**Methods**

*Census data*

We included populated census blocks of the contiguous United States (U.S.) for the year 2010 obtained from the National Historical Geographic Information System (NHGIS) website (Manson et al., 2018; US Census Bureau, 2010). Each block included information on total population of children <18 years, and whether the census block was designated as an urban or rural block. Median household income was available only for census block groups, which is a level higher than census block, divided into five categorized: <$20,000, $20,000 to <$35,000, $35,000 to <$50,000, $50,000 to <$75,000 and ≥$75,000. There were 2686 (0.04%) census blocks with missing median income data in 2010 which were excluded the analysis of median household income. Table 1 summarizes the geographical and demographic data.

*Asthma incidence and prevalence rates*

An incidence rate is defined as the number of new cases of a disease within a specified time period among an at-risk population. To estimate the childhood asthma incidence rate, we extracted the number of new asthma childhood cases and at-risk children for the year 2006 through 2010 using the Asthma Call Back Survey (ACBS) and Behavioral Risk Factor Surveillance System (BRFSS) (CDC, 2009, 2011) and following the methods described by Winer et al. (2012). In brief, participants in the BRFSS were asked “Has a doctor, nurse, or other health professional ever said that the [name of child] has asthma?” if the answer is “yes”, the respondent is requested to participate in the ACBS follow up survey. The ACBS survey further asks “How old was the [name of child] when a doctor or other health professional first said [he/she] had asthma? How long ago was that?” a new asthma incident case would answer “within the past 12 months”. At-risk children are the sum of new childhood asthma cases and total children who never had asthma (i.e. subtracting the prevalent cases from total children).

Each sample is multiplied by its assigned final weight. The sum of weights for the BRFSS represents the total children population while the sum of weights for the ACBS represent total population with lifetime asthma. Not all states participated in the ACBS each year. States that participated more than once had had their original weights reweighted by dividing with the number of years of participation. We then estimated the state-specific average asthma incidence rates for the years 2006 through 2010. States not included in the data set; thus, did not have a specific incidence rate, were assigned the overall average asthma incidence rate. States not within the contiguous U.S. were excluded from the analysis.

*NO2 exposure assessment*

Annual average NO2 concentrations for each populated census block were available at the centroid location for the year 2010. Concentrations were derived from a land use regression model utilizing Environmental Protection Agency (EPA), satellite data and several GIS covariates. A detailed description of the model can be found at Bechle et al. (2015). NO2 concentrations were converted from ppb to ug/m3through multiplying by 1.88 (WHO, 2005).

*Concentration-response function*

We used a concentration-response function (CRF) of 1.05 (95% CI = 1.02-1.07) per 4ug/m3 of NO2. The CRF was obtained from a meta-analysis of 20 studies examining the association between exposure to traffic-related air pollution (TRAP) and risk of developing asthma among children (Khreis et al., 2017).

*Burden of disease estimate*

To estimate the burden of disease, we used a standard assessment methods described by Mueller et al. (2017) with the following steps:

We estimated the at-risk children for each state by subtracting the total number of prevalent cases from the total children within the state. We then estimated the number of asthma cases for each state by multiplying the state-specific childhood asthma incidence rate with at-risk children for each census block.

*At-risk children = Total children – (Total children \* Prevalence rate) (1)*

*Asthma incident cases = At-risk children \* Incidence rate (2)*

We then calculated the relative risk (RRdiff) for asthma due to exposure difference between estimated exposure levels (NO2 concentration at the census block level) and no exposure (zero NO2 concentration).

*RRdiff = e((ln(RR)/RRunit\*Exposure level) (3)*

Where RR is the CRF and RRunit is the exposure unit for the CRF. The population attributable fraction (PAF) is then estimated.

*PAF = (RRdiff – 1)/(RRdiff) (4)*

The attributable number of asthma incident cases (AC) is estimated by multiplying the PAF with the number of incident asthma cases at each census block. The AC is then summed up to get the total AC.

**Results**

*Asthma incidence rates*

Childhood asthma incidence rate was estimated for 32 states (Table – 9; Childhood Asthma incidence rate by state). The average national incidence rate across 2006-2010 (IR = 12.1 per 1,000) was assigned to states that did not have a state-specific incidence rate. The state of Montana had the lowest childhood asthma incidence rate (IR = 4.3 per 1,000), while District of Columbia had the highest childhood asthma incidence rate (IR = 17.7 per 1,000).

*Asthma incident cases*

Using state-specific asthma incidence rates the estimated number of childhood asthma incident cases were 754,893 in 2010 (Table 3). By living location, 19% lived in a rural area, while 9% and 72% lived in an urban cluster and urbanized area, respectively. The largest percentage of childhood asthma cases (28%) lived in an income block group of $50,000 to <$75,000, while the lowest percentage (4%) lived in the lowest income block group of <$20,000.

*Attributable number of cases and fraction*

On average, we estimated a total of 132,829 childhood asthma cases attributable to NO2 exposure which accounted for 17.6% of all childhood asthma cases (Table 3). By living location, urbanized areas had the largest number of attributable cases totaling 109,581 cases and highest percentage of all asthma cases of 20.3%. Rural areas had total of 13,951 cases but accounting for the east percentage of all asthma cases with 9.8%, while urban clusters had only 9,296 cases representing 13% of all asthma cases. By income, $50,000 to <$75,000 had the largest number of cases attributable to NO2, 37,559 cases accounting for 16.8% of all asthma cases. However, the income group with the largest percentage of asthma cases was the lowest income group <$20,000, accounting for 20.8% of all asthma cases.

*Comparison with the main paper*

*Overall estimates*

*State estimates*

(Table 5)

**Discussion (bullet points)**

* Using state specific asthma incidence rates did not change the results much (within the range of the sensitivity analysis from the main paper)
* The state specific total number of asthma cases and attributable cases changed when applying state specific incidence rates (Table X “in excel format)
* The state-specific attributable fractions did not change. The reason is that the incident rate is applied uniformly across the state (spatially), thus the total asthma cases and total attributable cases will change with equal proportion when applying the new asthma incidence rate. Had we applied an incidence rate based on other factors like age, gender, race, income group, then the attributable fraction across the state would differ since the change won’t in incidence rate won’t be uniform within the state.
* The percentage of all asthma cases has a J shaped distribution. The lowest income group had the highest % then drops and rises again with the highest income group.

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