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Civil Rights and the “Twinkie” Tax: The 900-Pound Gorilla in the War on Obesity

INTRODUCTION

It is somewhat of an understatement to say that overweight and obese people are presently unpopular in our culture.¹ They are, on the whole, subject to greater expenses, paying more for “plus-sized” clothing, two seats on an airplane (required now by many airlines), and spending on average seven hundred dollars more per year on medical bills, insurance premiums, and co-payments than their thinner counterparts.² Life insurance premiums rise as girth increases.³ Disability insurance for obese people is exorbitant at best and nonexistent at worst.⁴ To make matters worse, studies indicate that a significant wage penalty exists for overweight people.⁵ Obese

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1. A famous study conducted in 1968 revealed a clear and deeply entrenched repugnance for fat in the American world view. Boys aged six to ten were shown silhouettes of various body types and asked to impute characteristics to them. Overwhelmingly, the boys attributed socially objectionable characteristics, such as cheats, lazy, forgets, sloppy, naughty, ugly, dirty, stupid, to the rotund silhouette. George Maddox, Kurt Back, & Veronica Liederman, *Overweight as Social Deviance and Disability*, 9 J. of Health and Soc. Behav. 287, 289 (1968). Apparently, friends of obese people also face severe social stigma. One study revealed that respondents viewed a man pictured with an obese woman twenty-two percent more negatively than a man with a thin woman. The man with the obese date was described as “miserable, self-indulgent, passive, shapeless, depressed, weak, insignificant, insecure.” *Study: Friends of Obese People Also Bear Stigma*, Baton Rouge Advocate, Oct. 15, 2003, at 6A. Fat is, contrary to what science alleges, communicable.

2. The total amount spent per year on obesity and obesity-related expenses is about ninety-three billion dollars. These costs are passed on to all Americans in the form of higher health insurance premiums and co-payments. The average taxpayer shells out \$150-\$200 per year to finance obesity-related Medicare/ Medicaid expenses. Sharon Epperson, *The Obesity Charge: Being Overweight Puts a Burden on Your Wallet as Well as Your Health*, Time, Sept. 8, 2003, at 100.

3. A life insurance policy at State Farm for a thirty-five year old male non-smoker weighing 251 pounds at five feet, ten inches would not be subject to any increased premium. A male similarly situated but weighing 252 pounds would pay an extra premium of \$2.65 for every \$1000 of coverage, which is eighteen percent more than normal. Interview by Sharon Epperson of insurance agent Bill Simons, *Profile: Cost of Fat Adding Up with Greater Medical Expenses and Higher Life Insurance Premiums*, CNBC: Business Center, July 31, 2003.

4. It is possible that an obese person would be denied coverage, rather than be provided with more expensive coverage. *Id.*

5. For instance, the average household income for an overweight person is \$18,372, while the average income for a non-overweight individual is \$30,586. Nearly thirty-two percent of overweight people fall below the poverty level, as compared to thirteen percent of non-overweight individuals. This disparity is quite

and overweight Americans can make less money than thinner people in the same profession.⁶ To add insult to injury, doctors, lawyers, researchers, and legislators exacerbate the problem and reinforce the stigmatization of fat by proposing “remedies” for the obesity epidemic. Rather, they suggest remedies to deal with the rising cost of obesity. Needless to say, the cost of obesity and its related health consequences, which is currently estimated at around \$117 billion per year, is substantial.⁷ These proposed regulatory solutions range from the absurd (e.g., nationally syndicated columnist Dr. Kenneth Walker’s suggestion that fat people be put in prison camps)⁸ to the retrogressive (e.g., University of Chicago law professor Richard Epstein’s proposal that discrimination against fat people be legalized in insurance, work, and education)⁹ to the seemingly plausible. Among these legislative panaceas are the notions of a “fat” tax on unhealthy foods and an insurance surcharge to be added to the already inflated premiums that overweight people pay.¹⁰ Health and Human Services Secretary Tommy Thompson suggests that insurers comparably raise premium rates for those individuals who can’t keep their BMI below thirty.¹¹ This comment will address these regulatory

possibly linked to a difference in education levels, viz., only nine percent of overweight people complete college, while twenty-one percent of non-overweight individuals do. George Bray, *Contemporary Diagnosis and Management of Obesity* 97, tbl. 6 (1998).

6. Epperson, *supra* note 2.

7. Estimates vary, but this figure is a mean average. See *An Ounce of Prevention: Obesity and Healthy Lifestyles*, Health Pol’y Monitor, Summer 2001, at 1-2; see also Epperson, *supra* note 2.

8. Dr. Walker deemed this harsh remedy necessary for the good of the country and the obese individuals themselves. Rebecca Puhl & Kelly Brownell, *Bias, Discrimination, and Obesity*, 9 *Obesity Research* 788, 788 (2001).

9. Professor Richard Epstein has suggested allowing employers, schools, and insurance companies to “viciously discriminate against any person who is obese.” The notion behind this policy is that it creates a powerful incentive for obese individuals to slim down. It fails to take into account that this incentive, due to the pervasive social stigma attached to obesity, already exists. Ronald Bailey, *Time for Tubby Bye Bye*, Reason, June 11, 2003.

10. These remedies, as stated by Yale obesity expert Kelly Brownell, would curb obesity using price incentives, social stigma, and discrimination. Presumably, the individuals that suggest these remedies are unaware that these factors are already in effect. Jacob Sullum, *Weight Problem*, Reason, Sept. 22, 1999.

11. A BMI of thirty is the current measure of obesity. Secretary Thompson touts the premium raise as an effective disincentive for gluttony. Debra Goldman, *The Body Politic: On the Front Lines Where the War on Obesity Meets Fat Acceptance*, Adweek, July 21, 2003, at 16. It should be noted that raising premium rates would only be effective against those overweight and obese individuals who have health insurance. Many employers demand that obese individuals pay higher premiums for health benefits, a practice that quite often makes such benefits unaffordable. One study of 445 obese people showed that twenty-six percent were denied benefits outright. Puhl & Brownell, *supra* note 8, at 790.

proposals and similar extant obesity legislation within the framework of a traditional civil rights context. Part I of this comment will explore the significant social demographics of obesity, including its increasing incidence in both national and global populations and its alarming nexus to both race and poverty. Part II of this comment will address the various interventions and legislative initiatives employed by both state governments and the federal government in ameliorating the obesity epidemic. In Part III of this comment, the constitutionality and lawfulness of these governmental interventions regarding obesity will be considered. In this determination, a broad civil rights framework will be utilized, and three main methods will be employed: 1) the reason and rationality of such legislative remedies will be addressed under equal protection scrutiny, 2) the disparate impact of obesity regulations on African-Americans, women, and the indigent will be considered within the context of the Civil Rights Act of 1964, and 3) the potentiality of obesity as a qualified disability will be analyzed under the Americans with Disabilities Act and the Rehabilitation Act of 1973. To this end, Part III will focus on litigation under these primary statutory methodologies involving obesity, and will also analogize obesity to other classifications that have invoked successful claims of discrimination using similar modes of address. Part III, therefore, will introduce the three weapons in the legal arsenal that could be used to address potentially discriminatory obesity interventions, to wit: the Civil Rights Act of 1964 (which can be used to attack private sector discrimination), the Equal Protection Clause of the Fourteenth Amendment (which reaches state-sanctioned discrimination), and the Americans with Disabilities Act and the Rehabilitation Act (which protect the rights of individuals qualifying as disabled). The final part of this paper will examine the utility of these legislative interventions, economic incentives and deterrents, viz., what ostensible benefit is there in tax-burdening the poor or charging excess insurance fees to people who, as a group, can rarely afford or even qualify for insurance coverage.¹² In this section of the comment, the reasonable basis and purported legislative intent for these measures will be considered in conjunction with less discriminatory alternatives, such as better preventive health care for the obese, better nutrition education, and counter advertising to defray the effects of marketing targeting.

12. John Banzhaf III, a George Washington University law professor and a primary force in the tobacco litigation of the 1960s, lobbied the National Association of Insurance Commissioners to support the already extant industry practice of charging obese people exorbitant premiums. He was successful in convincing them that this incentive (or disincentive) would help America slim down. Goldman, *supra* note 11, at 16.

I. THE PATHOGENESIS OF OBESITY: HISTORY, ETIOLOGY, AND THE SOCIAL EPIDEMIC

A. *The Gay Nineties and the Portly Trencherman: A Brief History of American Perceptions of Obesity*

“And ye shall eat the fat of the land”¹³

At the turn of the century, Lillian Russell, weighing over two hundred pounds, was viewed as the *sine qua non* of prosperous, well-heeled American beauty. She was famous and admired, as much a consumer of steaks and good booze as she was of diamonds and fulsome praise.¹⁴ She embodied the late nineteenth century ideal of womanly beauty; she was buxom, round, and sensuous. For men of the era, having a large gut was a sign of affluence and virility. William Howard Taft, “Diamond Jim” Brady, and Teddy Roosevelt (who were affectionately referred to as trenchermen because of their hearty appetites) wore waistcoat vests, festooned with conspicuous gold watch chains, and dined on elaborate multi-course meals.¹⁵ The economic boom of the late nineteenth century loosened staid Victorian ideals and paved the way for an orgy of excess. Gluttony and conspicuous consumption abounded in the Gay Nineties.¹⁶ Thinness was *déclassé*. It represented poverty and sickness. To be thin was to be frail, tubercular, unfit. Having an evident bone structure suggested the taint of both manual labor and low socio-economic class, two things the well-to-do American trencherman of the late nineteenth century wanted to be defined against. By the onset of World War I, however, cultural perceptions had significantly changed. Ms. Russell, far removed from her steak and diamond days, was relegated to giving interviews concerning her battle with the

13. *Genesis* 45:18.

14. Russell was widely considered the most beautiful woman of the late nineteenth century. She was the muse of many a love struck artist and the pampered pet of many a wealthy (and often a married) gentlemen. Her most fervent admirer, “Diamond Jim” Brady, once offered her a diamond ring if she could eat as much as he did. Russell slipped off her corset and won the bet. Laura Fraser, *Losing It: America's Obsession with Weight and the Industry that Feeds on it* 21-22 (1997); see also Terry Poulton, *No Fat Chicks: How Big Business Profits by Making Women Hate Their Bodies-and How to Fight Back* 12 (1997); see, e.g., Roy Walford, *The 120 Year Diet* 225 (1986).

15. Walford, *supra* note 14, at 225.

16. An 1890 *Cosmopolitan* article listed the ideal features for the American woman: “Golden hair united to brown or hazel eyes, soft, smooth skin with faint olive shading, little color in the cheeks, features sharply defined (although relieved by a slight facial fullness), and the figure healthily rounded.” An 1896 *Cosmopolitan* article wrote that a model “must be far from thin, with no suggestions of hollows in the face or of collar-bones, for the camera seems to accentuate such defects.” Fraser, *supra* note 14, at 22 (emphasis added).

bulge.¹⁷ This societal shift in perspective was particularly drastic for women.¹⁸ Women's magazines, previously devoid of all talk of body size (primarily because such talk was considered impolite), were suddenly filled with celebrity diet plans, endless advertisements for weight loss products, and express reinforcement of the notion that fat was unattractive and connoted laziness, lax moral fiber, and sloppiness. Physical deviance had never been particularly appreciated in the hyper competitive, capitalist pressure cooker of America, but obesity was surpassing other physical aberrations as the most intolerable.¹⁹ Obesity, under the purview of a fault-based paradigm, evidenced a lack of self-control.²⁰ Fat was, and still is, presumed to be the fault of the person carrying it. In a capitalist, market-driven society that has always placed a premium on self-determination and personal industry, such wanton irresponsibility merits retribution. The social punishment meted out, which was often manifested in popular culture and normalized through constant repetition, seemed to be visited primarily upon women. Arguably, it still is.²¹ It is questionable as to why society's harsh judgment of fat seems to fall so heavily on women. Some commentators speculate that it was the growing independence of American women in other areas, such as voting, political rights, and the workforce, that contributed to and spurred on the increasing association of moral guilt and obesity in the

17. Peter Stearns, *Fat History: Bodies and Beauty in the Modern West* 74 (1997).

18. In many ways, a society that detests fat is a society with some disregard for women. Women have much higher percentages of body fat, at all ages, than do men. The female body is, essentially, biologically geared to strive for a low muscle/high fat ratio. Bray, *supra* note 5, at 28.

19. One study asked ten and eleven year olds to rank drawings of children according to how much they liked them. Children with no physical handicaps were preferred, followed by a child in a wheelchair, an amputee, and a child with severe facial disfigurement. The picture of the obese child ranked last, i.e., the least liked. S.A. Richardson, A.H. Hastorf, N. Goodman, & S.M. Dornbusch, *Cultural Uniformity in Reaction to Physical Disabilities*, 26 *Am. Soc. Rev.* 241 (1961). In one study at the University of Florida, ninety-one percent of the formerly obese individuals surveyed responded that they would rather have a leg amputated than return to their former state. Milena O'Hara, "Please Weight to Be Seated": *Recognizing Obesity as a Disability to Prevent Discrimination in Public Accommodations*, 17 *Whittier L. Rev.* 895, 899 (1996).

20. One commentator notes that, "If the person can be blamed, that characteristic will be seen not as a misfortune, but as a defect." The derogation of obesity results "from the presumption that such persons are responsible for their physical deviance." The commentator states that the complex etiology of obesity must be recognized before we can be rid of the stigma. William DeJong, *The Stigma of Obesity: The Consequences of Naive Assumptions Concerning the Causes of Physical Deviance*, 21 *J. of Health and Soc. Behavior* 75, 76, 85 (1980).

21. From employment discrimination to wage penalties to current standards of attractiveness, weight, or the abundance of it, figures more prominently in societal valuations of women than it does for men. See Stearns, *supra* note 17, at 72.

brutal treatment of overweight women.²² While distaste for fat was growing, innovations in food technology, from TV dinners to canned meat products, all of which made food accessible and cheap, were making it more and more difficult to be thin.²³ The amount of fat and calories consumed on a daily basis has been steadily climbing.²⁴ Diets, from the bizarre grapefruit diet to the, in many ways, even

22. *Id.* The attention to weight created an obvious divide between men and women in a time period when other gender divides were diminishing. Women were becoming more independent but also more trapped by impossible aesthetic standards. *Id.*

23. Human beings adapted in environments with occasional food shortages. Those human beings who utilized food the most effectively (low metabolism/ easier weight gain) were selected for. Placed in an environment of surfeit, human beings quickly become obese. Researchers have discovered genomic markers in certain identifiable groups that make them even more susceptible to obesity. One of these groups, the Pima Indians of the southwest, illustrate this surfeit/shortage model. In Mexico, where food is scarce, the Pima still maintain a relatively high BMI of twenty-five (which is classified as overweight). In Arizona, where access to food is greater, the Pima women are dangerously obese, having an average BMI of thirty-six (which is classified as Class II obesity). Bray, *supra* note 5, at 43.

24. It should be noted that, depending on the control parameters of the study, estimates of caloric intake vary. Studies that operate on consumer recall of food consumption tend to show that caloric consumption has not measurably increased; other studies, which attempt to control for the phenomenon of under-reporting and recall bias in consumer surveys, show a significant increase in calorie consumption. The problem with consumer recall was noted in a 1991 study that compared what consumers actually ate with what they reportedly ate; it found that eighty-one percent of the individuals surveyed under-reported food intake by an average of 565 calories a day. Walker Mertz et al., *What are People Really Eating? The Relation Between Energy Intake Derived from Estimated Diet Records and Intake Determined to Maintain Body Weight*, *American Journal of Clinical Nutrition* 54 (2 [August 1991]): 291-95. The USDA, in order to ameliorate the effects of recall bias, relies on "disappearance data" to estimate caloric intake; this measure is a function of the food supply available (the sum of annual production, beginning inventories, imports minus exports, industrial non-food uses, farm uses, and end-year inventories) divided by the total U.S. population. This simple equation, which is further adjusted for food loss through spoilage, waste, and other means, reveals a jump in the amount of available calories by twenty percent between 1982 and 2000. Judy Putnam, Jane Allshouse, and Linda Scott Kantor, *U.S. Per Capita Food Supply Trends: More Calories, Refined Carbohydrates, and Fats*, *FoodReview*, Vol. 25, Issue 3, Economic Research Services, USDA, Winter 2002. Comparable figures, which show an increase from 3,300 calories per day in 1970-1979 to 3,900 calories per day in 1997 (an eighteen percent increase), have been cited by other obesity researchers. Michael Fumento, *Big Fat Fake*, *Reason Magazine*, March 2003, at 43. The modern scourge of super-sizing is a result largely of food manufacturers increasing their profit margin. It is easier to manufacture high calorie, cheap food products in bulk, sell them at a relatively low cost, and still turn a profit. John Gregerson, *Fat of the Land: New "Fat Taxes" and Other Initiatives Seek to Trim American Obesity, But Are They Addressing Its Real Causes*, *Food Processing*, July 1, 2003, at 44.

stranger Atkin's diet dominate reading materials.²⁵ Technological devices to aid weight loss abound, including a "gastric pacing system" which, surgically implanted in the stomach, sends small electric shocks to create a feeling of fullness.²⁶ Thinness became, and remains, a moral issue.²⁷ To be fat was (and is) to be immoral, socially deviant, lazy, and to have poor impulse control. To be thin was (and is) to be successful, restrained, controlled.

B. A Shocking Pandemic: The Epidemiology of Obesity

The rate of obesity in America has skyrocketed in a relatively short period of time. The National Institute of Health utilizes a Body Mass Index, or BMI, to determine obesity.²⁸ BMI is a measure of weight relative to height: $BMI = (\text{weight [in pounds]} \div \text{height [in inches]}^2) \times 703$. Obesity is recognized beginning at a BMI of thirty kg/m^2 .²⁹ For instance, a person standing five feet, six inches would be considered obese at 190 pounds, while a person standing an even six feet would be obese at 220 pounds.³⁰ Based on reported BMI measurements, the United States has experienced a dramatic increase in overweight and obese individuals in the past two decades. In the late 1970s, an estimated thirty-two percent of American adults were overweight, while fifteen percent were obese.³¹ In 1999, thirty-four percent of American adults were overweight, while twenty-seven percent were obese.³² In children, the numbers are even more astounding. Over the past twenty years, the percentage of overweight children has doubled, while the percentage of overweight adolescents

25. Fumento, *supra* note 24, at 41, 49. The Atkin's diet can dangerously raise blood lipid, cholesterol, and triglyceride levels. Atkin's thesis that fat and protein can not cause weight gain in the absence of carbohydrate consumption has been mocked by the AMA as a "thermodynamic miracle." *Id.*

26. Essentially, the "gastric pacing system" is a pacemaker for the stomach. *Techwatch*, *Popular Mechanics*, Sept. 2003, at 18.

