, Puerto Ricans and African Ameri-
9 cans had the highest lifetime prevalence of asthma
10 at 20.6 and 15.2 percent, respectively.

11 (3) According to the Centers for Disease Con-
12 trol and Prevention, among children, males have
13 higher rates of asthma than females, and in adults
14 women have higher rates of asthma than men. Indi-
15 viduals living below the poverty threshold also had
16 significantly higher rates of asthma in 2017 than in-
17 dividuals living above the poverty threshold.

18 (4) According to the Centers for Disease Con-
19 trol and Prevention, in 2017 more than 3,500 people
20 in the United States died from asthma. The rate of
21 mortality from asthma is higher among African
22 Americans and women.

23 (5) The Centers for Disease Control and Pre-
24 vention report that asthma accounted for approxi-

1 mately 180,000 hospitalizations and 1,800,000 visits
2 to hospital emergency departments in 2016.

3 (6) According to the Centers for Disease Con-
4 trol and Prevention, the annual cost of asthma to
5 the United States is approximately
6 \$81,900,000,000, including \$3,000,000,000 in indi-
7 rect costs from missed days of school and work.

8 (7) According to the Centers for Disease Con-
9 trol and Prevention, 5,200,000 school days and
10 8,500,000 work days are missed annually as a result
11 of asthma.

12 (8) Asthma episodes can be triggered by both
13 outdoor air pollution and indoor air pollution, in-
14 cluding pollutants such as cigarette smoke and com-
15 bustion by-products. Asthma episodes can also be
16 triggered by indoor allergens such as animal dander
17 and outdoor allergens such as pollen and molds.

18 (9) Public health interventions and medical care
19 in accordance with existing guidelines have been
20 proven effective in the treatment and management
21 of asthma. Better asthma management could reduce
22 the numbers of emergency department visits and
23 hospitalizations due to asthma. Studies published in
24 medical journals, including the Journal of Asthma
25 and The Journal of Pediatrics, have shown that bet-

1 ter asthma management results in improved asthma
2 outcomes at a lower cost.

3 (10) In 2016, the Centers for Disease Control
4 and Prevention reported that less than half of people
5 with asthma reported receiving self-management
6 training for their asthma. More education about
7 triggers, proper treatment, and asthma management
8 methods is needed.

9 (11) The alarming rise in the prevalence of
10 asthma, its adverse effect on school attendance and
11 productivity, and its cost for hospitalizations and
12 emergency room visits, highlight the importance of
13 public health interventions, including increasing
14 awareness of asthma as a chronic illness, its symp-
15 toms, the role of both indoor and outdoor environ-
16 mental factors that exacerbate the disease, and other
17 factors that affect its exacerbations and severity.
18 The goals of the Federal Government and its part-
19 ners in the nonprofit and private sectors should in-
20 clude reducing the number and severity of asthma
21 attacks, asthma's financial burden, and the health
22 disparities associated with asthma.

23 (12) The high health and financial burden
24 caused by asthma underscores the importance of ad-
25 herence to the National Asthma Education and Pre-

1 vention Guidelines of the National Heart, Lung, and
 2 Blood Institute. Increasing adherence to guidelines-
 3 based care and resulting patient management prac-
 4 tices will enhance the quality of life for patients with
 5 asthma and decrease asthma-related morbidity and
 6 mortality.

7 **SEC. 3. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
 8 **FOR DISEASE CONTROL AND PREVENTION.**

9 Section 317I of the Public Health Service Act (42
 10 U.S.C. 247b–10) is amended to read as follows:

11 **“SEC. 317I. ASTHMA-RELATED ACTIVITIES OF THE CENTERS**
 12 **FOR DISEASE CONTROL AND PREVENTION.**

13 “(a) PROGRAM FOR PROVIDING INFORMATION AND
 14 EDUCATION TO THE PUBLIC.—The Secretary, acting
 15 through the Director of the Centers for Disease Control
 16 and Prevention and the National Center for Environ-
 17 mental Health, shall collaborate with State and local
 18 health departments to conduct activities, including the
 19 provision of information and education to the public re-
 20 garding asthma including—

21 “(1) deterring the harmful consequences of un-
 22 controlled asthma; and

23 “(2) disseminating health education and infor-
 24 mation regarding prevention of asthma episodes and
 25 strategies for managing asthma.

1 “(b) DEVELOPMENT OF STATE STRATEGIC PLANS
2 FOR ASTHMA CONTROL.—The Secretary, acting through
3 the Director of the Centers for Disease Control and Pre-
4 vention, shall collaborate with State and local health de-
5 partments to develop State strategic plans for asthma con-
6 trol incorporating public health responses to reduce the
7 burden of asthma, particularly regarding disproportion-
8 ately affected populations.

