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Testimony from

**Sumita Khatri, MD, MS**

Vice Chair – Mission Programs and  
Chair of the Public Policy Committee  
**American Lung Association**

The Policy Assessment for Review of the National Ambient Air  
Quality Standards  
for Particulate Matter, External Review Draft, September 2019

Docket ID No. EPA-HQ-OAR-2015-0072

**December 3, 2019**

Good morning. I am Sumita Khatri, MD, a pulmonologist and a volunteer with the American Lung Association. Normally, I am seeing patients with lung diseases in my job as the Director of the Asthma Center at the Cleveland Clinic. But today, I’m speaking out in one of my other most important roles as a member of the Board of Directors of the Lung Association.

The Lung Association’s mission is to save lives by preventing lung disease and promoting lung health. Those reasons form the core concerns that drive our comments that I will share today. We have submitted our full comments in writing.

First the process. We continue to oppose the flawed process that EPA has adopted in this review. EPA’s changes restrict the full discussion and review of the information, undermining the core purpose of this process: to set standards that “protect health with an adequate margin of safety.” The Lung Association has long supported and, indeed, taken legal action to ensure the completion of the reviews in a timely manner. However, the current process undermines the ability of CASAC and EPA to arrive at appropriate and adequate decisions on these standards.

**Advocacy Office:**

1331 Pennsylvania Avenue NW, Suite 1425 North  
Washington, DC 20004-1710  
Ph: 202-785-3355 F: 202-452-1805

**Corporate Office:**

55 West Wacker Drive, Suite 1150 | Chicago, IL 60601  
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

We agree with the finding in the draft Policy Assessment (PA), that “a substantial portion of the U.S. population” faces increased risk from breathing particulate matter. Millions face greater risk from PM, including more than 15.3 million adults who have chronic obstructive pulmonary disease (COPD) and more than 25.2 million Americans who have asthma, including 6.2 million children.<sup>1</sup> We particularly call attention to the new evidence showing that African Americans face a three-time higher risk from PM than the entire population.<sup>2</sup> This adds to the evidence that African Americans, Hispanics and low-income communities face higher risk because social and environmental disparities.

The Lung Association strongly supports one of the key findings in this Draft PA: that overwhelming evidence that the current annual fine particulate (PM<sub>2.5</sub>) standard fails to protect public health. However, strong evidence exists that the 24-hour standard also fails to provide that required protection to public health. The Lung Association urges EPA to strengthen both the annual and the 24-hour PM<sub>2.5</sub> standards.

Recent U.S. studies and Canadian studies find evidence of premature deaths down to and below 8 micrograms per cubic meter ( $\mu\text{g}/\text{m}^3$ )<sup>3</sup> A large study looking at short-term exposures also added evidence of harm below the current annual standard.<sup>4</sup>

We strongly disagree with the specious arguments provided in the Draft PA to create some justification for retaining the current annual standard. The powerful evidence from these epidemiological studies alone undercut these rationalizations of uncertainty.

We also disagree with EPA’s evaluation that the 24-hour PM<sub>2.5</sub> standard provides sufficient protection for public health. EPA argues that its primary use is to supplement the annual standard. Even with that role, that combination fails to provide protection for many communities across the nation where the annual level is quite low. For communities in Alaska, parts of the Northwest and parts of New England, shorter-term exposures pose the primary risk because of the emissions from woodstoves and other sources that create days of elevated PM. Nearly all these areas have year-round concentrations that are well under the annual standard.

Based on the information in the Draft ISA and Draft PA, the Lung Association urges EPA to strengthen the annual PM<sub>2.5</sub> standard to 8  $\mu\text{g}/\text{m}^3$  and the 24-hour standard to 25  $\mu\text{g}/\text{m}^3$ .

Thank you.



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<sup>1</sup> Centers for Disease Control and Prevention. National Health Interview Survey, 2017. Analysis by the American Lung Association Epidemiology and Statistics Unit Using SPSS Software.

<sup>2</sup> Di Q, Wang Y, Zanobetti A, Wang Y, Koutrakis P, Choirat C, Dominici F and Schwartz JD. 2017. Air pollution mortality in the Medicare population. *NEJM*. 376(26): 2513-2522.

<sup>3</sup> Shi L., et al. 2016. Low Concentration PM<sub>2.5</sub> and mortality; estimating acute and chronic effects in population-based study. *Environmental Health Perspectives*, 124(1)46-52; Szyszkowicz M. 2009. Air pollution and ED visits for chest pain, *American Journal of Emergency Medicine*. 27(2): 165-168; Steib DM, et al. 2009 Air pollution and emergency department visits for cardiac and respiratory conditions: A Multi-city time series analysis. *Environmental Health: A Global Science Access Source*. 8(25):25; Weichenthal S. et al. 2016 Ambient PM<sub>2.5</sub> and risk of emergency room visits from myocardial infarction: Impact of regional PM<sub>2.5</sub> oxidative potential: a case-crossover study. *Environmental Health*. 15:46.; Weichenthal et al., 2016. "PM<sub>2.5</sub> and emergency room visits for respiratory illness: effect modification by oxidative potential." *AJRCCM*. 194(5): 577-586.

<sup>4</sup> Di Q, Dai L, Wang Y, Zanobetti A, Choirat C, Schwartz JD and Dominici F. 2017. Association of short-term exposure to air pollution with mortality in older adults. *JAMA* 318(24): 2446-2456.