27. Fat became a moral issue because it became associated with a lack of restraint. Some social scientists believe that a deeply ingrained Protestant work ethic, which places a strong emphasis on impulse control, is responsible for this shift (namely, the desire for middle class individuals to disassociate themselves from the lazy, salacious, shiftless lower classes). Maddox, Back, & Liederman, *supra* note 1, at 288.

28. U.S. Pub. Health Serv., U.S. Dep't of Health and Human Servs., The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity (2001), available at <http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf>.

29. *Id.* at 4.

30. *Id.* at 5, fig. 1. BMI measurements do present some inaccuracies by overestimating body fat in people who are very muscular and underestimating it in people who have lost muscle mass, like the elderly. *Id.* at 4.

31. *Id.* at 10.

32. *Id.*

has tripled.³³ Average body sizes have increased at an alarming rate. The average American male weighed 168 pounds in 1960; today, he weighs in at 180 pounds.³⁴ Within the same time frame, the weight of the average female increased from 142 pounds to 152 pounds.³⁵ As will be seen later in this paper, the percentages of obesity in both African-American and Hispanic communities have increased by an even greater margin. Many researchers attribute this increase in body size to a correlative increase in the amount of calories the average American consumes. This caloric increase results largely from snack consumption.³⁶ Another factor in the obesity calculus is the decrease in physical activity experienced by the average American. Calories are burned in three distinct ways: (1) the basal metabolism, i.e., the energy cost of keeping the body alive (and a linear function of weight corresponding to energy utilized), makes up sixty percent of the total energy expenditure, (2) the thermic effect of food, i.e., the energy used to process food, makes up ten percent of total daily energy expenditure, and (3) the physical activity component which varies proportional to weight.³⁷ As calories increase and physical activity decreases, the average American's weight varies in a directly proportional relationship to their heightened consumption (as calories increase, weight increases, and the differential of physical activity is negligible). Complicating matters is the fact that the economic and health burdens of obesity are not immediately apparent. The desire for immediate gratification, not to mention the addictive and comforting qualities of food, leads to an irrational model of consumption, i.e., the short term focus on desire to consume outweighs the fear of economic and health detriments occurring in the future.³⁸ As will be seen later in this comment, such an irrational model of consumption is difficult to define and even more difficult to remedy.

1. A Global Crisis: The Scourge of the Developed World

Other countries are not immune from the pervasive obesity epidemic. Many countries show significant increases in obesity rates for the general population. Obesity levels in Eastern Europe rival

33. *Id.* at 11.

34. David Cutler, Edward Glaeser, & Jesse Shapiro, *Why Have Americans Become More Obese 1* (Harvard Inst. of Econ. Res., Discussion Paper No. 1994, 2003), available at <http://post.economics.harvard.edu/hier/2003papers/2003list.html>.

35. *Id.*

36. *Id.* at 9. Dinnertime calories have actually decreased, while the caloric content of other meals have stayed roughly the same as in earlier years. *Id.* at 9-10.

37. *Id.* at 7-8.

38. *Id.* at 23.

American rates.³⁹ Both England and Australia have extremely high obesity levels, while the populations of France, Italy, and Sweden remain fairly thin.⁴⁰ Beyond the European continent, obesity is still relatively rare, although it is gaining more recognition and becoming more of a health concern than ever before. Even in Asia, where the average body size is exceedingly small by Western standards, obesity is becoming an evident and ever-growing problem. In China, a full five percent of the population is clinically obese; in Chinese cities, the numbers are even more alarming, with twenty percent of city-dwellers qualifying as obese.⁴¹ Japan has experienced a significant rise in childhood obesity levels over the past two decades, with obesity in Japanese boys increasing from just under three percent to nine and seven-tenths percent and obesity rates in girls shooting from three and four-tenths percent to eight percent.⁴² The obesity crisis is not just a problem for the developed world. The dangers of obesity, albeit indisputably more prevalent in first world countries, are manifest even in those areas where population groups have historically been too indigent to consume too much. Samoan populations, for example, have some of the largest average body sizes ever recorded in humans.⁴³ Even in the United States, the population segment struggling most with obesity and its deleterious effects is the impoverished.

2. *The Inversely Proportional Relationship of Income and Obesity*

*"There is something about poverty that smells like death. Dead dreams dropping off the heart like leaves in a dry season and rotting around the feet; impulses smothered too long in the fetid air of underground caves. The soul lives in a sickly air. People can be slave-ships in shoes."*⁴⁴

There is a definite correlation in our society between obesity and poverty.⁴⁵ Obesity is seven times more frequent among women in

39. *Id.* at 6.

40. *Id.*

41. Seth Mydans, *Clustering in Cities, Asians are Becoming Obese*, N.Y. Times, March 13, 2003, at A3.

42. *Id.*

43. Alexandra Brewis, *The Accuracy of Attractive-Body-Size Judgment*, 40 *Current Anthropology* 548, 549 (1999).

44. Zora Neale Hurston, *Dust Tracks on a Road* 87 (1942).

45. This connection could be fueled by stress where eating is used to ameliorate the pain of poverty. For a poor, overworked, and underpaid single mother, eating creates a "momentary reprieve from her worries" and is a logical, therapeutical solution because it is cheap, easy, and is a celebrated activity, particularly in the black culture. Becky Wangsgaard Thompson, "A Way Outa No Way": *Eating*

lower socioeconomic positions.⁴⁶ Low socioeconomic status is second only to heredity in the predictors of weight gain.⁴⁷ The differential health factors and obesity rates between indigent Americans and those of higher income status might hinge on a combination of stress, poverty, poor preventive medicine, and limited access to health care. There is also the possibility that living in a competitive, market-driven environment takes its toll on those on the bottom echelon.⁴⁸ Many researchers believe that stress, exacerbated by poverty and a sense of lost potential, is a large factor in interpreting national health discrepancies with regard to weight and overall health status. Numerous studies have demonstrated that societies with greater inequalities in wealth are less healthy than societies with greater income equality. In societies where income inequality is great, the population group suffering the most is the group with the least education and the highest poverty level. In the United States, thirty percent of African-Americans live below the poverty line as compared to ten percent of white Americans.⁴⁹ This demographic could explain why African-Americans also have substantially higher obesity rates than do white Americans.

Obesity is dangerous.⁵⁰ Poverty is even more dangerous.⁵¹ There is a significant gap in life expectancy rates between white and black Americans, with African-Americans (who are considerably poorer) lagging substantially behind.⁵² As income increases, mortality

Problems among African-American, Latina, and White Women, 6 *Gender and Society* 546, 550, 554 (1992).

46. This is because fatness may be less repugnant in poorer communities because it represents a form of conspicuous consumption. Maddox, Back, & Liederman, *supra* note 1, at 288-89.

47. Other determinants are the cessation of smoking, having multiple children, nutritional ignorance, and being recently married. Bray, *supra* note 5, at 156, tbl. 9.

48. Mary Anne Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 *Am. J. L. & Med.* 363, 373 (2003).

49. *Id.*

50. There are clear associations between obesity and many common medical conditions. For instance, overweight people are twice as likely to have hypertension. Women who gain more than forty-four pounds are twice as likely to have blood clot related strokes and twice as many women die each year from stroke than from breast cancer. Michael Fumento, *The Fat of the Land: The Obesity Epidemic and How Overweight Americans can Help Themselves* 10, 11 (1997).

51. Although, it is interesting to note that even when measures of socioeconomic strata (such as education and income level) and health behaviors (such as diet, exercise, alcohol use, and cigarette smoking) are controlled for, African-Americans continue to have poorer health than white Americans, suggesting that economic and lifestyle variables alone cannot account for this health disparity. William Dressler, *Health in the African American Community: Accounting for Health Inequalities*, 7 *Med. Anthropology Q.* 325, 340 (1993).

52. At age twenty-five, a white man can expect to live six and three-tenths years longer than a black man; a white woman can expect to outlive a black woman by

decreases.⁵³ With the exception of suicide, African-Americans have a higher rate of morbidity for all major causes of death, including infectious diseases, cancer, diabetes, and homicide, than white Americans.⁵⁴ High income provides high access to high quality health care, diet, housing, and health insurance. Black women in particular suffer from this health disparity gap, being twice as likely than white females to die of cervical cancer, and significantly less likely to get preventive measures like pap smears and breast exams.⁵⁵ There is ample evidence to suggest that many of these morbidity disparities could be addressed with increased education, screening, and treatment.⁵⁶ Much of this racial and socioeconomic gap in health

four and six-tenths years. Richard Rogers, *Living and Dying in the U.S.A.: Sociodemographic Determinants of Death Among Blacks and Whites*, 29 *Demography* 287, 288 (1992).

53. *Id.* Although there is a definite link between income and health status, infant mortality statistics for African-American infants suggest that there is another factor at work. African-American infants are twice as likely to die during their first year of life than white babies or children born in less developed countries like Kuwait, Costa Rica, and Singapore. Cara Fauci, *Racism and Health Care in America: Legal Responses to Racial Disparities in the Allocation of Kidneys*, 21 *B.C. Third World L.J.* 35, 42 (2001).

54. Blacks are seventy percent more likely to die from infectious diseases like tuberculosis, cholera, measles, and syphilis than their white counterparts. These diseases, which can be prevented or treated with proper medical care, immunizations, vaccinations, and antibiotics, are thought to be the result of overcrowding, poor housing, inadequate nutrition and sanitation, and limited access to health care. Presumably, they could be eliminated if poverty was reduced and education was increased. Rogers, *supra* note 52, at 291, 297. It is interesting to note that many researchers attribute the lower suicide rate in African-Americans to a variety of cultural phenomena. One such cultural difference, as perceived by one commentator is that white society seeks to consume and control while black culture shares and adjusts. White culture abhors variance; black culture respects it. Frances Foster, *Changing Concepts of the Black Woman*, 3 *J. of Black Studs.* 433, 442-43 (1973).

55. Rogers, *supra* note 52, at 290. This disparity is particularly evident in the case of breast cancer. Between 1989 and 1992, white women had a five and five-tenths percent decrease in breast cancer mortality, while black women experienced a two and six-tenths percent increase in breast cancer deaths. *Breast Cancer Rates Diverge: Deaths Fall for White Women, Rise for Black*, *Wash. Post*, Jan. 17, 1995, at Z9.

56. More than fifty percent of the female racial gap in morbidity is due to circulatory disease from hypertension. Hypertension is easily treated with medicine and easily detected with simple screening. If black women had more awareness of the warning signs of hypertension and greater access to treatment, the gap would undoubtedly narrow. See Rogers, *supra* note 52, at 290. Despite their increased morbidity from breast cancer, black women are twenty-five percent less likely to have mammograms. Black patients overall are seven percent less likely to visit physicians for ambulatory care. Barbara Noah, *Racial Disparities in the Delivery of Health Care*, 35 *San Diego L. Rev.* 135, 140 (1998).

status is related to obesity.⁵⁷ For instance, non-insulin dependent diabetes mellitus, the most common form, has a thirty percent higher incidence in African-Americans.⁵⁸ Its presence is usually a corollary to obesity, and it is estimated that control of obesity could prevent three hundred thousand cases of diabetes per year.⁵⁹ It is no surprise then that, given the prevalence of obesity in the black community and a lack of adequate health resources, African-Americans are three times more likely to die from diabetes than white Americans.⁶⁰ African-Americans, on the whole, are largely underinsured.⁶¹ They are less likely to see a physician, to be hospitalized, or to have access to health care providers.⁶² Even when African-Americans seek medical assistance, the health care problems continue. One study conducted on people admitted to emergency rooms for coronary artery occlusions showed that white people were more likely to be treated with sophisticated diagnostic tests and twice as likely to receive technologically innovative medical care.⁶³ Simply blaming the health care inequality on poverty is not enough.⁶⁴ The solution, like the causality, is multifaceted.⁶⁵ To address this health care

57. For instance, the chance of getting diabetes increases tenfold with even moderate obesity. Obese people are also at increased risk for high cholesterol, cancer, arthritis, gallbladder disease, dying during surgery, dying from trauma, getting gout, developing cataracts and associated blindness, and having children with birth defects. Fumento, *supra* note 50, at 11, 12-15.

58. Rogers, *supra* note 52, at 290. While African-Americans are twice as likely as white Americans to develop Type II diabetes, other minorities are at an even greater risk. Hispanics are three times more likely to develop it, while Native Americans are five to six times more likely than whites to get diabetes. Fumento, *supra* note 50, at 11.

59. Rogers, *supra* note 52, at 297. Hyperinsulinemia is common in the obese due to the relationship between fat and insulin secretion. The higher the degree of fatness, the greater the amount of insulin secreted by the pancreas. Increased insulin production eventually leads to insulin resistance. Bray, *supra* note 5, at 55-56.

60. Rogers, *supra* note 52, at 290.

61. About forty-two percent of African-Americans under sixty-five lack private health insurance as compared to nineteen percent of white Americans in the same age bracket. Rogers, *supra* note 52, at 288. In 1993, 39.7 million Americans were not covered by any form of health insurance. Bureau of the Census, U.S. Dep't of Commerce, Statistical Abstract of the United States 118 (115th ed. 1995), available at <http://www.census.gov/prod/www/statistical-abstract-us.html>.

62. Rogers, *supra* note 52, at 299.

63. Dressler, *supra* note 51, at 331-32.

64. Many commentators feel that the "culture of poverty" debate, which essentially states that it is the victim's own fault that he is too ignorant to save himself, is detrimental to the interests of the people who fall within this category because this paradigm "tends to ignore the larger social context; in specific terms, it ignores social agenda such as the differential targeting of ethnic groups in the marketing and sale of tobacco or alcohol products." *Id.* at 334.

65. Simply adhering to a poverty explanation is disingenuous and lazy. As one

disparity necessitates addressing the underlying social causes for it. As the rest of this comment will evince, imposing further crippling mechanisms on the problem by adding obesity penalty taxes and insurance surcharges, which would have a disparate impact on African-Americans and the indigent, is no solution. Poverty itself is a heavy burden; the additional weight of regressive taxes and insurance surcharges only make it more so.

3. *The Mammy Complex: The Cultural Anachronism of Obesity and Race*

*"I'm a woman and colored. Ain't that the same as being a man?"*⁶⁶

By 1920, and, more importantly, the enfranchisement of women, cultural notions of thinness as a moral success were firmly entrenched in our societal mythology.⁶⁷ The one American subculture that was not at all impressed with dieting was the black culture.⁶⁸ As can be seen in the following health survey chart, obesity levels in African-American women are twice the corresponding percentages for white women, and exceed the obesity rates of every other ethnic or sex-based subgroup.

2002 Obesity Percentages for Adults over Age Twenty:⁶⁹

Sex	Race	Percent Obese	95% Confidence Interval
Men	Hispanic	26.0	23.5-28.5
	White	23.6	22.6-24.7
	Black	29.7	27.1-32.3

commentator notes, the "class theory...oversimplifies the issue and completely ignores the independent role of race in American society. Race influences not only life-style, personal behavior, psycho-social behavior, physical environment, and biology, but also socioeconomic status," thus "removing economic barriers does not remove racial barriers." Health Law: Cases, Materials and Problems 789 (Barry Furrow et al. eds., 4th ed. 2001).

66. Toni Morrison, *Sula* 142 (1982).

67. Stearns, *supra* note 17, at 89.

68. *Id.*

69. Nat'l Ctr. For Health Stat., Ctrs. for Disease Control and Prevention, Early Release of Selected Estimates Based on Data from the 2002 National Health Interview Survey 32, fig. 6.3 (June 18, 2003) (emphasis added).

Women	Hispanic	26.1	23.9-28.2
	White	20.5	19.6-21.4
	Black	40.4	38.3-42.6

In some areas, like New York City, the percentage of black females who are obese is more than double the obesity rate for white females.⁷⁰ For African-American children, the rates of obesity are progressively climbing higher. In 1986, eight percent of black children were obese, ten percent of Hispanic children were, and eight percent of white children qualified as obese.⁷¹ In a little over a decade, all of those percentages had substantially increased, with the level of obesity for black children growing the most; by 1998, a full twenty-two percent of black children were obese, compared to twenty-two percent of Hispanic children, and twelve percent of white children.⁷² In response to this growing and worrisome trend in African-American and other minority children, the United States Department of Health and Human Services has delineated several strategies for reducing childhood obesity, such as increasing the number of breast-fed children (who show markedly lower rates of obesity), reducing the amount of time spent watching television, retaining physical education programs in schools, and providing physical activity opportunities for children that are safe.⁷³

The Office of the Surgeon General has also created the communication, action, research, and evaluation (or CARE) program to address the needs of obese children.⁷⁴ The goal of the program is to increase access to safe physical activity outdoors and promote nutritional education in inner-city areas, particularly among minority

70. Thorpe, L.E., et al., *One in 6 New York City Adults is Obese*, NYC Vital Signs, 2003:2(7) 1-4. Almost twenty-five percent of individuals, primarily black and Hispanic, living in the Bronx are obese. Despite the fact that most of New York City's fruit and vegetables are delivered through ports adjacent to these urban neighborhoods, the people living in the Bronx eat less of these products than the rest of the city. Kerry Burke & Lisa L. Colangelo, *Fat Stat: No Shocker: Folks Say Bronx Food is Cheap and Greasy*, New York Daily News, Aug, 14, 2003, at 1. While obesity rates continue to rise for the entire country, the south is still, by far, the fattest region. In Mississippi, a quarter of the population is obese. In Louisiana, twenty-three percent of the population is obese and another six percent is stricken with diabetes. Kristen Gerencher, *Ten Most Unhealthy States: South Tops Rankings with Highest Heart Disease, Obesity*, CBS.Marketwatch.com, Oct.10, 2002.

71. *An Ounce of Prevention*, *supra* note 7, at 1-2.

72. *Id.*

73. Surgeon General's Call to Action, *supra* note 28, at 18-19.

74. *Id.* at 16-17.

children.⁷⁵ The program also asserts that research should be done to assess what factors help contribute to the disproportionate burden of obesity in low-income and minority communities.⁷⁶ The increasing rates of obesity in African-American populations is a complex and convoluted tapestry interwoven with a myriad of potential factors, not the least of which is a long-standing historical acceptance of antiquated cultural trends.

