

The Continued Burden of Asthma in the U.S.

Group Policy Analysis, Part 3

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Bardach 1. Short Summary of the Problem

Accessibility and affordability play a significant role in improving asthma-related health outcomes. Many people continue to face financial barriers as out-of-pocket costs for health care have significantly increased in the past decades. As a chronic disease, the level of one's economic burden is significantly impacted by asthma severity. Individuals with uncontrolled asthma medically accrue higher amounts of health care resources, costs, and lost time from employment (Burnette, et al, 2023). Yet, those who report financial barriers (e.g. minority groups, uninsured, have fair or poor health) often indicate delaying or foregoing necessary medical services and treatment. Strategies to effectively address gaps in care are necessary for improving access to affordable, quality care.

Bardach 3, 4, 5 & 6. How do solutions identified in Part 2 impact each other?

Potential Solution 1: *Decreasing direct/indirect costs for asthma services*

Efficacy and effectiveness

Throughout the research on access to health resources and care for asthma, such as alternative methods for asthma treatment, options for alternative cost-reduction for respiratory therapy have been made. Because of the burden of COVID-19, options such as telehealth, mobile services, and primary prevention tactics are implemented to effectively reduce direct and indirect costs for this kind of health issue (Codispoti et al., 2022). Though it might be a challenge to implement these practices in areas with low or undetermined funding, the various delivery methods oppose the money put into resources causing drastic health costs, like recurring medical visits and medication.

Sustainability

Multiple supporting factors allow respiratory health, specifically asthma-related, to be sustained and arise in access to health, especially considering the COVID-19 pandemic that caused major respiratory issues in several populations. Because the susceptibility of these kinds of health issues often occurs as symptoms of different diseases, on a positive note, they allow the promotion of basic respiratory health and access to it to be easily advertised. In specificity to lowering the costs of these services, the ongoing and recurring issue of inaccessibility for asthma-related services for those with monetary concerns allows for a relationship to be made between the two for further policy development.

Political feasibility

Though attainable for political implementation on lower-costing asthma and respiratory health services, the feasibility of a governmental/state decision on monetary changes to health access may be hard with the state of healthcare obtainability such as ACA and its associated complications like ineligibility, oversight, and discrimination. Another reason why I feel political feasibility may be a challenge to accomplish is because of how each state operates with its healthcare system. This makes it hard for individuals in a certain area within state borders to become familiar with how their providers function and the kind of healthcare access they have in their community. Overall, I believe that the implementation of political engagement is possible, but we are not as close as we should be at this time (Marye & Atav, 2023).

Potential Solution 2: *Increasing insurance coverage for managing asthma-related care*

Equity

Individuals with uncontrolled asthma are often disproportionately affected by poor health outcomes resulting from financial barriers to affordable care. In 2022, approximately 27.6 million people of all ages (8.4%) were uninsured, with the largest proportion of the uninsured

among working adults aged 18-64 (Cohen, Briones, & Martinez, 2024) (Appendix A1-A2) . In the absence of insurance or with high out-of-pocket costs for those underinsured, individuals are more likely to forego medical services, less likely to adhere to medications, or to obtain self-management knowledge. Despite evidence-based guidelines for managing asthma, lack of affordable care continues to exacerbate asthma-related health burdens by reducing access to medications and physicians. In turn, patients are unable to adhere to effective treatment. This domino effect drives up health care costs due to urgent care and hospitalizations.

Political feasibility

Challenges to address health equity and affordability of coverage are multifactorial. Despite the increased coverage following the Affordable Care Act, adoption of Medicaid expansion has not been universal. Currently, “ten states have not adopted the Medicaid expansion, leaving approximately 1.5 million people within those states in a coverage gap” (Drake, Tolbert, & Rudowitz, 2024). Additionally, executive actions under the Trump administration undermining the ACA further contributed to variable and inconsistent coverage throughout the U.S. If universal coverage was attained as originally intended under the ACA, 1.4 million non-elderly adults along with those currently in the coverage gap would be eligible for Medicaid in the non-expansion states (Appendix A3-A4). However, due to wide divisions in addressing national health expenditures, variability continues to exist between states to ensure affordability.