9 “(c) COMPILATION OF DATA.—The Secretary, acting
10 through the Director of the Centers for Disease Control
11 and Prevention, shall, in cooperation with State and local
12 public health officials—

13 “(1) conduct asthma surveillance activities to
14 collect data on the prevalence and severity of asth-
15 ma, the effectiveness of public health asthma inter-
16 ventions, and the quality of asthma management, in-
17 cluding—

18 “(A) collection of data on or among people
19 with asthma to monitor the impact on health
20 and quality of life;

21 “(B) surveillance of health care facilities;
22 and

23 “(C) collection of data not containing indi-
24 vidually identifiable information from electronic

1 health records or other electronic communica-
2 tions;

3 “(2) compile and annually publish data regard-
4 ing the prevalence of childhood asthma, the child
5 mortality rate, and the number of hospital admis-
6 sions and emergency department visits by children
7 associated with asthma nationally and in each State
8 by age, sex, race, and ethnicity, as well as lifetime
9 and current prevalence; and

10 “(3) compile and annually publish data regard-
11 ing the prevalence of adult asthma, the adult mor-
12 tality rate, and the number of hospital admissions
13 and emergency department visits by adults associ-
14 ated with asthma nationally and in each State by
15 age, sex, race, and ethnicity, as well as lifetime and
16 current prevalence.

17 “(d) COORDINATION OF DATA COLLECTION.—The
18 Director of the Centers for Disease Control and Preven-
19 tion, in conjunction with State and local health depart-
20 ments, shall coordinate data collection activities under
21 subsection (c)(2) so as to maximize the comparability of
22 results.

23 “(e) COLLABORATION.—

24 “(1) IN GENERAL.—The Centers for Disease
25 Control and Prevention are encouraged to collabo-

1 rate with national, State, and local nonprofit organi-
2 zations to provide information and education about
3 asthma, and to strengthen such collaborations when
4 possible.

5 “(2) SPECIFIC ACTIVITIES.—The Division of
6 Population Health is encouraged to expand its ac-
7 tivities with non-Federal partners, especially State-
8 level entities.

9 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
10 carry out this section, there are authorized to be appro-
11 priated \$65,000,000 for the period of fiscal years 2021
12 through 2025.

13 “(g) REPORTS TO CONGRESS.—

14 “(1) IN GENERAL.—Not later than 3 years
15 after the date of enactment of this Act, and once 2
16 years thereafter, the Secretary shall, in consultation
17 with patient groups, nonprofit organizations, medical
18 societies, and other relevant governmental and non-
19 governmental entities, submit to Congress a report
20 that—

21 “(A) catalogs, with respect to asthma pre-
22 vention, management, and surveillance—

23 “(i) the activities of the Federal Gov-
24 ernment, including an assessment of the
25 progress of the Federal Government and

1 States, with respect to achieving the goals
2 of the Healthy People 2030 initiative; and

3 “(ii) the activities of other entities
4 that participate in the program under this
5 section, including nonprofit organizations,
6 patient advocacy groups, and medical soci-
7 eties; and

8 “(B) makes recommendations for the fu-
9 ture direction of asthma activities, in consulta-
10 tion with researchers from the National Insti-
11 tutes of Health and other member bodies of the
12 Asthma Disparities Subcommittee, including—

13 “(i) a description of how the Federal
14 Government may improve its response to
15 asthma, including identifying any barriers
16 that may exist;

17 “(ii) a description of how the Federal
18 Government may continue, expand, and
19 improve its private-public partnerships
20 with respect to asthma, including identi-
21 fying any barriers that may exist;

22 “(iii) the identification of steps that
23 may be taken to reduce the—

24 “(I) morbidity, mortality, and
25 overall prevalence of asthma;

1 “(II) financial burden of asthma
2 on society;

3 “(III) burden of asthma on dis-
4 proportionately affected areas, par-
5 ticularly those in medically under-
6 served populations (as defined in sec-
7 tion 330(b)(3)); and

8 “(IV) burden of asthma as a
9 chronic disease that can be worsened
10 by environmental exposures;

11 “(iv) the identification of programs
12 and policies that have achieved the steps
13 described under clause (iii), and steps that
14 may be taken to expand such programs
15 and policies to benefit larger populations;
16 and

17 “(v) recommendations for future re-
18 search and interventions.

19 “(2) SUBSEQUENT REPORTS.—

20 “(A) CONGRESSIONAL REQUEST.—During
21 the 5-year period following the submission of
22 the second report under paragraph (1), the Sec-
23 retary shall submit updates and revisions of the
24 report upon the request of the Congress.

1 “(B) FIVE-YEAR REEVALUATION.—At the
2 end of the 5-year period referred to in subpara-
3 graph (A), the Secretary shall—

4 “(i) evaluate the analyses and rec-
5 ommendations made in previous reports;
6 and

7 “(ii) determine whether an additional
8 updated report is needed and if so submit
9 such an additional updated report to the
10 Congress, including appropriate recommen-
11 dations.”.

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