America has long clung to the traditional images of black femininity. One commentator has suggested that the cultural stereotyping for black women falls into four categories: Topsy, Peaches, Caldonia, and Aunt Chloe.⁷⁷ Topsy is the stuff of airbrushed customized vans and roadside velvet artistry, the big-eyed, sad-eyed, ragdoll-gripping, little black girl with the skinny legs and head full of braids.⁷⁸ Peaches is the wanton, the luscious, sly, loose woman bent on sexual promiscuity of the first order while Caldonia is the matriarch, obnoxious, loud, and emasculating.⁷⁹ Aunt Chloe is, as every southerner raised on *Gone with the Wind* and Aunt Jemima maple syrup knows, the mammy figure, the old black woman who has “donned a flowered dress and rundown shoes” and become a “stalwart Christian or the Voodoo crone.”⁸⁰ This cultural pigeonholing of the black female in American culture could constitute a significant part of the complex etiology of why black women are so much more comfortable with their weight than white women. Another possible reason for the racial disparity in weight obsession is the difference in cultural standards of what is attractive.⁸¹ In the black community, standards of attractiveness still favor a larger woman.⁸² With African-American women, there might be a direct correlation between their place in society and their size.⁸³ Many black

75. *Id.* at 18-19.

76. *Id.*

77. Foster, *supra* note 54, at 433.

78. *Id.*

79. *Id.*

80. *Id.*

81. Of prime time television programs, *Moesha* and the *Jamie Foxx Show*, both of which are targeted to a black audience, include the largest number of overweight actors. Gabriel Packard, *United States: Unhealthy Food, Figures Feature in TV for Blacks—Study*, Inter Press Service, Aug. 14, 2003.

82. This predilection for larger women is evinced in African-American television, music, and literature. The ideal of a bigger woman is somewhat associated with the ideal of freedom, e.g., one Harlem Renaissance poet writes, “these hips are big hips/ they need space to/ move around in./ they don’t fit into little/ petty places. These hips/ are free hips.” Lucille Clifton, *Homage to My Hips*, in *A Book of Women Poets from Antiquity to Now* 682 (Aliko Barnstone and Willis Barnstone eds., 1980).

83. Stearns, *supra* note 17, at 92. Black author and Pulitzer Prize winner Toni Morrison noted this connection between societal place and body size in her novel

women have worked outside the home,⁸⁴ and in work, particularly with physical labor, size is an advantage.⁸⁵ The prevalence of single parent households and a pervasive matriarchal structure has led to a continued appreciation for motherhood in black families. This emphasis on maternal strength, combined with a more varied and relaxed concept of attractiveness, could explain the dramatically higher incidence of obesity in the black female population.⁸⁶ The greater obesity rates for African-Americans are negligible in comparison to the health concerns they precipitate. African-Americans have a thirty percent greater chance of developing chronic hypertension than white Americans.⁸⁷ Black women have a sixty-four percent higher rate of death from heart disease than do white women.⁸⁸

While there is some speculation that exposure to the mammy image made fat more acceptable in black culture, it is only one of the many factors in the Byzantine etiology of race and obesity.⁸⁹ Fat is possibly more acceptable in black culture because of the eternal, maternal black woman, the "mammy-brickhouse Black woman image," but this is not the only reason.⁹⁰ There are also

Sula. The title character, a wild young woman longing to be free in a racist and untenable world, muses pensively about the fate of African-American women in such a stagnant environment, commenting that: "[t]he narrower their lives, the wider their hips." Morrison, *supra* note 66, at 121.

84. In 1940, twenty-seven and eight-tenths percent of black wives worked outside of the home, compared to twelve and seven-tenths percent of white wives. By 1994, the gap had narrowed with sixty-five and six-tenths percent of black wives working, and sixty and three-tenths percent of white wives working. Pamela Smith, *Romantic Paternalism—The Ties that Bind also Free: Revealing the Contours of Judicial Affinity for White Women*, 3 J. Gender Race & Just. 107, 132, 180 (1999). The low wages historically received by black males might explain why so many more black women worked outside the home; they had to supplement their spouse's income.

85. There is some scholarship that suggests that beauty, from an African-American standpoint, is still very much interlaced with utilitarianism [to wit: having a big, strong body means that you are a big, strong woman]. The focus of black art, since its heyday in the seventies, has been on reality rather than idealism. Foster, *supra* note 54, at 446. Stamina, pride, self-determination, and a sense of the absurd are also advantages in a working environment fraught with racist sentiment: "Sixty years in these folks' world,/ The child I works for calls me girl,/ I say 'Yes ma'am' for working's sake./ Too proud to bend,/ Too poor to break,/ I laugh until my stomach ache,/ When I think about myself." Maya Angelou, *When I think about Myself*, in *The Collected Poems of Maya Angelou* 29 (1994).

86. See Mavis Thompson, *The Black Health Library Guide to Obesity 2* (1993).

87. *Id.* at 17.

88. *Id.* at 20.

89. *Id.* at 45; see also Fumento, *supra* note 50, at 127.

90. Retha Powers, *Fat is a Black Women's Issue*, *Essence*, Oct. 1989, at 134.

socioeconomic and ideological reasons.⁹¹ Black women may diet less openly than white women because they feel that it is something only white women do.⁹² Popular black magazines, *Ebony* and *Essence*, rarely deal with issues of weight control.⁹³ Black women are twice as overweight as white women but fewer consider themselves overweight. This individual assessment of weight, where black women underestimate their weight and white women overestimate their weight, is likely due to the fact that women assess themselves by what they presume to be the cultural norm in their society.⁹⁴ There is comparatively little interest in diet or weight in the black community. Health food products and diet aids take up relatively little room in the pages of black women's magazines or in commercials aired during black-targeted programming.⁹⁵ It has been suggested that certain companies target black consumers in the advertisement of alcohol and junk food.⁹⁶ African-Americans, who make up thirteen percent of the

91. It can be argued that African-American women have, unlike white women, come to a greater sense of self-determination; namely, they have found it necessary to define themselves rather than allow a discriminatory world define them. "She heard the names,/ swirling ribbons in the wind of history:/ nigger, nigger bitch, heifer,/ mammy, property, creature, ape, baboon,/ whore, hot tail, thing, it./ She said, But my description cannot/ fit your tongue, for/ I have a certain way of being in this world,/ and I shall not, I shall not be moved." Maya Angelou, *Our Grandmothers*, in *The Collected Works of Maya Angelou* 254 (1994).

92. Thompson, *supra* note 86, at 46. In general, the African-American community tends to associate dieting and weight control with a self-obsessed, neurotic white culture with too much time and money. One black poet, a Jamaican cab driver from New York, addressed this issue with a certain degree of bitterness, writing, of white men, "Choke to death on your damn designer/ bagel from Balducci's/ low cholesterol, naturally," and, of white women, as the white man's "pencil thin/ Evian drinking/ calorie counting/ caffeine limiting/ sodium sparing/ Nutrasweet sweetening/ rear-view mirror preening/ carrot nibbling, bunny." Everton Sylvester, *Well?, in Aloud: Voices from the Nuyorican Poets Café* 488-89 (Miguel Algarin and Bob Holman eds., 1994).

93. One study found that both magazines had only ten advertisements for weight control products over a period of six years. Charlotte Pratt & Cornelius Pratt, *Nutrition Advertisements in Consumer Magazines: Health Implications for African-Americans*, 26 *J. of Black Studs.* 504, 517 (1996).

94. *Id.*

95. *Ebony* had almost no ads for vegetables, milk, or health foods, but a large proportion of ads for alcohol and cola. *Id.* at 512. Black prime time television shows, like *Moesha*, feature more junk food commercials than white-targeted programming like *Frasier* or *Friends*. Black shows in prime time air five food commercials each half-hour, while the average for all prime time is three per half-hour. Packard, *supra* note 81.

96. Blacks account for twenty to twenty-five percent of all domestic beer sales and fifteen percent of all cola sales. Both *Ebony* and *Essence* featured a disproportionately large number of liquor and cola advertisements. *Ladies Home Journal*, a magazine with a predominantly white female readership, had the lowest number of alcohol ads and the highest number of ads for milk, other dairy products, breads and cereal, and desserts. Pratt & Pratt, *supra* note 93, at 512-13.

general population, account for twenty to twenty-five percent of all domestic beer sales and fifteen percent of all cola sales.⁹⁷ This disparity between population size and consumption of unhealthy food products has led many researchers and social scientists to theorize that the black consumer is being exploited. Whatever the causality, the health impact of rising obesity levels is devastating for the African-American community, particularly in light of the poor health status and susceptibility to both heart disease and diabetes that exist in minority populations.

C. Obesity and the Genomic Model: Surfeit, Shortage, and the Impetus of Culture

There is no question that obesity is a matter of input and output, a linear equation as required by the law of thermodynamics wherein the differential in body fat varies proportionally with the energy expended and energy consumed. When human beings consume more calories than they expend, they gain weight. The ever-increasing number of obese individuals across the world lends credence to this simple logarithm. At no other time in recorded history have human beings been this obese. The human body was, initially, a model built to survive in times of shortage, not surfeit. In fact, those human beings who most easily gained the most mass from the least calories were selected for as prime evolutionary success stories. To be able to get reasonably fat from a diet of twigs, seeds, and little animal matter was enormously beneficial, as the next drought, famine, or catastrophic natural event was very likely around the nearest corner. Now, for most of the developed world anyway, technology has outpaced the brutal uncertainties of the natural world. Every season is a season of surplus. Food is a ubiquitous and easily attained luxury. On the one hand, such a period of surfeit enhances mankind; full bellies provide an opportunity for reflection, and for the investment of time and energy in matters other than finding food, e.g., law, medicine, philosophy, and art. The other side of the coin, however, is decidedly less pleasant. The availability and the cheapness of food has led to skyrocketing rates of obesity, particularly for those individuals who demonstrate a genetic predisposition for weight gain.

97. *Id.* at 506, 512. The differential allocation of junk food ads in black magazines is an important factor when investigating the culpability of the food manufacturing industry. The notion that fattening, sugary foods are addictive is not new. Dr. David Ludwig, a researcher at Harvard, demonstrated that foods high in glycemic content, like sugary breakfast cereals, actually make consumers hungrier after eating. High glycemic foods quickly raise blood sugar and then plunge it to below fasting levels. This triggers an overwhelming sense of hunger and increases the likelihood of overeating. Gregerson, *supra* note 24, at 44.

These two factors, a genetic predisposition for weight gain and a culture that embraces the omnipresent nature of food, are important in determining not only the medical solution to obesity, but the legal solution as well. This dichotomy of culture and genetics in the etiology of obesity is important in evaluating the legal consequences of discrimination against the obese. As will be addressed later in this comment in regards to the Americans with Disabilities Act, the question of voluntariness or involuntariness is a significant matter.

1. What Watson and Crick Never Saw Coming: When the Double Helix Leads to Double XL

In order to examine the genetic indicators of obesity, it is first necessary to evaluate the nature of fat in the human body. There are two types of fat in the human body. One type, the kind associated with virtually all health problems, is visceral fat. Visceral fat is “deep” fat. It surrounds the organs and complicates their functioning; it also creates the “apple” body shape that is widely associated with heart disease.⁹⁸ The other kind, which constitutes seventy to eighty percent of the fat in the body, is subcutaneous. This fat is “shallow,” just under the skin, and is responsible for the “pear” shape. Some research suggests that subcutaneous fat might actually have protective qualities in terms of cholesterol levels and hypertension.⁹⁹ There are also two subcategories of fat: white adipose tissue and brown body fat. Brown body fat is a high burner of calories and a spectacular heat generator. Adults have very little brown body fat (infants have the most), but there is some speculation that people who are predisposed to leanness have a higher brown-fat-to-white-ratio and therefore burn calories faster.¹⁰⁰ This is not the only genotypic factor that affects weight gain. Much like the Human Genome Project that recently finished identifying the entire genetic spectrum of the human family, the Human Obesity Gene Map, which has been formatted in an electronic version by bioinformatic specialists and genomic scientists at the Pennington Biomedical Research Center, describes the location and properties of genes and chromosomes implicated in human obesity.¹⁰¹ Many doctors and scientists who study obesity and its

98. Glenn Gaesser, *Big Fat Lies: The Truth about your Weight and your Health* 134-38 (1996).

99. *Id.*

100. *Id.*

101. The e-version of the map lists the genes and chromosomes implicated in human obesity and provides hypertext links to phenotypes associated with the selected gene. The Human Genome Project, benefitting from a collusion of scientists and researchers from the United States, Britain, Japan, and France, was recently completed in early 2003. Human Genomics Laboratory, Pennington Biomedical Research Center, Human Obesity Gene Map, *at*

genetic implications cite the fault-based paradigm of a conduct-oriented perception of obesity as the largest barrier to effectively treating the disease.¹⁰² They note that obesity is a disease that stems from a multiplicity of factors and is not merely a question of eating too many doughnuts. Many of the root causes of obesity have related genetic components.¹⁰³ The genetic link to obesity can be incidental or extreme.

Single gene mutations, so-called monogenic aberrations, may produce massive obesity.¹⁰⁴ Other external factors may produce obesity by manipulating and altering crucial functions of the basic human physiology, as when obesity results from damage to the ventromedial hypothalamus of the brain.¹⁰⁵ Animal studies have advanced the theory that genes have a powerful impetus on obesity; obese mice that possess a leptin deficient gene and mice with leptin receptor defects slim down when leptin is administered.¹⁰⁶ Scientists have noted that some fat mice lack a prohormone-converting enzyme, the absence of which contributes to their obesity; this has also been found in obese members of the human family as well.¹⁰⁷ Also found in obese mice is a gene that alters the proper functioning of the hypothalamic neurons, an abnormality that causes obesity.¹⁰⁸ There is also strong evidence for the genetic model when the heritability of obesity is considered. Three group studies of twins, adoptees, and families have suggested that obesity might be heritable in humans.¹⁰⁹ Epidemiological research shows that metabolic rate, thermic response to food, and spontaneous physical activity have genetic components

<http://obesitygene.pbrc.edu>.

102. "There are a number of barriers to the effective use of anorexiant (appetite-depressing) agents. First, obesity is a stigmatized condition. That is, the public perceives obesity not as a disease, as proposed by the 1985 NIH Consensus Conference, but rather a condition associated with a lack of will power and gluttony. Willpower, the power to push oneself away from the table, is all that is thought to be needed to treat obesity. This simplistic public perception of obesity is reflected in professional attitudes of health care workers as well." George Bray, *Drug Treatment of Obesity*, 55 *Am. J. of Clinical Nutrition* 538s (1992).

103. Bray, *supra* note 5, at 35.

104. *Id.* Besides monogenic genetically-related diseases, there are also polygenic, i.e., requiring the interaction of more than one gene, and multifactorial, i.e., a genetic predisposition exists but expression is reliant on nongenetic or outside forces, conditions. Heredity studies suggest that obesity is most often the result of the latter configuration. *Id.*

105. *Id.*

106. *Id.* at 38-39.

107. *Id.*

108. *Id.*

109. The family studies suggest a heritability percentage between thirty and fifty percent, the adoption studies a percentage between ten and thirty percent, while the twin studies show a whopping heritability percentage between fifty and ninety percent. *Id.* at 41, tbl. 3.

that can be inherited.¹¹⁰ In animal studies, more than a dozen chromosome locations have shown a high probability of being linked to the onset of obesity; in humans, more than six links on different chromosomes show a similar probability.¹¹¹ In the face of such evidence, the idea that obesity is a mutable and voluntary condition created solely by an individual's egregious conduct and poor impulse control becomes less persuasive.

II. THE CONDUCT THAT AMERICA LOVES TO HATE: STATE AND FEDERAL PANACEAS FOR THE OBESITY EPIDEMIC

A. *Obesity and Economics: The Market Failure Paradigm*

It is unquestionable that obesity is an issue weighing heavily on the minds of legislators in both the state and federal realms. Practically innumerable legislative interventions have been proposed to ameliorate both the deleterious health effects of obesity and the enormous costs incurred in treating the co-morbid conditions that crop up as corollaries to it. These plans propose to intervene in a number of ways. Many of them fall under the rubric of economic disincentives. Fat taxes would presumably make desirable snacks, i.e., those snacks with a certain percentage of fat or an excessive number of calories, undesirable by increasing their cost to the consumer. Allowing insurance companies to discriminate on the basis of obesity, by either denying coverage outright, limiting coverage for the obese, or charging prohibitively high premiums, would ostensibly let obese people know that being obese is, in fact, bad.

The primary concern driving these initiatives is the cost factor. The government, and the federal government in particular, spends an enormous amount of money on obesity and its related illnesses. In 1998, Medicaid spending related to obesity totaled 14.1 billion dollars, while Medicare spent 23.5 billion dollars mitigating, treating, or attempting to treat the effects of obesity.¹¹² The public sector finances roughly half of all obesity expenditures.¹¹³ The majority of the total obesity expenditure is precipitated by the treatment of co-morbid conditions that almost inevitably result from obesity, e.g., hypertension, diabetes, and cardiovascular distress. In spite of this, many health insurers, including Medicaid, do not cover the costs of

110. *Id.* at 42.

111. *Id.* at 43.

112. Eric Finkelstein et al., *National Medical Spending Attributable to Overweight and Obesity: How Much, and Who's Paying?*, Health Affairs—Web Exclusive, May 14, 2003, at W3-223, exhibit 4.

113. *See id.*

obesity treatment and prevention at the outset; in contrast, many providers, including Medicaid, cover the cost of smoking cessation treatment as a covered benefit.¹¹⁴ The effects of smoking are costly as well, but are attenuated by the fact that smokers have a substantially decreased life expectancy, leading to lower social security payments and fewer years of Medicare eligibility; overall, smokers constitute a net benefit for the government, where the savings created by their typically premature demise exceeds the costs of treating them in the short term.¹¹⁵ This does not seem to be the case in obesity. While the obese tend to have somewhat shorter life spans, the differential is not significant enough to create a net gain for the government or to offset the exorbitant costs of obesity treatments which are generally not effective in short duration; at best, it would be a situation of breaking even.

A large percentage of obese individuals are beneficiaries of the Medicaid program. This further supports the contention that a significant nexus exists between obesity and poverty. As is seen in the figure below, the percentages of obese people on Medicare and Medicaid exceeds the corresponding percentages that have private insurance or are uninsured.

Obesity Percentages by Insurance:¹¹⁶

Insurance	Percent Obese	Overweight/ Obese Combined
Uninsured	17.1%	50.6%
Private Insurance	17.0%	53.2%
Medicaid	27.4%	55.6%
Medicare	18.8%	56.1%

The federal and state outlay for health care costs related to obesity is obviously enormous. Any program that effectively reduces obesity will also reduce the costs of obesity. This is a worthy goal as long as the means used to advance it are not discriminatory and unlawful. There is always the danger, though, that obesity, in becoming the new conduct that America loves to hate, could end up like smoking, to wit: four decades of regulation and taxes and de jure segregation later, and smoking is still winning pastime popularity contests with

114. *Id.* at W3-224.