Costs

According to the U.S. Centers for Medicare & Medicaid Services the national health spending grew 4.1%, totaling 4.5 trillion in 2022. The federal government accounted for 33%, households 28%, private business 18%, state and local government 15%, and other private

revenues 7% (CMS, 2024). As a result of higher financial risks, insurance companies look to cost-cutting strategies (higher co-payments, deductibles, or premiums), but this can negatively impact individual consumers. Health insurance is intended to protect individuals from devastating medical expenses, thus provisions to ensure affordability are critical to reduce ongoing health disparities. Suri, Macinko, Inkelas, & Needleman, J. (2022) conducted a study to evaluate the impact of insurance status and the ACA on asthma control. Though there was a significant correlation between insurance and improved asthma outcomes, the ACA implementation did not demonstrate a statistically significant association for improved asthma. However, the fact remains that a lack of insurance, financial barriers among those underinsured, and inconsistent asthma care escalates health care utilization further contributing to a cycle of rising costs and poor health outcomes.

Potential Solution 3: *Having an effective asthma management plan*

Efficacy and effectiveness

Education on asthma self-management is essential for the general health and well-being of people with asthma and helps them better regulate their condition. The needs of adults with asthma are not given the same attention as those of children with asthma, despite the fact that many programs and initiatives are aimed at this population (Gardner, E.A., et al, 2021).

According to Gardner, et al (2021) “The American Lung Association developed Breathe Well, Live Well, an adult asthma self-management education program, and launched it nationwide in 2007. The program for adults has a flexible delivery format for community-based implementation.

Patients who actively participate in their own care and have productive interactions with their healthcare professionals are more likely to successfully control their asthma. Asthma self-

management entails self-monitoring, avoiding asthma triggers, identifying and treating asthma symptoms, and taking controller medication as directed (Gardner, E.A., et al, 2021). Adult asthma self-management education programs are beneficial in lowering asthma symptoms and lowering medical visits, as well as generate financial savings and a favorable return on investment (Gardner, E.A., et al, 2021).

The University of Alabama at Birmingham's Asthma Self-Management Program (ASMP), emphasized improving participants' cognitive abilities, fostering positive attitudes, giving them chances to succeed and set an example for others, and assisting them in finding supportive social networks for their asthma (Gardner, E.A., et al, 2021). The ASMP comprised two follow-up reinforcement calls and letters, a skill-oriented workbook, and asthma self-management education group sessions led by a health educator. Two RCTs showed that the ASMP considerably reduced reports of asthma symptoms and increased adherence to asthma medication (Gardner, E.A., et al, 2021).

Costs

Asthma incurs around \$82 billion in direct and indirect costs to society annually, including \$3 billion in lost work productivity (Gardner, E.A., et al, 2021). Such self-management initiatives may cost less when programs are offered through community organizations or by non physician staff, such as respiratory therapists, health educators, or community health workers (Gardner, E.A., et al, 2021). Adherence to guideline recommendations would lead to a reduction in needless and expensive (cost-prohibitive) treatments such β 2-agonist rescue inhalers, nebulization at home, improper prescription of antibiotics, mucolytics, cough syrups, and antihistamines, as well as Emergency Response and hospital stays (Green, 2014).

According to Green (2014) “Hospitalizations and the expense of managing uncontrollable symptoms would decline with the use of inhaled corticosteroids, more spirometry testing, and patient education, even if prices would.” Depending on the intensity, a single exacerbation might cost anything from several hundred to several thousand rands. If home nebulization is utilized, treating uncontrollable symptoms can cost several hundred rands. In addition to immediate financial savings, guidelines-based management is probably going to improve life quality and lead to fewer sick days from work or school (Green, 2014).

An effective asthma management plan can have several positive impacts on both costs and insurance coverage for managing asthma-related care:

- **Cost Reduction:** Patients can lower their need for ER visits, hospital stays, and other acute care services by controlling their asthma well. As a result, patients and healthcare systems save money.
- **Indirect Costs:** Reducing missed workdays, school days, and productivity losses due to improved asthma control results in indirect cost savings.
- **Enhanced Coverage:** Compared to people without asthma, Americans with asthma are more likely to have health insurance. Compared to adults, children with asthma typically have greater full-year health insurance coverage (CDC, 2013).
- **Obstacles to care:** Some people still experience financial difficulties when receiving asthma treatment, even if they have insurance. Access to primary care or asthma specialists, as well as the cost of asthma drugs, are some of these obstacles.