115. *Id.* at W3-225.

116. *Id.* at W3-222, exhibit 1.

teens everywhere. In any case, it is clear that obesity is a growing problem in America that will soon be addressed by any number of legislative panaceas. The United States Office of Management and Budget requires a government regulatory impact analysis to identify what market failures the proposed legislation is intended to remedy. A market failure exists as an external cost imposed upon some individuals by the economic activity of others. With obesity, the obvious theory for market failure is that the individual health behaviors of obese people exacts a substantial cost from others who do not engage in the same behavior.¹¹⁷ Weight is an easily identifiable characteristic that can be ascertained with minimal expense; this is why life insurance increases with weight regardless of health or lifestyle. Many other behaviors impose external costs on others, but are not so easily identifiable. Smokers can lie about their indecorous pastime, and the cost of ascertaining the truth is, at the very least, the cost of a physical evaluation by a clinician. Still other behaviors, like a penchant for promiscuous sex with strangers or a love of driving one hundred miles per hour while refusing to wear a safety belt, impose substantial costs when they necessitate expensive health expenditures, but are not readily detectable from a cursory inspection of the offending individual. In essence, the fervor leading legislators nationwide to cook up remedies for obesity is largely a result of the conspicuous nature of the disease.

B. The Evolution of the Nanny State: Federal Medicine for a Costly Epidemic

The role of federal government in the arena of public health is one that extends back to the very inception of the country itself. The National Marine Service, which was founded in 1798 to help sick and disabled seamen, was one of the very first acts of the national government designed to provide health care for a specific segment of the population.¹¹⁸ Currently, millions of Americans receive health care through the armed services, Veteran Affairs hospitals, and the Indian Health Service.¹¹⁹ The federal government funds the

117. A tangential question to consider in the economic assessment of the market failure associated with obesity is whether or not human beings should be treated as commodities. Kantian philosophy suggests that only things have market value; hence, their worth is defined by what uses they serve. Do humans fit within this paradigm? A principle that considers human beings to have inherent dignity, separate from extraneous valuation, would suggest that humans are distinct from commodities and cannot, therefore, have market value or experience market failures.

118. Karen O'Connor & Larry Sabato, *American Government: Continuity and Change* 636 (2000 ed.).

119. *Id.*

overwhelming majority of medical research, primarily through the National Institute of Health and its instrumentalities, like the National Cancer Institute, the National Heart, Lung, and Blood Institute, the National Institute of Allergy and Infectious Disease and other NIH institutes.¹²⁰ The federal government expends more than ten billion dollars annually on biomedical research, most of it in the form of research grants.¹²¹ Medicare and Medicaid utilize government funds to offer health coverage to people receiving Social Security benefits, pregnant women and children under age six in families with incomes less than 133% of the official poverty level, the disabled, the elderly, and the indigent.¹²² Though Medicaid is jointly financed by both state governments and the federal government, the national government pays fifty percent to seventy-nine percent of total Medicaid costs.¹²³ A number of factors contribute to the rising cost of health care in America, namely, 1) increased life expectancy, 2) growing range and sophistication of diagnostic procedures and treatments which are expensive, 3) the reduction of direct health care costs due to the expansion of private health insurance, Medicare, and Medicaid which leads to an increased demand for services and higher indirect costs overall, 4) the high quality of health care costs more, and 5) medicine in the United States focuses more on curing illnesses, which is more expensive than preventing them.¹²⁴

1. Trimming the Fat: Federal Remedies for the Obesity Epidemic

The likelihood that Congress will pass some anti-obesity legislation by next year is considerable. Several legislative proposals are already surfacing. One such proposal, the "Improved Nutrition and Physical Activity Act" (IMPACT),¹²⁵ would create a sixty million dollar budget to fund local obesity programs. This seemingly innocuous proposal has already been the target of criticism; the

120. *Id.*

121. *Id.*

122. *Id.* at 637-38.

123. *Id.* at 638.

124. *Id.* at 640.

125. S. 1172, 108th Cong. (2004). IMPACT has two main parts; Title I involves the allocation of training grants to provide instruction for health students and professionals, as well as grants for research to prevent obesity and treat it; Title II involves community-based solutions to increase activity, promote nutrition, improve nutrition in at-risk populations, targeting race and ethnic minorities, and grants to establish incentives for health food co-ops to open stores in economically depressed areas. The bill would allocate 60 million dollars for the fiscal year 2004 and whatever funds were necessary thereafter for the implementation of the program. *Id.*

Council on Size and Weight Discrimination maintains that the bill condones weight discrimination by blaming fat people.¹²⁶ The main two purposes of the bill would be to eliminate health disparities associated with obesity which disproportionately impact the medically underserved and to promote healthy lifestyles. Yet another bill introduced deals with preempting lawsuits aimed at fast food manufacturers, and seeks “to prevent frivolous lawsuits against manufacturers, distributors, sellers of food and non-alcoholic beverage[s].”¹²⁷ Under this proposal, the manufacturers of a food product would only be liable if it could be proven that the product was out of compliance with statutory regulations.

At least one bill introduced deals with the issue of discrimination, although only tangentially with the issue of obesity discrimination. The Genetic Information Nondiscrimination Act would prohibit employers from using genetic information in hiring or firing.¹²⁸ Claims of genetic discrimination could be brought to the EEOC in the same manner as allegations of race or sex discrimination. Insurance companies as well would be precluded from using genetic information to deny medical coverage or set premiums.¹²⁹ This bill is especially trenchant for obesity discrimination in light of recent research that shows significant genetic components implicated in obesity. Other federal interventions are already in place that deal with obesity and its effects.¹³⁰

126. Karen MacPherson, *Congress Rolls out Plans to Trim Fat From Kids, Not Just the Budget*, Pittsburgh Post-Gazette, Sept. 16, 2003.

127. Personal Responsibility in Food Consumption Act, H.R. 339, 108th Cong. (2003).

128. S. 1053, 108th Cong. (2003), states that it shall be prohibited to discriminate on the basis of genetic information. It prohibits discrimination in group premiums based on genetic information and defines genetic information as the occurrence of a disease or disorder in family members of the individual or information from genetic testing, exceptions would be information about sex or age of the person, information from clinical diagnosis such as chemical, blood, or urine analysis used to determine health status, and information about physical exams of the individual. The Act would prohibit insurers from using the genetic information to determine availability or premium rates. *Id.*

129. Jim Abrams, *Bill Would Bar Companies from Genetic Discrimination*, Baton Rouge Advocate, Oct. 15, 2003, at 14A.

130. 42 U.S.C. § 280h-2 (2003) mandates that the CDC develop a national campaign to educate children and parents on the risks of obesity, inactivity, and poor nutrition; 42 U.S.C. § 285b-7a (2003) deals with obesity in women, focusing on prevention and information; 10 U.S.C. § 1079 (2003) is an exclusion of obesity benefits for spouses and children of members of the armed forces that states that treatment of obesity is not covered if obesity is the major condition being treated; and 7 U.S.C. § 5925 (2003) states that obesity is a high priority research initiative and requires the Secretary of Agriculture to allocate grants to research obesity, to combat obesity in kids, and to develop community strategies to reduce obesity in children with recreation, education, and health partnerships.

B. When a Spoonful of Sugar Costs a Dollar More: State Action on Obesity

Local governments began to involve themselves in the area of public health in the first half of the nineteenth century. State health departments were established in the latter half of the nineteenth century and addressed problems of public sanitation, clean water, pasteurization of milk, immunization against communicable disease, and otherwise reduced the incidence of infection and sickness in the general population.¹³¹ As a result of these state health programs, life expectancy in the United States rose from forty-seven years in 1900 to seventy-five years in 1990.¹³² The initiatives currently employed by a majority of states to remedy the obesity epidemic fall under this same public health concern. These legislative remedies run the gamut from tax schemes to even more invasive policies. The “fat” tax is, in at least seventeen states, not just an idea.¹³³ It’s a reality. Generally, these states tax foods high in sugar, fat, and carbohydrates at around one percent (often more) of the purchase price. At this writing, none of the funds collected from this tax scheme have been specifically earmarked for nutrition education or fitness promotion.¹³⁴ As for invasive legislative remedies, several states are considering a variety of Orwellian interventions. In Arkansas, where sixty percent of adults are obese and ten percent of preschoolers are overweight, students at public schools will soon be issued “health report cards” which assign them a grade based on their BMI.¹³⁵ Many students anticipate that this BMI grading scale will lead to more teasing and further stigmatization,¹³⁶ but, with the dangers and levels of obesity growing, especially in children, desperation increases.¹³⁷

131. O’Connor & Sabato, *supra* note 118, at 636.

132. *Id.*

133. These seventeen states impose taxes on food products that exceed a certain level of fat, sugar, and carbohydrates. Gregerson, *supra* note 24, at 44. In what has become the civil rights foil to this taxing regime, several states and municipalities, like Santa Cruz, California for instance, have instituted ordinances to prevent discrimination against the obese in a variety of setting, from public accommodations to employment. O’Hara, *supra* note 19, at 906, 908.

134. Money collected from these taxes is predominantly poured into general funds. Gregerson, *supra* note 24, at 45.

135. Claudia Wallis, *Guess what F is for? FAT*, Time, Sept 15, 2003, at 68.

136. *Id.*

137. A study of 14,000 people in Bogalusa, Louisiana found significant indications of heart disease in children. Fatty streaks were found in the arteries of overweight three-year-olds, and data collected showed hypertension to be prevalent in children as young as five-years-old. Fumento, *supra* note 50, at 16.

1. When Twinkies Attack: The Inherent Evils of Sugary Goodness

Fat taxes, though popular, are not without their detractors. Fat taxes increase the price of snack foods, which disproportionately affects the poor, not only because they have smaller incomes but also because they have less access to affordable snack options.¹³⁸ Most state fat taxes apply to snack foods, viz., soft drinks, candy, chewing gum, potato chips, and the like. Many economists feel that a small snack tax will have little effect in terms of dissuading consumption of tasty consumables. In fact, if such a tax can be compared to that on cigarettes, less than a two percent sales decrease would result.¹³⁹ Irrespective of the unlikelihood of success, many states have enacted fat taxes. Still others, finding them ineffective or responding to pressure from the food industry or from the general public, have repealed their fat taxes.

Survey of Selected States with Fat Taxes and Percentage of Tax:¹⁴⁰

State	Year Enacted	Tax & Foods to which it Applies	Annual Income	Use of Revenue
California	1933	Sales Tax (7.25%) on soft drinks	218,000,000	General Funds
District of Columbia	1993	Sales Tax (5.75%) on snack foods and soft drinks	4,000,000	General Funds

138. Several commentators have noted this disparity. One such surveyor of the fat tax noted that it is "considered delicate only because taxing fast food would be seen as an attack on poor people who rely on junk food to eat cheaply. But in the long run, it would be an act of kindness." Sean Macaulay, *The Million-Pound Reason Why the United States Should Impose a Fat Tax*, *The Times of London*, Apr. 16, 2003, at 20.

139. Michael Jacobson & Kelly Brownell, *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, 90 *Am. J. of Pub. Health* 854 (2000).

140. *Id.* at 855.

Maine	1991	Sales Tax (5.5%) on snack foods, soft drinks, carbonated water, ice cream, toaster pastries	14,600,000	General Funds
Minnesota	1982	Sales Tax (6.5%) on candy, carbonated drinks, fruit drinks, chewing gum, single-serve ice cream	45,000,000	General Funds
Texas	1961	Sales Tax (6.25%) on carbonated and noncarbonated packaged soft drink beverages, diluted juice, and candy	160,000,000	General Funds

States and/or Municipalities that Have Repealed Fat Taxes:¹⁴¹

State	Year enacted	Year repealed	Tax	Annual Income	Use of revenue/ Reason repealed
Louisiana	1938	1997	2.5% whole-sale tax on bottled	13,000,000	General Funds; repealed due to contract with

141. *Id.* at 856.

			soft drinks and syrups		Coca-Cola to build bottling facility
Maryland	1992	1997	5% sales tax on snack foods	15,000,000	General Funds; repealed due to Frito-Lay's threat to not build local plant
Mississippi	1969	1992	5% of wholesale value of soft drinks, artificial fruit drinks, bottled teas	8,765,000	General Funds; repealed due to food and beverage industry lobbying
North Carolina	1969	1999	\$.01 per bottle; 1\$ per gallon of syrup, milk shake mixes, powdered drink bases	40,000,000	General Funds; soft drink bottlers association lobbied for repeal

Ohio	1993	1994	\$.008 per ounce of carbon- ated bever- age; \$.64 per gallon of syrup	59,800,000	General Funds; soft drink industry got constitu- tional amend- ment to repeal tax
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a. Fat Taxes and the Poverty Line Equation

The decision to purchase and consume certain types of food depends on ethnic and cultural values of food, its availability, transportation to food stores, cost and taste, perceived prestige and nutrition value.¹⁴² Access to grocery stores in many urban and inner-city areas is profoundly limited.¹⁴³ One study revealed that grocery stores in African-American neighborhoods carry a very limited supply of healthy food. In Los Angeles, thirty-eight percent of stores in black areas sold skim milk, as compared to eighty percent of stores in white areas. Inner city schools also have high concentrations of junk food, with fast food giants like Pizza Hut, Burger King, and Taco Bell (whose products are sold in 4,000 American schools) being a regular staple in cafeteria lines.¹⁴⁴ This factor, as well as the effect of even minimal fat taxes on the already limited income of the indigent (who rely on cheap snack goods from the locally-situated convenience stores for sustenance), is an important variable in any evaluation of a fat tax scheme. There are numerous arguments in support of fat taxes: they ostensibly offset the cost of obesity, create an economic disincentive to purchase unhealthy foods, and constitute only a small percentage of the purchase price. There are also compelling arguments against the use of fat taxes: they are not always a small percentage of the purchase price, they rely on an incorrect assumption that obese people will react to price incentives (which hasn't worked with smokers), and, most importantly, they are a regressive tax disproportionately burdening the poor. This last factor is especially

142. Pratt & Pratt, *supra* note 93, at 505.

143. One study found that produce consumption increased thirty-two percent in predominantly black neighborhoods with the addition of a supermarket. Eileen Salinsky & Wakina Scott, *Obesity in America: A Growing Threat* 6 (Nat'l Health Pol. Forum Background Paper, 2003).

144. Packard, *supra* note 81.

relevant to how the federal poverty line is calculated. The poverty line is determined by the percent of income that must necessarily go to the family food basket. The determination of what size food basket is necessary for survival is calculated by the size of the family and varies by locality. These food basket calculations are predetermined by government economists. Fat taxes are dangerous in this context because they would increase the direct cost of food to poorer families; this increase would not be reflected in the predetermined calculations because such calculations fail to take into account the restrictions of locality and time, two factors that limit the food choices of poorer individuals. For example, the average food basket expenditure for a family of three may be determined at a set rate of 500 dollars per month. This family of three, living in an inner-city area without a car and having only convenience stores in walking distance, may be forced to choose from consumer goods that are subject to fat taxes, i.e., vienna sausages, potato chips, hot dogs.¹⁴⁵ The family might also have only one wage-earner, a single mother for instance, who, working more than forty hours per week, cannot expend the time necessary to cook a dinner of broccoli-flourished cornish hens, even if such goods were available to her. The government has estimated that 500 dollars per month is enough to feed her family, but with the price of the previously affordable snack goods increasing, her lack of time to cook homemade meals and the restricted access to fresh, healthier foods, she cannot meet that budget. Therefore, she spends more, but doesn't fall below the poverty level (and receive the subsidies that are conditioned upon that) because the percent of her income spent on food was not calculated under the variables of time, access, and fat taxes. The government thinks that her income should reasonably cover the 500 dollars a month necessary to sustain her family. However, poverty, like sound, does not exist in a vacuum.

b. When Blueberry Muffins Are Bad but English Muffins Triumph: The Arbitrary Nature of Fat Taxes

Many critics of fat taxes maintain that they simply do not work. These opponents suggest that the taxes, besides being discriminatory and regressive, are difficult to administer, arbitrary, and confusing to consumers and retailers. Maine, for example, enacted a snack tax in 1991 that applied a sales tax to snack foods, taxing frozen baked

145. Many of Baton Rouge's inner city neighborhoods are without access to grocery stores; most people in these areas can't afford cars and do not drive. It is a twenty minute walk from some of these neighborhoods to the nearest grocery store. The closer stores are mostly corner stores with limited selections. Derrick Nunnally, *Groceries May Be On Their Way*, Baton Rouge Advocate, Mon., Oct. 27, 2003, at 1B.

apple pie but not frozen unbaked apple pie, blueberry muffins but not english muffins.¹⁴⁶ Ultimately, the bizarrely applied tax was repealed in 2000. The critics of fat taxes maintain further that, even with taxes, junk food will still be cheaper, certainly in terms of time output and probably in terms of dollars as well, than healthier foods. The disincentive to buying snack food is unquestionably nonexistent when no alternative exists, as in the case of many urban areas with limited availability of healthy food and few supermarkets.¹⁴⁷ Alternatives do exist, however, for treating obesity in a less discriminatory manner.

The United States Preventive Services Task Force found that education, behavior-oriented counseling, and patient reinforcement and follow-up was the most effective intervention in preventing and treating obesity.¹⁴⁸ Despite the fact that such intervention is successful, primary care physicians typically undertreat obesity because of the limited reimbursement for weight loss treatment.¹⁴⁹ Preventive services are generally not covered under Medicare unless they are specifically mandated by Congress. Medicare doesn't recognize obesity as an illness so hospital and physician services for weight loss are not covered.¹⁵⁰ Following this lead, private sector insurance policies often require the presence of a co-morbid illness as a condition for covering weight loss treatment.¹⁵¹ The federal government is currently considering two proposals, the Medicaid Obesity Treatment Act and the Obesity Prevention Act, which would address the obesity problem through Medicaid.¹⁵² Many states, including Louisiana, are proposing similar measures.

2. Obesity and Insurance: Conduct, Risk, and State Regulation

As has been evidenced earlier in this comment, the health care costs associated with obesity are overwhelming. In response to this,

146. Grocers of America, *A Complex Problem: A Sensible Solution*, at www.gmabrands.com/nutrition/solutions.htm.

147. At least one commentator has noted the ineffectiveness of fat taxes in the absence of any viable alternative, remarking that "taxing food, making food more expensive will certainly make people thin . . . High-priced food has made people dead." Fred Smith, president of Competitive Enterprise Institute, *on Crossfire: Fatter Tax on Snacks* (CNN television broadcast, June 13, 2003). Smith debated law professor John Banzhaf. Banzhaf wholeheartedly supports a fat tax, which he maintains will discourage consumption; he compares fat taxes to cigarettes and alcohol taxes. This approach, popular with fat tax supporters, is specious—cigarettes are a luxury item; food is necessary for life. *Id.*

148. Salinsky & Scott, *supra* note 143, at 19.

149. *Id.*

150. *Id.*

151. *Id.* at 20.

152. H.R. 2024, 108th Cong. (2003); H.R. 2227, 108th Cong. (2003).

Louisiana is conducting a new experiment designed to defray the exorbitant costs of treating obesity-related illnesses. This experiment will provide forty state workers with the opportunity to have gastric bypass surgery.¹⁵³ The state, which is attempting to keep down medical expenses for state workers, will evaluate the long term savings of preempting the health care costs of treating obesity's comorbid conditions. The surgery costs twenty-five thousand dollars per person, and Group Benefits, the insurance provider for state workers, would spend twenty-five million dollars per year if required to cover the surgery. The Louisiana legislature also considered requiring all health plans to cover bypass surgery, but the bill quickly died in the House Insurance Committee.¹⁵⁴ The likelihood that such a bill will be introduced again is great, especially given Louisiana's poor health status and the astounding number of Louisiana citizens suffering from obesity-related illnesses.¹⁵⁵ Within federal guidelines, Louisiana, as well as other states, can determine the type, amount, duration, and scope of Medicaid services.¹⁵⁶ Also, private insurance can be regulated under the McCarran-Ferguson Act, which grants states the right to regulate the business of insurance within their jurisdiction.¹⁵⁷ The business conducted by insurance companies within the state is not a right, but a privilege granted by the state. Insurance coverage involves a substantial public interest, and so it provokes the application of the state police power. The only limitation on the state's power to regulate such business is that the

153. *Grant Pays for Stomach Surgery for Overweight*, Baton Rouge Advocate, Oct. 14, 2003, at 2B.

154. *Id.*

155. In 1999, Louisiana residents spent a total of 383,708 days in the hospital due to cardiovascular disease at a cost of \$1.4 billion. State Ctr. for Health Statistics, La. Office of Pub. Health, 2001 Louisiana State of the Heart Report 9 (2001). In 2002, Louisiana ranked forty-ninth, second worst in the nation, in health indicators. Breast and cervical cancer rates for black women exceed national rates. Louisiana has the highest death rate due to diabetes in the nation, 32.5 per 100,000 as compared to a national rate of 18.5 per 100,000; 89.9% of Louisiana diabetics report not engaging in regular activity, while 78.4% consume less than the recommended five servings of fruit and vegetables per day. African-Americans in the state report a lack of health care coverage at 33%, while 17.2% of whites report that they are uninsured. In the past year, the Office of Public Health developed the Cardiovascular Health Core Capacity Program, and Louisiana was one of only eleven states to get funding to implement the program. State Ctr. for Health Statistics, La. Office of Pub. Health, 2002 Louisiana Health Report Card (2002).

156. *Id.* at 184.

157. 15 U.S.C. §§ 1011-1013 (2000). Whether the regulated practice falls within the business of insurance is determined by three criteria: 1) whether risk is being spread, 2) whether the practice is an integral part of the policy relationship between insurer and insured, and 3) whether the practice is limited to those entities within the insurance industry. See *Phillips v. Lincoln Nat'l Health & Cas. Ins. Co.*, 774 F. Supp. 1277 (D. Colo. 1991).

action must be related to public interest and must not violate equal protection, free speech, due process, or constitute an unconstitutional taking.

In response to their power to regulate insurance, many states have adopted the policy of requiring insurance companies to cover the treatment of obesity. The majority of states that impose this requirement usually do so under narrow restrictions, often limiting the coverage to morbid obesity or limiting the scope or duration of the treatment. In 2000, Indiana introduced a bill to create model programs to target minority and low income residents; another section of the bill allowed Medicaid recipients to have access to weight control treatments.¹⁵⁸ Many other states have legislation already in place to make coverage of obesity treatment mandatory in insurance policies issued within the state.¹⁵⁹

Several states, perhaps realizing that obesity is a complex disease meriting a complex solution, have allocated funds to the continued research of the epidemic.¹⁶⁰ Still others, taking note of the significant cultural stigma applied to obesity, have taken legislative steps to protect the obese from discrimination.¹⁶¹

158. H.B. 1382, 111th Gen'l Assembly (Ind. 2000).

159. See Ark. Code Ann. § 23-79-510(2)(T) (2003) (requiring Arkansas insurers to cover treatment for the morbidly obese where medically necessary); Ind. Code § 27-13-7-14.5 (2003) (mandating that Indiana insurers, HMOs and any insurer who issues basic healthcare services insurance policies, cover the surgical treatment for obesity); Ga. Code Ann. § 33-24-59.7 (2003) (a morbid obesity anti-discrimination act, requiring that insurance cover treatment for morbid obesity); Md. Code Ann., Ins., § 15-706 (2003) (requiring insurers in Maryland to offer coverage for medically necessary nutrition meetings and dietician meetings); Va. Code Ann. § 38.2-3418.13 (2003) (stipulating that coverage for treatment of morbid obesity is required by insurers, individual and group, and HMOs, and requiring that they make available gastric bypass coverage for the morbidly obese as defined by being at least 100 pounds over the ideal weight on the 1983 Metro. Life Insurance Table).

160. See Cal. Health and Safety Code § 152 (2003) (intending to close the gaps in health disparities in race, includes gaps related to obesity); Cal. Health and Safety Code § 100239 (allocating research grants to study diseases affecting women and minorities, including obesity, sickle cell, & AIDS); La. R.S. 46:2612 (2003) (creating the Louisiana Council on Obesity Prevention and Management to promote research in treatment, awareness of health risks, and to advise agencies with implementation of obesity programs); La. R.S. 40:1299.117 (authorizing the state health officer to classify obesity as a disease when BMI exceeds 30 kg/m² and the individual suffers from type II diabetes, hypertension or sleep apnea); Neb. Rev. St. § 71-1628.07 (2003) (requiring Nebraska's Office of Minority Health to target infant mortality, cardio disease, obesity, diabetes, and asthma in counties with at least five percent minority population); Miss. Code Ann. § 41-101-1(2003) (creating the Council on Obesity Prevention and Management to study the feasibility of awarding a tax incentive for work sites that promote reduction activities); Tex. Educ. Code Ann. § 38.013 (2003) (creating Texas health programs in schools to prevent obesity due to the fact that 28.6% of low income kids in Texas between two and five are obese while 38.7% of fourth graders in Texas are obese).

161. See Cal. Gov't Code § 19702 (2003) (prohibiting physical or mental

D. The Twinkie Shadow Looms Large: Speculative Proposals for Obesity Legislation

Pending State Obesity Legislation¹⁶²

State	Bill	Sponsor	Description	Status
Colorado	HB03-1145	Sen. Alice Madden (D)	Requires state to develop and implement obesity treatment program for purpose of treating recipients of medical assistance with BMI of 30 or more and whose weight has significantly impaired the individual's health	Introduced 1/14/03. Postponed indefinitely 1/31.
Illinois	SB0103	Sen. Miguel del Valle (D)	Requires Dept of Public Health to classify obesity as a disease	Introduced 1/29/03. Hearing scheduled 2/27.

disability discrimination) (amended in 1992 to remove a specific exclusion of obesity as a physical handicap, thus impliedly including it in the definition of physical disability under the current statute).

162. 2003 State Legislation Tracker, Obesity Policy Report, *available at* <http://www.obesitypolicy.com/> (June 29, 2003).

	SB1080	Sen. Iris Martinez (D)	Amends Illinois insurance code and other acts to require coverage for surgical treatment of morbid obesity	Introduced 2/19/03. Referred to Rules Committee 2/29/03.
Louisiana	HB68	Rep. Jean Doerge (D)	Mandates offering of optional insurance coverage for treatment of morbid obesity	Postponed indefinitely.
	HB 518	Rep. Ronnie Johns (R)	Limits liability for damages related to the consumption of certain products; limits liability of manufacturer, sellers of food, etc.	Signed into law by the Governor on 6/2/03; Becomes Act 158.
Michigan	HB 4441	Rep. Frank Accavitti (D)	Prohibits sale of soft drinks, gum, candy bars, etc. in certain schools	Pending.

Mississippi	HB 1428	Rep. Chester Masterson	Requires insurance policies to offer coverage for diseases of obesity and morbid obesity	Introduced in 2003 session; referred to Insurance Commission 1/20; died in committee 2/4.
New Jersey	A3592	Assemblyman Herb Conaway (D)	Requires managed care plans to over treatment of overweight and obese adults on fee-for-service basis	Pending.
Texas	SB343	Sen. Elliott Shapleigh (D)	Would bar sales at high schools of all soft drinks, sport drinks, etc. containing less than 50% fruit juice; restrict sale of snack food at schools, etc.	Introduced 2/11/03; referred to education committee

Virginia	SB1081	Sen. Benjamin Lambert (D)	Mandates health insurance coverage for morbid obesity treatment; requires that standards used by insurers to restrict access to surgery for morbid obesity shall be based upon current clinical guidelines; clarified whether insurers can consider diet	Introduced and referred to Committee on Education and Health 1/08/03; Passed Senate 1/21/03. House voted 99-0 to block vote passage 2/14.
Washington	SB5928	Sen. Rosa Franklin (D)	Imposes sales tax on candy to create "disincentives for unhealthy behavior, including poor eating habits."	Pending.

1. Spreading the Risk or Spreading the Blame: Insurance Surcharges and Obesity

Several recommendations by the National Association of Insurance Commissioners to charge overweight people substantially

higher health insurance premiums have recently been made.¹⁶³ Many state legislators believe that higher premiums for the overweight coupled with discounts for thinner people would improve overall health and ultimately reduce the cost of insurance to everyone. Representative Joan Stern of Maryland summarized this idea in a decidedly less than eloquent manner: "You can be as fat as you want, but when you become a burden on the health care system, when you start going to the emergency room, when you start having to take insulin and other drugs, the insurance premiums of everyone else go up."¹⁶⁴ Another vocal advocate of higher premiums for fat people, George Washington University law professor, John Banzhaf III, has suggested that charging everyone the same health insurance premiums unfairly forces people with healthy weights to subsidize the obese.¹⁶⁵ Other proponents of higher premiums mention that they create a terrific incentive to lose weight. This notion, like so many others relating to obesity legislation, is premised on the ludicrous contention that there is not already a disincentive to lose weight, i.e., these paternalistic incentive arguments evidently forget that being unable to walk properly, to breathe effectively, to venture into public domains without being mercilessly harassed is incentive enough. Representative Dan Morhaim, a legislator from Maryland and a medical doctor, disagrees with the idea of an insurance surcharge.¹⁶⁶ He maintains that insurance coverage should focus more on prevention of obesity and obesity treatment; the worst outcome, he believes, would be for overweight people to drop their health care coverage when it became too expensive.¹⁶⁷ Morgan Downey, executive director of the American Obesity Association, alleges that the higher surcharge is patently unfair and rhetorically muses on the question of whether charging more to Jewish people with a genetic predisposition for Tay-Sachs syndrome would be fair.¹⁶⁸ Earlier in this comment, the possibility of obesity as the result of a multifactorial genetic condition was examined. The importance of the genes versus culture debate is particularly great where insurance is concerned. Several federal statutes, like HIPAA and the ADA, prohibit discrimination based on genetic information in insurance.¹⁶⁹

163. Charles Fleming, *Costlier Insurance May Lie Ahead for the Overweight*, Wall Street Journal, April 6, 2004, at D5. See, e.g., John Banzhaf III, *Using Legal Action to Help Fight Obesity*, at <http://banzhaff.net/obesitylinks.html> (last visited Nov. 3, 2003).

164. Steven Dennis, *Shape Up or Shell Out*, Gazette.net, July 21, 2003, at <http://www.gazette.net/200327/montgomerycty/state/165758-1.html>.

165. *Id.*

166. *Id.*

167. *Id.*

168. *Id.*

169. HIPAA prohibits group health plans from basing eligibility on an

The whole idea of insurance is to share risk. Obesity, because of its physical conspicuousness, would be treated differently than other so-called voluntary conducts that are easier to conceal, like alcoholism; an unfair distribution of risk would result. Considering that most health insurers already discriminate against the obese, the insurance surcharge question is really a moot point. BlueCross BlueShield refuses to offer health insurance to people who fail to meet their predetermined health profile, which looks at conditions like smoking and obesity.¹⁷⁰ If coverage is offered, higher deductibles are mandatory.¹⁷¹ Large corporations that self insure are free to charge higher rates to obese employees; smaller companies often seek to create health plans with insurers that penalize obesity.¹⁷² The justification for charging prohibitively high premiums to obese people is focused on the notion that such an action benefits everyone else. Obese people may not be able to afford insurance, but presumably the premium rates for the rest of the insured will fall. This idea encompasses the crude teleological precept that the individual should be sacrificed for the good of the whole. In a nation that has consistently viewed individual freedom as tantamount to the ultimate good (and conversely viewed the limitation of freedom as the original sin), such an approach is curiously in contravention of the most basic American ideals.

III. THE DOCTRINE OF UNINTENDED CONSEQUENCES: ANALYSIS OF LEGISLATIVE REMEDIES UNDER A CIVIL RIGHTS FRAMEWORK

Legislative penalties addressing obesity can be both regressive and burdensome. Redress for those individuals disproportionately affected by economic and health access penalties for obesity would be difficult to obtain under the current statutory framework. States and a few municipalities have instituted regulations prohibiting discrimination against the obese,¹⁷³ but there is no federal law that

individual's health status, including genetic information. Health Insurance Portability and Accountability Act § 702, 29 U.S.C. § 1182 (2000). Although the statute itself does not explicitly address genetic discrimination in insurance, the EEOC has adopted the view that the ADA prohibits discrimination based on genetic conditions or genetic make-up. U.S. EEOC, Notice No. 915.002, *Policy Guidance on Executive Order 13,145: To Prohibit Discrimination in Federal Employment Based on Genetic Information* (July 26, 2000).

170. Dennis, *supra* note 164.

171. *Id.*

172. *Id.*

173. Michigan has a state law prohibiting weight-based employment discrimination. The District of Columbia, Santa Cruz, and San Francisco have ordinances that prohibit discrimination based on appearance, including obesity. Puhl & Brownell, *supra* note 8, at 798-99.

prohibits discrimination against overweight or obese people directly.¹⁷⁴ A majority of courts have ruled that obesity is not a disability covered by the Americans with Disabilities Act, the Rehabilitation Act of 1973, or the Equal Employment Opportunity Commission.¹⁷⁵ Though obesity disincentives and denials are ignominious and damaging for both white and black Americans, courts have consistently shied away from declaring the obese a protected class. For this very reason, another means of establishing the civil rights of these affected individuals is needed. Since a disproportionate number of African-Americans would be disadvantaged by these regulations, a different mode of redressability is available in regard to this protected class. A traditional civil rights approach, premised on the notion of disparate impact, may well be effective. Also, a new line of cases, which will be analyzed later in this paper, involving the Americans with Disabilities Act suggests that an illness or disability can be protected under the Act even before the disease becomes symptomatic. If obesity, due to its genetic components and the metabolic dysfunction that it precipitates, can be compared to those asymptomatic diseases that have been found to be protected under the Act, then recourse under the ADA may prove feasible.

A. An Overview of Civil Rights Law: Deontological vs. Consequential Approaches

Generally, two different approaches have been taken in regard to anti-discrimination legislation. One philosophy, which could be called the deontological approach as it focuses on means and not necessarily ends, encompasses the notions of disparate treatment, equal protection, and equal rules. If the means employed to regulate are acceptable, i.e., they are not facially discriminatory, then the end result is permissible even if it creates a disparate impact for one class.¹⁷⁶ The test of right action under such a precept is whether or not that action can be universalized without violating the inherent equity of all human beings. The second philosophy, which could be

174. *Id.*

175. *Id.* The EEOC does not consider obesity alone as an impairment, but the potentiality exists that if obesity was related to a physiological disorder, it would be protected. *Id.* at 799.

176. This is really the approach of the Kantian ethical philosopher. The Kantian imperative addresses an ideal very similar to the golden rule, i.e., do unto others as you would have done to you or, the converse, do not do to others what you would not have done to you. This philosophy embraces the notion that consequences do not make an action right or wrong. Rather, it is the principle upon which the agent acts that is the locus of the ethical question. Kantian ethical theory is often referred to as deontological ethical theory, from the Greek word *deon*, meaning "duty."

called the consequential (or teleological) approach as it focuses on the adequacy and propriety of the end, would encompass the theories of disparate impact, equal achievement, and affirmative action.¹⁷⁷ In this approach, the end is the chief good; it may be necessary to consider the impact of otherwise neutral laws if such laws inhibit equal achievement.

The philosophies of disparate treatment and equal protection promote meritocracy, viz., they embody the proverbial pull-yourself-up-by-the-boot-straps approach so integral to the American cultural mythology. Disparate impact, affirmative action, and equal achievement theories take into account various other factors, such as a history of slavery, cultural oppression, and pervasive discrimination, which have overburdened a disfavored people and made their axiomatic boot straps a little harder to reach. This idea promotes the elimination of obstacles that hinder advancement of the underrepresented group where such elimination is possible and reasonable.¹⁷⁸

The determination of whether such obstacles are reasonable is made under the rubric of a rational basis test. The rational basis test is a sliding scale, dependent upon whether the class affected is a protected class and whether the interest advanced by the state is a legitimate one. For instance, government classes established to protect the public health, as in anti-smoking laws or the setting of health standards, are accorded maximum deference under the rational basis test.¹⁷⁹

177. This is the utilitarian mode of ethics that finds the chief good in any action to be a maximization of happiness. Affirmative action may provide what some view as unequal or unfair access to one chosen class (and many view this means as discriminatory), but the action would be good under a utilitarian approach as the end result, equal achievement, is good. Utilitarian theory is often called teleological theory, from the Greek *telos*, meaning end.