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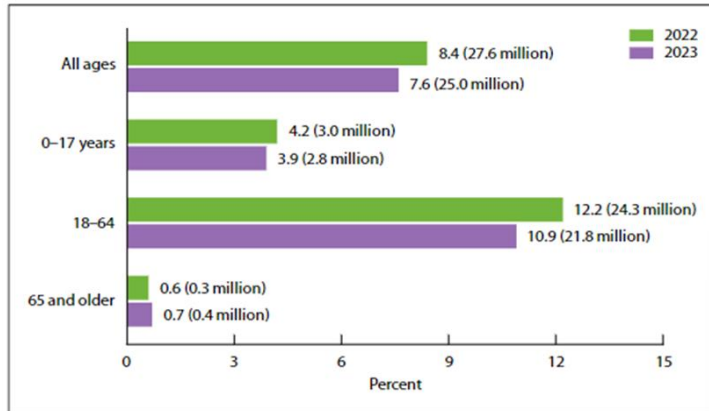
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Appendix

U.S. Insurance Coverage



NOTES: People were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan or military plan. People were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2022-2023.

Figure A1. Percentage and number of people who were uninsured, by age group and year: United States, 2022-2023. *Source:* Cohen, Briones, & Martinez (2024).

| Age group | Uninsured (%) | Public Health Plan | Private Health Insurance |
|------------------|---------------|--------------------|--------------------------|
| | | Coverage (%) | Coverage (%) |
| All ages | 8.4 | 39.5 | 61.0 |
| Age 0-17 | 4.2 | 43.7 | 54.3 |
| Age 18-64 | 12.2 | 22.0 | 67.8 |
| Age 65 and older | 0.6 | 95.2 | 45.7 |

Figure A2. Percentage of people who were uninsured, had public health plan coverage, or had private health insurance coverage by age group in the U.S., 2022. *Source:* Cohen, Briones, & Martinez (2024).

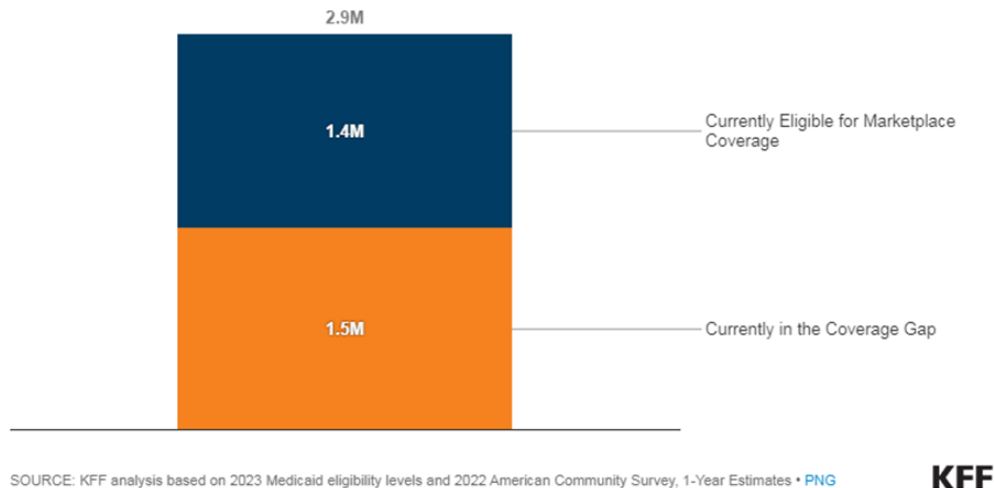


Figure A3. Uninsured nonelderly adults in non-expansion states who would become eligible for Medicaid if their states expanded, 2022. *Source:* Drake, Tolbert, & Rudowitz, (2024, February 26).

| | Total | Currently in the Coverage Gap (<100% FPL) | Currently May Be Eligible for Marketplace Coverage (100% - 138% FPL) |
|-----------------------------------|-----------|---|--|
| All States Not Expanding Medicaid | 2,882,000 | 1,471,000 | 1,411,000 |
| Alabama | 174,000 | 101,000 | 73,000 |
| Florida | 570,000 | 285,000 | 286,000 |
| Georgia | 359,000 | 175,000 | 183,000 |
| Kansas | 72,000 | 39,000 | 33,000 |
| Mississippi | 123,000 | 74,000 | 49,000 |
| South Carolina | 141,000 | 76,000 | 66,000 |
| Tennessee | 194,000 | 95,000 | 99,000 |
| Texas | 1,214,000 | 617,000 | 597,000 |
| Wisconsin | 15,000 | 0 | 15,000 |
| Wyoming | 20,000 | 9,000 | 11,000 |

Figure A4. Uninsured nonelderly adults in non-expansion states who would become eligible for Medicaid if their states expanded, 2022. *Source:* Drake, Tolbert, & Rudowitz, (2024, February 26).