178. This dichotomy in anti-discrimination philosophy can be represented in chart form, as seen below.

Simple Discrimination	Accommodation
Disparate Treatment	Disparate Impact
Status Blind Policies	Affirmative Action

179. See *Macck v. School Dist. of Lincoln*, 491 N.W.2d 341 (Neb. 1992) (where the court upheld a statute that excluded children not immunized for measles as rational under the state's role in regard to public health); see also *Doe v. Coughlin*, 518 N.E.2d 536 (N.Y. 1987) (where the court upheld a denial of conjugal visits to prisoner with AIDS); see, e.g., *State v. Powell*, 497 So.2d 1188 (Fla. 1986) (where the court held that removing corneal tissue for transplant during autopsy despite objections of next-of-kin was permissible because restoring eyesight was a rational goal); *Insurers' Action Council, Inc. V. Markman*, 653 F.2d 344 (8th Cir. 1981)

Cost-containment measures employed by the state relating to health care are also accorded great deference under the rational basis test, as is evinced in the cases upholding medical malpractice liability caps.¹⁸⁰ Typically, state taxation schemes are afforded great deference and generally upheld under equal protection scrutiny; legislatures need only believe that the proffered tax scheme will achieve a legislative purpose.¹⁸¹ Recently, though, courts have shown a greater willingness and affinity for finding some tax schemes violative of equal protection.¹⁸²

In a tier I rational basis test, the courts intervene only where egregious facts exist, where particularly important interests are presented, or where members of politically unpopular groups are challenging the unfairness. Legislation will be challenged where it is arbitrary or fails to bear a reasonable relationship to a legitimate government interest; however, a law is not suspect simply because a less discriminatory policy could have been employed.¹⁸³ There has been an increasing trend of court invalidation of various state legislation under the rational basis test.¹⁸⁴ A three part test has

(where the court affirmed a district court ruling that health insurers may be required, as is consistent with due process, to offer minimum benefits, participate in programs for the uninsurables, and permit group members to convert to individual coverage).

180. See *Davis v. Omitowaju*, 883 F.2d 1155 (3rd Cir. 1989) (where the court sustained a \$250,000 noneconomic malpractice cap); see also *Hoffman v. United States*, 767 F.2d 1431 (9th Cir. 1985) (\$250,000 cap on noneconomic damages valid); see, e.g., *Arceneaux v. Marler*, 542 So. 2d 203 (La. Ct. App. 3rd Cir. 1989) (where the court found that submission of medical malpractice claims to a medical review panel before filing lawsuit was valid); *English v. New England Med. Ctr., Inc.*, 541 N.E.2d 329 (1989) (\$20,000 liability limit for charitable institutions did not violate equal protection).

181. See *United States v. Baker*, 63 F.3d 1478 (9th Cir. 1995) (Washington cigarette tax scheme that allowed Dept. of Revenue to revoke permission of sale of unstamped cigarettes to Indian tribes, but not federal instrumentalities did not violate equal protection); see, e.g., *Mapes v. United States*, 576 F.2d 896 (Ct. Cl. 1978) (income tax distinction between married and single taxpayers upheld); see also *Heublein, Inc. v. State*, 351 S.E.2d 190 (Ga. 1987) (where the court upheld a tax on distilled spirits as valid to defray costs of regulation under the twenty-first amendment).

182. See *Allegheny Pittsburgh Coal Co. v. County Com'n of Webster County, W. Va.*, 488 U.S. 336, 109 S. Ct. 633 (1989) (where the Court invalidated a taxing scheme that resulted in egregious disparities in assessed values of comparable properties through reassessment based on purchase price over a long period of time); see also *Williams v. Vermont*, 472 U.S. 14, 105 S. Ct. 2465 (1985) (tax applied to new residents with automobiles purchased out-of-state invalidated despite purported rationality of scheme).

183. See *Scariano v. Justices of Supreme Court of State of Ind.*, 38 F.3d 920 (7th Cir. 1994) (rationality review does not include less discriminatory alternatives analysis).

184. See *U.S. Dept. of Agriculture v. Moreno*, 413 U.S. 528, 93 S. Ct. 2821 (1973) (where the Court held that denying food stamps to households consisting of

typically been used to test the rationality of the legislative action. There must be a plausible policy reason for the action, legislative facts rationally may be considered true, and the relationship of the challenged classification to the state goal must not be so attenuated as to render the distinction arbitrary or irrational.¹⁸⁵

In cases involving mid-tier scrutiny, the government interest must be actually served; where scheme appears arbitrary, courts may require the defendant to make a showing that the means employed serve a valid health, safety, or welfare concern rather than merely articulate a valid concern.¹⁸⁶ Many legal scholars have theorized that a level of scrutiny exists that resembles something akin to substantive equal protection. This scrutiny selectively uses a more rigorous standard than traditional rational basis.¹⁸⁷ Wealth as a categorization has never been accorded any special status, but

unrelated persons failed rational basis review for failing to plausibly serve a legitimate state interest); *see also* *City of Cleburne, Tex. v. Cleburne Living Ctr.*, 473 U.S. 432, 105 S. Ct. 3249 (1985) (town's exclusion of group home and denial of permit for home for mentally retarded was irrational).

185. *Nordlinger v. Hahn*, 505 U.S. 1, 10-11, 112 S. Ct. 2326, 2332 (1992).

186. *See Romer v. Evans*, 517 U.S. 620, 116 S. Ct. 1620 (1996) (where the Court invalidated state constitutional amendment prohibiting government from acting to protect homosexuals from discrimination; the court enunciated an anti-caste principle that precludes law that adversely affect classes of citizens or harm politically unpopular group, and applied rational basis justification). *But see* *Bush v. Gore*, 531 U.S. 98, 121 S. Ct. 525 (2000) (where the Court held that hand recount of Florida ballots, where different counties could apply different standards, was an arbitrary scheme that violated equal protection; the court reviews the actual counting process rather than the statute on its face; initial issue in equal protection is to establish intent or purposefulness in discrimination; the court ignores absence of any allegation stating classification designed to discriminate on basis of political party or whatever else).

187. As in *Cleburne*, 473 U.S. 432, 105 S. Ct. 3249, and *Romer*, 517 U.S. 620, 116 S. Ct. 1620, *Bush* could be read as a rejection of overly general state policies that fail to include precise standards and might lead to varying discretion in local implementation. *See O'Neal v. City of Seattle*, 66 F.3d 1064 (9th Cir. 1995) (refusal to provide water service for unpaid bill invalidated under rational basis test despite claim that scheme served interest in debt collection); *In re Mota*, 788 P.2d 538 (Wash. 1990) (failure to award good time credit for time served in county jail prior to trial due to inability to make bail violates equal protection; intermediate scrutiny applied due to denial of liberty based on indigence); *see also* *Moore v. Mobile Infirmary Ass'n*, 592 So. 2d 156 (Ala. 1991) (where the court found \$400,000 noneconomic cap for medical malpractice liability to be invalid under the state equal protection clause, which provided enhanced scrutiny, and court balanced direct burden placed on injured person against indirect and speculative benefit conferred on society); *Brill v. Hedges*, 783 F. Supp. 340 (S.D. Ohio 1991) (the court found Ohio statute requiring unmarried mothers to register child by mother's surname met the rational basis due process test but failed rational basis equal protection test). For discussion of disparate impact, *see Santiago v. Miles*, 774 F. Supp. 775 (W.D. N.Y. 1991) (statistical disparity supports equal protection violation in discrimination in prison housing, job assignments, and discipline).

handicapped individuals may be granted additional scrutiny under the rational basis model.¹⁸⁸ The obese as a class have not been granted special protection under the Equal Protection Clause or declared a protected class.¹⁸⁹

B. When Equal Protection is Neither Equal nor Protective

“The interpretation of constitutional principles must not be too literal. We must remember that the machinery of government would not work if it were not allowed a little play in its joints.”¹⁹⁰

An equal protection action is unlikely to prevail in the ordinary case of obesity discrimination. The state action requirement of the Fourteenth Amendment would shield those entities in the private sector who discriminate against the obese from a claim of an equal protection violation. In the context of state action, e.g., anti-obesity legislation, only those policies that deprive an individual of a fundamental right, create a suspect or quasi-suspect class, or operate to disadvantage a suspect or quasi-suspect class would warrant a heightened standard of review.¹⁹¹ Other policies would most likely

188. See *City of Cleburne*, 473 U.S. 432, 105 S. Ct. 3249; *Life Ins. Ass'n of Mass. v. Comm'r of Ins.*, 530 N.E.2d 168 (Mass. 1988) (AIDS victims are not a protected class, but the state insurance commissioner has power to regulate insurers limiting extent of pre-insurance HIV testing).

189. See *United States v. Santiago-Martinez*, 58 F.3d 422 (9th Cir. 1995) (peremptory jury strikes based on obesity not subject to heightened scrutiny as obese not protected class). But see *Gerdorn v. Continental Airlines, Inc.*, 692 F.2d 602 (9th Cir. 1982) (Title VII invalidation of strict weight limit for female flight attendants).

190. Justice Oliver Wendell Holmes, *Bain Peanut Co. Of Tex. v. Pinson*, 282 U.S. 499, 501, 57 S. Ct. 228, 229 (1931).

191. An example of suspect, quasi-suspect, and other classes as viewed under three main standard of review:

Classification	Standard of Review	Test	Example
Fundamental Freedoms: religion, press, assembly, privacy;	Strict scrutiny or heightened standard	Is classification necessary to accomplishment of a permissible state goal? It is the least restrictive way to reach that goal?	<i>Brown v. Board of Education of Topeka, Kansas</i> : racial segregation not necessary to accomplish goal of educating students

merit the mildest standard of review—rational basis review. Most laws are subject to the rational basis or minimum rationality test. This lowest level of scrutiny means that the government must allege a rational foundation for any distinction they make. When certain rights are impinged upon, the policy is subjected to a heightened standard of review. These rights are considered so fundamental that a heavy burden must be put on the government in order to restrict those rights. When fundamental rights such as First Amendment rights or suspect classifications, like race, are involved, the standard of review for the legislative policy is strict scrutiny. If the state, in an attempt to ameliorate the costs associated with obesity, passed a

privacy; suspect classes: race and national origin			
Quasi- suspect classes: gender and illegiti- macy <i>cf.</i> , <i>U.S. V. Santiago-Martinez</i> , 58 F.3d 422 (holding that the obese are not a protected class)	Intermediate Standard	Does the classification serve an important governmental objective, and is it substantially related to those ends?	<i>Craig v. Boren</i> : keeping drunks off road important objective, but allowing 18-21 women to drink and not men of same age isn't substantially related to that goal
Others: including age, wealth, sexual preference, maybe obesity?	Minimum rationality standard	Is there any rational foundation for the discrimination?	<i>Romer v. Evans</i> : CO constitutional amendment precluding state executive, judicial, legislative action designed to bar discrimination based on sexual preference is not rational or reasonable.

statute that taxed insurance policyholders who were obese, it is unlikely that a cause of action under the Equal Protection Clause would be effective in invalidating the policy. First, the obese are not a suspect class. Second, health coverage is not a fundamental right. As long as the state could articulate a rational foundation for the discrimination, such as cost-containment, the policy would be valid. Equal protection could reach state action that discriminated against obesity if no rational basis could be articulated or if the basis articulated was implausible. Even in these instances, where no rational basis is found, the inquiries into the intent and purposefulness of the discrimination must be satisfied before the challenge will prevail. As will be shown later in this comment, the questions of intent and purposefulness are a difficult hurdle to clear in cases alleging equal protection violations.

The requirement that intent or purposefulness be shown in relation to any discrimination occurring in conjunction with an illegitimate state action has hindered many claimants from receiving redress under the Equal Protection Clause. The situation is particularly difficult when a facially neutral statute is being employed arbitrarily for the purpose of having a disparate impact on a protected class. It is nearly impossible in these cases for the claimant to single out the intent behind the action, as most legislators are not so stupid as to include their discriminatory purpose conveniently in the House Report. This is not to say that proof of disparate impact is not important in an equal protection case; indeed, it is important in that it can often be the starting point for a finding of intent.¹⁹² However, disparate impact alone is not enough. The question of class definition, too, is a tricky one.¹⁹³ The Supreme Court of the United States has held that a discriminatory policy against an arbitrarily defined class is not valid under constitutional scrutiny.¹⁹⁴ It has also been noted that a state could

192. See *Columbus Bd. of Educ. v. Penick*, 443 U.S. 449, 450, 99 S. Ct. 2941, 2943 (1979) (where the Court held that disparate impact and foreseeable consequences, without more, do not establish a constitutional violation, but actions having a foreseeable and anticipated disparate impact are relevant evidence in proving the ultimate fact of forbidden purpose).

193. See, e.g., *Califano v. Boles*, 443 U.S. 282, 99 S. Ct. 2767 (1979) (where the mother of illegitimate son challenged constitutionality of a Social Security Act section that restricted insurance benefits to widows and divorced wives of wage-earners and the Court held that only when it is shown that legislation has a substantial disparate impact on classes defined in a different fashion may analysis continue on the basis of those classes, and speculative impact on illegitimate children not sufficient to treat denial of mother's insurance benefits as discrimination against those children).

194. See *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 40 S. Ct. 560 (1920) (where the Court found that a Virginia statute that imposed a tax on corporations

employ a stricter standard of review in regard to the equal protection clause of the state constitution.¹⁹⁵

This focus on the state's right to define a certain class as worthy of greater protection is particularly relevant in Louisiana. The equal protection clause in the Louisiana Constitution states that "[n]o person shall be denied the equal protection of the laws. . . . No law shall arbitrarily, capriciously, or unreasonably discriminate against a person because of birth, age, sex, culture, *physical condition*, or political ideas or affiliations."¹⁹⁶ The inclusion of physical condition in the Louisiana equal protection scheme evinces the state's intention to grant greater protection to those individuals falling under this classification. Obesity is certainly a physical condition. In Louisiana at least, a law or policy that discriminated against the obese would be subject to a heightened standard of review. Consequently, even though the federal courts have not granted the obese a protected classification, a differential adverse effect on obese persons in Louisiana may constitute a trigger for constitutional scrutiny that can consider disparate impact.

Traditionally, the Equal Protection Clause of the Fourteenth Amendment has been used to remedy civil rights violations. However, in some areas of discrimination, like environmental racism, it has proved ineffective as a mode of redress due to the purpose requirement it entails. Unlike Titles VI and VII of the Civil Rights Act, a violation of the Equal Protection Clause must be shown to be the result of an invidious purpose or discriminatory intent. This burden of proof requires the claimant to show that the subjective intent of the defendant was discriminatory. This is often a difficult task, and one that often proves prohibitive to those individuals who are unable to ferret out the smoking gun of purposeful discrimination.

doing business both inside and out-of-state, but exempted domestic corporations doing no business within the state was an arbitrary classification and could not be sustained). *But see* Kahn v. Shevin, 416 U.S. 351, 94 S. Ct. 1734 (1974) (where the Court found that the differential treatment of widows and widowers under Florida scheme whereby widows, and not widowers, were given a \$500 exemption from property taxes was valid under equal protection because the classification rested upon some ground having a fair and substantial relation to legislative objection).

195. *See* Boy Scouts of America v. Wyman, 335 F.3d 80 (2d Cir. 2003) (where the court held that under the Fourteenth Amendment it is possible that the state that has adopted a policy of equal protection with respect to a certain group may have a compelling interest in the enforcement of that policy even if the federal government has not recognized the same group's claim to heightened scrutiny and policy of Boy Scouts that excluded homosexuals, under the state's gay rights act was discrimination: such a differential adverse impact may suffice to trigger constitutional scrutiny).

196. La. Const. Art. 1, § 3 (emphasis added).

1. Pervasive Racism and the Fallaciousness of Intent in Equal Protection

*“The experience of Negroes in America has been different in kind, not just in degree, from that of other ethnic groups. It is not merely the history of slavery alone but also that a whole people were marked as inferior by the law. And that mark has endured.”*¹⁹⁷

Two cases are preeminent in the jurisprudence concerning discriminatory purpose and the equal protection approach. In *Washington v. Davis*,¹⁹⁸ the Supreme Court of the United States definitively held that discriminatory impact alone does not render a facially neutral law unconstitutional.¹⁹⁹ In *Washington*, black applicants, who were rejected by the District of Columbia police force after failing a written test required for recruiting purposes, brought a class action suit alleging that the recruiting procedures were racially discriminatory and violated the Due Process clause of the Fourteenth Amendment.²⁰⁰ To be accepted by the D.C. Police Department, an applicant was required to make a score of forty out of a possible eighty on Test 21, a test generally designed to test verbal acuity, vocabulary, reading skills, and comprehension.²⁰¹ The test was not created by the Police Department, but was used throughout the federal government and was designed by the Civil Service Commission.²⁰²

The Supreme Court found that the test quite possibly created a disparate impact for minority recruits; however, disparate impact, under constitutional standards, was not enough, and proof of discriminatory intent was needed.²⁰³ The Court specifically rejected the notion that a law or regulation could be found unconstitutional based wholly on disparate impact without any proof of discriminatory intent or invidious purpose.²⁰⁴ The Court noted that such intent was nonexistent on the part of the District of Columbia Police Department.²⁰⁵ The opinion mentioned that discriminatory impact

197. Justice Marshall, *University of California v. Bakke*, 438 U.S. 265, 401, 98 S. Ct. 2733, 2804 (1978)

198. 426 U.S. 229, 96 S. Ct. 2040 (1976).

199. *Id.* at 230, 96 S. Ct. at 2043.

200. *Id.* at 229, 96 S. Ct. at 2040.

201. *Id.* at 234, 96 S. Ct. at 2045.

202. *Id.*

203. *Id.* at 230, 96 S. Ct. at 2043. The Supreme Court found that the Court of Appeals, which had held the recruiting procedures to be a constitutional violation, “erroneously applied the legal standards applicable to Title VII cases in resolving the constitutional issue before it.” *Id.* at 238, 96 S. Ct. at 2046.

204. *Id.* at 239, 96 S. Ct. at 2047.

205. *Id.* at 235, 96 S. Ct. at 2045. The Court made much of the fact that the Department had regularly tried to recruit minority applicants in the past; it was also

was not totally irrelevant, but it was not “the sole touchstone of an invidious racial discrimination forbidden by the Constitution.”²⁰⁶ The Court in *Washington* seemed to leave the door open for an inference of intent premised on impact;²⁰⁷ it suggested that such an inference of discriminatory intent may be warranted if the facts support it.²⁰⁸ Moreover, the Court noted that neutral regulations or statutes should not be applied in such a manner that they serve to discriminate on the basis of race.²⁰⁹ The line between discriminatory purpose and discriminatory impact is, even by the Court’s admission, admittedly blurry.²¹⁰ In an effort to lend clarity to the decision, a separate concurrence added that not every disparate impact was a constitutional violation, but when the disparate impact is egregious “it really does not matter whether the standard is phrased in terms of purpose or effect.”²¹¹ The concurring opinion mentioned that intent would usually be found only in objective evidence as the defendant’s subjective state of mind would be difficult to ascertain.²¹² After finding the police department to be absent of discriminatory intent, the Court addressed the justification of the contested recruitment procedures and found them to be necessary to the job they screened for.²¹³ The Court itself was aware of the cognitive dissonance that the

mentioned that the Department had hired several black applicants, but many of them had failed to report for duty. Also important in the calculus of intent was the racial make-up of the Department, which was roughly equal to the racial make-up of the surrounding community. *Id.* at 235, 237, 96 S. Ct. at 2045, 2046.

206. *Id.* at 242, 96 S. Ct. at 2049.

207. The Court explicitly states that “an invidious discriminatory purpose may often be inferred from the totality of the relevant facts, including the fact, if it is true, that the law bears more heavily on one race than another.” *Id.*, 96 S. Ct. at 2048-49.

208. This fact-dependent inquiry shifts the focus away from intent, and, arguably, back toward impact. This schizophrenic split is further amplified by the Court’s admission that any facially neutral statute must not be applied “to discriminate on the basis of race.” *Id.* at 241, 96 S. Ct. at 2048.

209. *Id.*

210. In a separate concurrence, Justice Stevens suggested that “the line between discriminatory purpose and discriminatory impact is not nearly as bright . . . as the reader of the Court’s opinion might assume.” *Id.* at 254, 96 S. Ct. at 2054.

211. Justice Stevens cited two cases, *Gomillion v. Lightfoot*, 364 U.S. 339, 81 S. Ct. 125 (1960) and *Yick Wo v. Hopkins*, 118 U.S. 356, 6 S. Ct. 1064 (1886), as examples of a particularly egregious disparate impact that amounted to a Constitutional violation. *Washington*, 426 U.S. at 254, 96 S. Ct. at 2054.

212. Thus, intent would almost always be an inference based on a finding of disparate impact. *Id.* at 253, 96 S. Ct. at 2054.

213. The Court found that the test required for hiring purposes was useful and essential to training for police officers who would often need to communicate effectively. The finding of this rationale is somewhat strange, as the Court stated that a *prima facie* case of unconstitutional discrimination was not made out. Since the claimant had failed to make out a *prima facie* case, it is unusual that the Court progressed to the next step of finding a justifiable business necessity for the result.

opinion in *Washington* created; for this very reason, it added on an necessary finding of justification for the contested practice (for which a *prima facie* case of discrimination was never made) as a prophylactic to any further confusion.

In *Village of Arlington Heights v. Metropolitan Housing Development Corp.*,²¹⁴ the Supreme Court of the United States again addressed the question of disparate impact and discriminatory purpose. *Arlington Heights* involved an allegation of racial discrimination from a real estate developer who had purchased a tract of land on which he planned to erect low income, racially-integrated housing.²¹⁵ The developer filed suit for injunctive and declaratory relief based on the fact that local authorities had refused to rezone the land, a denial that was alleged to be discriminatory in purpose.²¹⁶ The developer, Metropolitan Housing Development Corporation, had contracted to purchase the land contingent upon securing the proper rezoning requirements for the low-income housing.²¹⁷ The land was originally zoned to accommodate single family dwellings; Metropolitan Housing filed a petition with the Arlington Village Plan Commission to have the area rezoned for multiple family dwelling.²¹⁸ The petition filed with the Plan Commission stipulated that the low income housing would be constructed with federal subsidies, and therefore would be required to be racially integrated.²¹⁹ The Commission held three public meetings to consider the rezoning request; at these meetings, opponents of the idea repeatedly mentioned the fact that the housing would be integrated.²²⁰ Other opponents decried the fact that the rezoning would unfairly affect those people who had built on the land in reliance on it always remaining single family and that rezoning for multiple families would threaten property values for neighboring sites.²²¹ Ultimately, the Village's Board of Trustees denied the rezoning request by a vote of six to one, pursuant to a recommendation from the Commission.²²² The district court, while admitting that the denial had a disproportionate impact on African-Americans, held that the rezoning refusal was not discriminatory as it evidenced only a desire of the Village to protect property values and maintain the prevailing zoning

Id. at 250, 96 S. Ct. at 2052.

214. 429 U.S. 252, 97 S. Ct. 555 (1977).

215. *Id.* at 252, 97 S. Ct. at 556.

216. *Id.*

217. *Id.*

218. *Id.* at 257, 97 S. Ct. at 559.

219. *Id.*

220. *Id.* at 257-58, 97 S. Ct. at 559.

221. *Id.* at 258, 97 S. Ct. at 559.

222. *Id.*, 97 S. Ct. at 560.

regime.²²³ The Court of Appeals reversed this decision and focused on the "ultimate effect" of the denial which was discriminatory.²²⁴ The Court of Appeals ruled that the denial did not require a clear showing of intent to be found unconstitutional; rather, when examined in the light of "historical context and ultimate effect," the result was enough to prove the means violative.²²⁵ The Supreme Court reaffirmed the principle ostensibly stated in *Washington* that intent is required in showing a violation of the Equal Protection Clause.²²⁶ The Court reversed the decision of the Court of Appeals, finding no discriminatory intent in the denial of rezoning.²²⁷ Again the Supreme Court, as they did in *Washington*, suggested that an inference could be made based on impact.²²⁸ The Court established five factors for determining discriminatory intent. These factors are, for the most part, wholly concerned with inferences based on probative evidence: 1) whether the impact weighs more heavily on one race than another, 2) whether the history of the decision reveals a series of actions taken for invidious purposes, 3) whether the sequence of events leading to the action suggests a discriminatory purpose, 4) whether substantive departures from normal procedures have occurred, and 5) whether a consideration of the legislative history of the statute denotes a racist purpose.²²⁹ The Court also noted that racial purpose does not have to be the sole or primary purpose, only a motivating factor.²³⁰ Many commentators feel that the focus on discriminatory intent in equal protection proceedings is counterproductive to the goal of eliminating distinctions based on

223. *Id.* at 252, 97 S. Ct. at 557.

224. *Id.* at 259, 97 S. Ct. at 560. The Court of Appeals based their decision on the fact that African-Americans made up forty percent of those residents whose low income made them eligible for the proposed housing project and yet constituted only eighteen percent of the population of the Chicago area where the project would be located. *Id.* at 269, 97 S. Ct. at 565.

225. *Id.* at 260, 97 S. Ct. at 560. The Court of Appeals stated that racially discriminatory effects could only be tolerated if they served a truly compelling interest. Protection of property values did not meet this standard of interest. *Id.*

226. *Id.* at 253, 265, 97 S. Ct. at 557, 563.

227. *Id.* at 270, 97 S. Ct. at 566.

228. *Id.* The Supreme Court found that nothing in the testimony warranted "an inference of invidious purpose." *Id.*

229. *Id.* at 266-68, 97 S. Ct. at 564-65. It was noted by the Court that the determination of discriminatory purpose involved a "sensitive inquiry into such circumstantial and direct evidence of intent as may be available." This elicits the questions of whether or not disparate impact would be enough evidence to support a finding of invidious purpose. *Id.* at 266, 97 S. Ct. at 564.

230. *Id.* at 265-66, 97 S. Ct. at 563-64. The Court apparently did not find the fact that the rezoning was opposed by some because of the integration it portended to be a motivating factor not negated by the fact that protection of property value was the primary reason. *Id.*

irrational or biased notions.²³¹ They contend that it creates an escape hatch.²³² The focus on intent or purpose enables regulations to be passed that have disparate impact on one protected class, but are not redressable under an equal protection argument because the discriminatory intent is hidden.²³³ Evidence of intent is not required under Title VII but is required under the Constitution.²³⁴ Courts have previously stated that, in equal protection claims, a finding of disproportionate impact is relevant evidence in beginning the search for intent and purposefulness.²³⁵ Disparate impact theory under the Civil Rights Act of 1964 does not require a discriminatory motive, only a disproportionate effect.²³⁶ Some commentators have suggested that it may not be fair to hold a defendant liable for socially-created inequities.²³⁷ There is also some question as to whether or not civil rights claims are being addressed at all.²³⁸ Laws which are facially neutral but have a disparate impact are often found invalid on statutory grounds, but survive constitutional scrutiny when there is no proof of discriminatory intent.²³⁹ The exception to this rule is when

231. "By creating facially neutral classes such as 'veteran' and 'nonveteran' rather than sex-specific distinctions like 'men' and 'women,' governmental entities are able to avoid a finding of discrimination." Ruth Colker, *Anti-Subordination Above All: Sex, Race, and Equal Protection*, 61 N.Y.U. L. Rev. 1003, 1032-33 (1986).

232. That is, almost any legislative act can be justified by the invocation of some legitimate purpose, e.g., general welfare. Pamela Karlan, *Discriminatory Purpose and Mens Rea: The Tortured Argument of Invidious Intent*, 93 Yale L.J. 111, 124 (1983).

233. The purpose requirement also overlooks the fact that disparate impact for minority populations, even when not purposeful, are not tolerable; sanctioning these impacts "reflects the willingness of the state, in pursuit of a nondiscriminatory goal, to place disproportionate burdens on those groups who are least able to bear them and least able to complain effectively." Karlan, *supra* note 233, at 124.

234. Colker, *supra* note 232, at 1034.

235. See *Washington v. Davis*, 426 U.S. 229, 96 S. Ct. 2040 (1976); see also *Larry P. By Lucille P. v. Riles*, 793 F.2d 969 (9th Cir.1984).

236. Colker, *supra* note 232, at 1034.

237. *Id.* at 1035.

238. A 1999 study of Justice Department records revealed that between 1992 and 1996, federal prosecutors took no action in ninety-six percent of the approximately 2,000 claims of civil rights violations referred to them by the FBI or other agencies (most of these claims involved allegations of police abuse or misconduct). By comparison, the Justice Department prosecuted ninety percent of the immigration cases and seventy-five percent of the drug cases referred to them. *Complaints of Civil Rights Violations Rarely Prosecuted, Associated Press Study Reveals*, *Jet*, Apr. 5, 1999, at 6.

239. Many commentators feel that this approach is disingenuous and not supportive of the purpose of the Fourteenth Amendment which "requires that a legislature consider the rights of [minority] groups when it makes its 'calculus of effects.'" Thus, legislation should be weighed on a balance of benefit for all and burden to minorities. Karlan, *supra* note 233, at 123.

the disparate impact is extreme and cannot be explained on grounds other than discrimination.²⁴⁰

2. Gomillion and Yick Wo: When Impact is Intent

In both *Washington* and *Arlington Heights*, the Supreme Court opined that, in at least some circumstances, impact itself is determinative in finding a constitutional violation.²⁴¹ In *Gomillion v. Lightfoot*,²⁴² an action taken by the Alabama legislature which redefined the city boundaries of Tuskegee was challenged as a violation of the Due Process and Equal Protection Clauses of the Fourteenth Amendment.²⁴³ Local Act Number 140 changed the city boundaries from a square to a twenty-eight-sided figure; it also effectively removed all but five of the four hundred African-American voters from the city.²⁴⁴ The newly disenfranchised African-Americans instituted an action for declaratory judgment, alleging that the strangely irregular redrawing of city boundaries constituted racial discrimination in violation of the Constitution.²⁴⁵ The Supreme Court agreed with this contention and held that the Act, which removed nearly all of the black voters and not one white citizen, was "tantamount for all practical purposes to a mathematical demonstration" of the Alabama legislature's discriminatory purpose.²⁴⁶ In response to the contentions that redistricting was a matter of state concern and a nonjusticiable political issue, the Court cited Justice Holmes: "Of course the petition concerns political action," but "the objection that the subject matter of the suit is political is little more than a play upon words."²⁴⁷ The Court held that state actions which were normally insulated from federal judicial review forfeited that immunity when those actions attempted to deprive citizens of federally protected rights.²⁴⁸

240. The Court in *Arlington Heights* voiced this opinion, saying that when "a clear pattern, unexplainable on grounds other than race, emerges from the effect of the state action even when the governing legislation appears neutral on its face" the statute or action is violative. *Village of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 266, 97 S. Ct. 555, 564 (1976).

241. *Washington v. Davis*, 426 U.S. 229, 254, 96 S. Ct. 2040, 2054 (1976) (Stephens, J., concurring); *Arlington Heights*, 429 U.S. at 266, 97 S. Ct. at 564.

242. 364 U.S. 339, 81 S. Ct. 125 (1960).

243. *Id.* at 340, 81 S. Ct. at 126.

244. *Id.* at 340-41, 81 S. Ct. at 126-27.

245. *Id.*

246. *Id.* at 341, 81 S. Ct. at 127.

247. *Id.* at 347, 81 S. Ct. at 130 (citing *Nixon v. Herndon*, 273 U.S. 536, 540, 47 S. Ct. 446, 471).

248. *Id.*

*Yick Wo v. Hopkins*²⁴⁹ is another case in which the Supreme Court found that disparate impact was enough to render a statute unconstitutional.²⁵⁰ *Yick Wo* involved a San Francisco ordinance which prescribed the kinds of buildings in which laundries could be located; it also gave local officials the right to deny licensing to those laundry owners whose buildings were not up to ordinance standards.²⁵¹ The plaintiff in the suit was a native of China and had owned the same laundry business in San Francisco for twenty-two years, regularly renewing his license from the board of fire wardens to certify the safety of the establishment.²⁵² After the laundry ordinance was passed, the local authorities, acting with discretion granted to them by the ordinance, refused to renew the claimant's license on the grounds that his laundry was made of wood.²⁵³ At the time when the ordinance was passed, there were 320 laundries in San Francisco, 240 of which were owned by natives of China, and 310 of which were made of wood.²⁵⁴ Laundry owners who were not Chinese were granted license renewals; all Chinese laundry owners were denied.²⁵⁵ The Supreme Court of California upheld the ordinance, stating that the state has the power to regulate all occupations within its borders for the purposes of public safety.²⁵⁶ The Supreme Court of the United States reversed this decision,²⁵⁷ and found that the ordinance, though facially neutral, was applied in such an unequal fashion that it constituted a denial of equal rights.²⁵⁸ Despite the weak justification of public safety, the Court could find no purpose behind the ordinance except for racial discrimination and an attempt to create a monopoly for white-owned laundries.²⁵⁹ The Court expressed disdain for the notion that the state was beyond reproach while regulating within its own borders.²⁶⁰ The Court also criticized the

249. 118 U.S. 356, 6 S. Ct. 1064 (1885).

250. *Id.*

251. *Id.* at 357, 6 S. Ct. at 1065.

252. *Id.* at 358, 6 S. Ct. at 1065-66.

253. *Id.* at 358-59, 6 S. Ct. at 1066.

254. *Id.* Not only were the laundries primarily wood constructions, but nine-tenths of the houses in the city were made of wood as well. *Id.*

255. *Id.* at 359, 6 S. Ct. at 1066.

256. *Id.* at 360, 6 S. Ct. at 1066-67.

257. *Id.* at 374, 6 S. Ct. at 1073. In their opinion, the Supreme Court of the United States questioned the reasonableness of the Supreme Court of California: "Can a court be blind to what must be necessarily known to every intelligent person in the state?" *Id.* at 363, 6 S. Ct. at 1068.

258. *Id.* at 373-74, 6 S. Ct. at 1073.

259. *Id.* at 362, 374, 6 S. Ct. at 1068, 1073.

260. *Id.* at 370, 6 S. Ct. at 1071. The Court summarized the issue of state sovereignty by stating that "in our system, while sovereign powers are delegated to the agencies of government, sovereignty itself remains with the people, by whom and for whom all government exists and acts." *Id.*

unbridled discretion afforded by the ordinance to the local authorities, stating that "the law is the definition and limitation of power."²⁶¹ In *Yick Wo*, the Supreme Court held that facially neutral ordinances that serve to discriminate against a class are intolerable for that effect.²⁶²

3. Reason and Rationality: The Unprotective Prophylactic of Equal Protection

The Supreme Court of the United States has, in at least two cases, held that a constitutional violation can be found when a facially neutral state action has a disparate impact on a minority group. In these situations, the effect of the discrimination exceeds the boundaries of disparate impact and allows the court to make an inference of discriminatory purpose.²⁶³ In *Washington* and later in *Arlington Heights*, the Court reaffirmed the notion that discriminatory intent must be shown when a constitutional violation is alleged; however, in each of these cases, the Court specifically noted that objective evidence, i.e., disparate impact, might be enough to constitute intent when evidence pertaining to the actor's subjective state of mind is lacking.²⁶⁴ The line between discriminatory intent and discriminatory impact is not altogether clearly demarcated. The fuzziness surrounding these concepts has been criticized by the Supreme Court Justices themselves.²⁶⁵ Many commentators feel that requiring an actual showing of discriminatory purpose is counterintuitive to the goal of the equal protection doctrine.²⁶⁶ In support of this contention, it has often been noted by opponents of the

261. *Id.* The Court opined that such discretion, which made one man wholly subject to the will of another, was "the essence of slavery itself." *Id.*

262. Such ordinances, if allowed to stand, would be "evading and in effect nullifying the provision of the national Constitution." *Id.* at 1068, 65 S. Ct. at 1068.

263. *Gomillion v. Lightfoot*, 364 U.S. 339, 81 S. Ct. 125 (1960), and *Yick Wo v. Hopkins*, 118 U.S. 356, 6 S. Ct. 1064 (1886). In each of these cases, the Court imputed a discriminatory motive to the challenged laws primarily because there existed no alternative justification and the impact on one affected class was particularly egregious.

264. *Washington v. Davis*, 426 U.S. 229, 96 S. Ct. 2040 (1976); *Village of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 97 S. Ct. 555 (1977). Each case contemplates that discriminatory purpose could be revealed by considering the totality of the relevant facts available. This fact-dependent inquiry is, in effect, an inference of intent rather than a showing of intent. Robert Nelson, *To Infer or Not to Infer a Discriminatory Purpose: Rethinking Equal Protection Doctrine*, 61 N.Y.U. L. Rev. 334, 341 (1986).

265. The purpose standard has been questioned and criticized by both Justice Marshall and Justice Rehnquist. Nelson, *supra* note 265, at 343.

266. The purpose standard is viewed as hostile to the ideals of equal protection because it "effectively immunizes from constitutional challenge a whole range of suspect government conduct . . . simply because explicit proof of such purpose is lacking." *Id.* at 336.

purpose requirement that Congress specifically rejected it in the Voting Rights Act of 1982 and Titles VI and VII of the Civil Rights Act of 1964.²⁶⁷ Congress, in allowing for a showing of discrimination through disparate impact, wisely realized that the purpose standard placed the whole of the evidentiary burden on the claimant, who might find the time and expense necessary to prove impact and intent too burdensome, too expensive, or just not worthwhile.

Generally, when the court fails to find a relationship between the ostensible legislative purpose and the means used to address it, the classification is subject to a finding of irrationality. When a legislative scheme appears arbitrary and capricious, the court may require the defendant to show that the scheme serves a valid concern and not simply articulates one.²⁶⁸ Generally, where there is a debatable relationship to a genuine government interest, the court is unwilling to invalidate a regulation based on a rational basis test. Still, when the legislation fails to bear a reasonable relationship to a legitimate government interest, it is open to scrutiny. In some areas, such as in the setting of health standards or in the protection of public health, great deference is accorded to the legislature.²⁶⁹ Tax schemes are also accorded great deference unless found to be clearly irrational. In a rational basis challenge concerning a tax strategy, the legislature need only show that the legitimate objective *could* be met with the challenged scheme, and not that the objective is *actually* promoted. However, a tax scheme that disproportionately affects minorities,²⁷⁰

267. Congress obviously believed that the purpose requirement, in the words of one commentator, only protected against government actions by officials who are "either stupid or honest enough to express their racist, sexist or otherwise unconstitutional purpose." *Id.* at 345-47.

268. See *Williams v. Vermont*, 472 U.S. 14, 105 S. Ct. 2465 (1985) (where the Court held that a sales tax credit for vehicles purchased out of state limited to residents served no valid purpose); see also *Dahl v. Sec'y of U.S. Navy*, 830 F. Supp. 1319 (E.D. Cal. 1993) (where the court held that a homosexual exclusion policy was based on an irrational prejudice and evidence did not support the pretextual rationale as stated).

269. This is not only the case in regulations regarding quarantine or inspection laws, but also in regulations created to reduce the cost of health care. See *Silverstein v. Gwinnett Hosp. Auth.*, 861 F.2d 1560 (11th Cir. 1988); see also *Cnty. Servs. Mgmt. Corp. v. Dep't of Pub. Welfare*, 482 A.2d 1192 (Pa. Commw. Ct. 1984).

270. Many tax schemes already in place disproportionately burden low-income and minority families. Annual income taxes have serious detrimental effects for low-income families, who often have volatile incomes changing from year to year. This income volatility leads to the constant incurrence of additional expenditures, which are necessitated by the change in standard of living, and an inability of the individual to plan for future expenses. Blacks, whose incomes fluctuate by thirty-three percent, are more likely to move often, incur high-interest rate debt, and be unable to keep up with payments for consumer goods. Lily Batchelder, *Taxing the Poor: Income Averaging Reconsidered*, 40 Harv. J. on Legis. 395, 397, 414, 403 (2003).

as the “fat” taxes and insurance surcharges undoubtedly would do (and currently do in the seventeen states where they are employed), would be more likely to be subject to heavy scrutiny under the rational basis test.²⁷¹

C. Discriminatory Intent vs. Disparate Impact: The Civil Rights Act of 1964

“*Sir, Hell is paved with good intentions.*”²⁷²

Title VII of the Civil Rights Act is intended to, at its core, eliminate simple discrimination.²⁷³ As this is the focus of the Act, there is not much emphasis placed on the notion of disparate impact. This is not to say that a differential impact is not considered within the purview of the Act; however, if the disparate impact results from a valid policy based on business necessity, then it is permissible.²⁷⁴ In the Title VII calculus, group status is especially germane when members of a historically marginalized group are faced with persistent market-irrational treatment. A theory of disparate impact can be used to smoke out disparate treatment. Disparate impact supplements and enhances the doctrine of disparate treatment by granting those disadvantaged groups affirmative rights; in essence, disparate impact offers these marginalized individuals the freedom to equal treatment in employment rather than just a freedom from intentional, blatant discrimination. Title VII would have a crucial role in obesity discrimination occurring in the workplace when that discrimination against the obese disproportionately affected African-

271. The traditional goals of tax policy, horizontal and vertical equity, require this heightened scrutiny. It is a well-recognized precept that those with the highest income should pay the bigger proportion of taxes. *Id.* at 399. See *Williams v. City of Dothan*, 745 F.2d 1406 (11th Cir. 1984) (where court denied summary judgment when municipality tax assessments created disproportionate impact for black communities); see also *Allegheny Pittsburgh Coal Co. v. County Com’n of Webster County*, 488 U.S. 336, 109 S. Ct. 633 (1989) (where Court invalidated a scheme that reassessed property based on purchase price).

272. Samuel Johnson (1775); 1 James Boswell, *Life of Johnson* [1791] 555 (Everyman ed.).

273. Civil Rights Act of 1964 §§ 701-718, 42 U.S.C. 2000e-2000e-17 (2000). The Civil Rights Act of 1964 outlawed discrimination in voter registration, barred discrimination in public accommodations in interstate commerce, authorized the United States Justice Department to initiate lawsuits to desegregate public schools, provided for withholding of federal funds from discriminatory state and local programs, prohibited discrimination in employment on grounds of race, color, religion, national origin, or sex, and created the Equal Employment Opportunity Commission to monitor and enforce bans on employment discrimination. Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, 241 (1964).

274. The theory of disparate impact was codified in the 1991 amendments to the Civil Rights Act. 42 U.S.C. § 2000e-2(k).

Americans, such as refusals of health, life, and disability insurance benefits to obese employees. Also, Title VI, which will be discussed later in this comment, could effectively reach discrimination that disproportionately disadvantages African-Americans in programs receiving federal funds.

The issue of race and racial discrimination is still prominent in American society and inherent in many social and cultural policies. Two areas of particular concern, which can be analogized to obesity penalties in their disparate impact on minorities, are insurance and health care practices. The effects of health care regulations on African-Americans and other minorities are egregious and abundant.

Accusations that insurance companies charge African-Americans higher premiums are quite common.²⁷⁵ A mode of redress often used in these cases is a disparate impact claim under the Civil Rights Act of 1964.²⁷⁶ The theory of disparate impact, as opposed to disparate treatment, allows the claimant to make a showing of discrimination without having to prove the defendant's state of mind.²⁷⁷ Thus, an undesirable and untenable effect is ameliorated, and the condition of the disadvantaged group is improved. The disparate impact theory supports an ideal of equal achievement. It is not, like its counterpart disparate treatment, meant to be colorblind.²⁷⁸ Rather, it is meant to take note of color and adjust for those effects that, purposefulness or not, inhibit equal achievement. The effect of burdensome taxes and prohibitive insurance measures are one such barrier complicating the equal achievement of African-Americans. Disparate impact theory may be the solution. In order to consider how it would be applied with respect to obesity regulations, it is necessary to examine another

275. In June 2000, American General Corporation paid out more than \$215 million to settle claims that it charged African-American customers higher life insurance premiums. *American General to Pay \$215 million over Premiums Issue*, Wall St. J., June 22, 2000, at c1.

276. The Civil Rights Act of 1964 consists of eight sections: Title I addresses voting rights, Title II, public accommodation; Title III, public facilities; Title IV, public education; Title V, civil rights commission; Title VI, federally assisted programs; Title VII, employment; and Title VIII, voting statistics. The Civil Rights Act of 1964, 42 U.S.C. §§ 2000a-2000h-6 (2000). Title VI prohibits discrimination based on race in any program receiving federal assistance. *Id.* §§ 601-606, 42 U.S.C. §§ 2000d-2000d-4a.

277. Disparate impact theory is a theory of color-consciousness rather than color-blindness. It is premised on the notion that in order to eliminate obstacles, one must be aware that they exist. Martha Chamallas, *Evolving Conceptions of Equality under Title VII: Disparate Impact Theory and the Demise of the Bottom Line Principle*, 31 UCLA L. Rev. 305, 317 (1983).

278. Disparate treatment was created to prevent race from being a factor in a selection process; disparate impact works to promote the status of an under represented group by removing those barriers which, though facially neutral, prevent advancement of the group. *Id.* at 314.

area in which civil rights approaches have been effective in addressing racial disparities, i.e., in health care and health care access.

1. Traversing a New Middle Passage: Title VI and the Health Care Debacle

The racial health care gap in America is constantly growing. Few laws exist to guard against discrimination based on race in health care practices; those laws that do are often ineffective in achieving their end.²⁷⁹ Title VI of the Civil Rights Act of 1964 prohibits discrimination based on race in any program that receives federal funding.²⁸⁰ Hospitals are more often than not recipients of federal funds.²⁸¹ Of all the components of the wide and varied health care industry, hospitals potentially employ the most facially neutral policies that disproportionately affect African-Americans.²⁸² Another area of health care where a disproportionate disadvantage is clearly evidenced is in the allocation of kidneys to transplant recipients. African-Americans have a substantially higher rate of kidney failure than do white Americans.²⁸³ Despite this greater need for kidneys,

279. Indeed, the lack of federal enforcement regarding health care has led many commentators to suggest that new civil rights legislation be instituted to specifically address health care. Health Law, *supra* note 65, at 791.

280. 42 U.S.C. § 2000d (2000) ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."); 45 C.F.R. § 80 app. A (1996) (includes a list of programs that trigger Title VI scrutiny).

281. See *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1046 (5th Cir. 1984) (where the court noted a concurrence in jurisprudence that the receipt of Medicare and Medicaid funds constituted federal assistance and thus invoked Title VI).

282. Policies that disproportionately disadvantage African-Americans are rife in hospital settings; such policies include admitting only patients whose treating physicians have staff privileges at the hospital, requiring substantial deposits before admission, refusing to deliver babies whose mothers lacked significant prenatal care, and creating barriers to admission for Medicaid patients. Noah, *supra* note 56, at 160.

283. *Id.* at 143. African-Americans comprise roughly twelve percent of the population of the United States, but constitute thirty-four percent of people suffering from end stage renal disease. *Id.* Many researchers believe that the high rate of renal failure in black populations is at least partly biological. They theorize that African-American kidneys evolved in an arena of limited access to sodium, and so those individuals with cellular mechanisms that better retained salt were more likely to survive. Fauci, *supra* note 53, at 54. This selection process may have been further induced by the journeys of the middle passage, with slave ships, which had inadequate supplies of salt and water, acting as a selective device to weed out individuals who did not retain salt effectively. Laura Dooley & Robert Gaston, *Stumbling Toward Equity: The Role of Government in Kidney Transplantation*, 1998 U. Ill. L. Rev. 703, 714 (1998).

black patients are less likely to receive them.²⁸⁴ With kidney allocation, the disparate impact is mainly due to the zero antigen mismatch policy espoused by the United Network for Organ Sharing.²⁸⁵ This policy gives priority to those individuals who have higher antigen matches with the donor kidney.²⁸⁶ Since whites donors provide ninety percent of all kidneys, white recipients are often a better match.²⁸⁷ Furthermore, physicians and health care providers determine who gets listed on transplant waiting lists and when.²⁸⁸ This is a great deal of discretion; studies show that physicians are much more willing to list patients who are most like themselves.²⁸⁹ Not surprisingly, a drastic disparate impact is created. This disparity may be addressed under Title VI of the Civil Rights Act or the Equal Protection Clause.²⁹⁰ As was shown earlier in this comment, a claim under the Equal Protection Clause is unlikely to succeed given the inherent difficulty in proving discriminatory intent.²⁹¹ Title VI is a more reliable cause of action because the onerous burden of showing intent is notably absent. Moreover, the hospitals providing the transplants and the regulatory agencies governing them invoke Title VI scrutiny as they are recipients of federal funding.²⁹²

Previously, Title VI has been used to prevent hospitals in black communities from closing down and relocating to white areas.²⁹³ To make a *prima facie* case of discrimination under Title VI, a claimant

284. Fauci, *supra* note 53, at 55. White patients have a seventy-eight greater chance of getting a kidney than do black patients. *Id.* At the University of Alabama, whose kidney waiting list is sixty-five percent black, only one out of every thirty-three kidneys received is allocated to black recipients. Robert Gaston, *Racial Equity in Renal Transplantation*, 270 JAMA 1352, 1353 (1993).

285. Bioethics: Health Care Law and Ethics 395-96 (Barry Furrow et al. eds., 4th ed. 2001).

286. The zero antigen mismatch policy is supported by the rationale that the greater the match, the greater the survival rate. In 1999, kidney recipients with only one antigen mismatch had a ninety and one-tenth percent one year survival rate. Those recipients with kidneys having a mismatch of five antigens had a eighty-six and seven-tenths percent one year survival rate. Many question if these differences are significant enough to warrant the continued enforcement of this policy, especially since immuno-suppressant drugs have the potential to overcome these differences but would increase the cost of each transplant operation. *Id.* at 394.

287. *Id.*

288. *Id.*

289. Given that the majority of doctors are both prosperous and white, it is really no surprise that the bulk of the organ registry waiting list is white and middle-class. Research shows that when physicians are forced to make difficult decisions with scarce resources, they almost always allocate them to people they resemble and exclude those that they do not based on factors of occupation, education level, and family environment. *Developments in the Law—Medical Technology and the Law*, 103 Harv. L. Rev. 1519, 1630-31, 1637-37 (1990).

290. Fauci, *supra* note 53, at 35.

291. *Id.* at 61.

292. *Id.* at 61-62.

293. *Id.* at 63.

must show three elements: 1) state action plus federal assistance, 2) regulation that treats races unequally, and 3) disproportionate impact for one race.²⁹⁴ If the claimant is successful, the burden shifts to the defendant to show a justification of the unequal effect.²⁹⁵ If the defendant were successful in this showing, the claimant would then need to prove that a less discriminatory alternative for meeting the same end exists.²⁹⁶ In the allocation of kidneys, a plaintiff alleging that the zero antigen mismatch policy disproportionately affected blacks would have to prove that a less discriminatory alternative existed for ensuring adequate survival rates for transplantees. There is at least one possible argument to counter the assertion that the policy is necessary, viz., anti-rejection drugs have the potential to make antigen matching obsolete, albeit while making each transplant more expensive.²⁹⁷ Even under Title VI, a claimant would have great difficulty proving that the impact was unjustified given that a reasonable goal of health care is cost-containment. This difficulty would also extend to cases alleging disparate impact in other hospital policies and, for the purposes herein discussed, insurance policies limiting or denying obesity treatment (that is, those insurance denials occurring under the federal subsidy of Medicaid/ Medicare—which is the crucial component invoking Title VI scrutiny).

One area of particular concern, where discriminatory impact is significant for African-Americans, is in the new field of managed care. Managed Care Organizations (hereinafter MCOs) discriminate by providing inferior services to Medicaid members, most of whom are black.²⁹⁸ By 1996, thirty-eight and six-tenths percent of Medicaid beneficiaries were enrolled in some sort of MCO.²⁹⁹ The inferior services provided to Medicaid beneficiaries include limiting hours of health care providers in black areas, having fewer locations in these areas, and “cherry picking” among recipients through enrollment counseling.³⁰⁰ For those Medicaid beneficiaries who become

294. *Id.*

295. *Id.* at 63-64.

296. *Id.* at 64.

297. *Id.* at 57.

298. Marianne Engelman Lado, *Unfinished Agenda: The Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 Tex. F. on C.L. & C.R. 1, 41-42 (2001).

299. Many states make Medicaid benefits contingent upon enrollment in a MCO. The idea is that MCOs cut patient costs by limiting services thereby providing an adequate level of care to many members at a cheaper rate. Studies show that the health care needs for many poor blacks suffer from MCO affiliation rather than improve. *Id.* at 38-39.

300. This is a common practice whereby counselors for the MCO discourage some individuals with chronic diseases, e.g., sickle cell anemia, from enrolling by telling them that the disease cannot be treated by their physicians (and implying by negative inference that other physicians can treat these often untreatable diseases).

members of a MCO, their health care access often suffers; it is a common practice to over assign Medicaid members to one doctor, and to create incentives for those physicians to underutilize health care resources for these patients.³⁰¹ Hospitals themselves discriminate against Medicaid patients in a variety of manners. It is regular practice in not-for-profit hospitals to separate the privately insured patients from the uninsured or Medicaid patients.³⁰² These hospitals then limit the number of beds allocated for Medicaid patients.³⁰³ Since the goal of the Medicare program is to provide an adequate level of care while containing costs, a claimant under Title VI would have some difficulty in showing that the inferior treatment and impact was unjustified.³⁰⁴ Private hospitals have entertained in the past a habitual practice of routinely transferring black patients to public hospitals.³⁰⁵ The Emergency Medical Treatment and Active Labor Act (or EMTALA) addresses this practice and makes it illegal.³⁰⁶ However, many commentators believe that EMTALA is not appropriately enforced.³⁰⁷ In any case, neither EMTALA nor any other federal statute addresses the crucial issue of discrimination in coverage decisions, another arena of health care practice that often creates a disparate impact for African-Americans. This is particularly relevant in obesity matters, as many insurers exclude obesity treatment from their covered benefits.³⁰⁸ Hospitals often limit

Id. at 41-42.

301. This is partly a result of the physician shortage in African-American and Hispanic communities, which are four times more likely to suffer from such shortages as white areas. *Id.* at 11. Another factor here is system of managed care itself. There is a significant disincentive for physicians, particularly in Health Maintenance Organizations, to provide greater access. HMOs capitate each physician at a certain rate for all services for all enrollees. HMOs create risk pools which the physician will be able to share in if expenditures per enrollee fall below the agreed-on amount for that type of enrollee. The less money spent per enrollee, the greater the physician's profit, and the more likely the incentive to under treat or prevent access. Robert Miller, *Healthcare Organizational Change: Implications for Access to Care and Its Measurement*, 33 *Health Services Res.* 653, 653, 655 (1998).

302. Lado, *supra* note 299, at 12.

303. *See* Fauci, *supra* note 53, at 44.

304. Noah, *supra* note 56, at 160-61.

305. *See* Fauci, *supra* note 53, at 45.

306. Now, hospitals must stabilize the patient before transferring, but EMTALA only applies to those hospitals that accept payment from Medicare and operate an emergency department. *Id.*

307. *Id.*

308. One commentator has suggested that the exclusion of obesity treatment, as in the Oregon Medicaid List of Prioritized Health Services for example, is challengeable under Title VI because forty-eight percent of black women are clinically obese (compared to thirty-two percent of white women). Obesity also increases the risk of developing other diseases. Amy Jurevic, *Disparate Impact*

services for obese people, mainly due to the fact that many machines cannot accommodate individuals of a certain size.³⁰⁹ This denial of certain technological testing procedures could lead to a vast number of African-Americans being routinely unable to access essential health care services; more notably, such denials, when impacting race, could trigger Title VI inspection of hospital policies. Coverage limitations of obesity treatments, such as those existing pursuant to current Medicaid stipulations, would also merit scrutiny under Title VI if a disparate impact on African-Americans could be established.

Despite the fact that health care remains an enormous political issue, little has been done to remedy the problem of race and health status in this country.³¹⁰ While universal health care coverage would eliminate the racial differences in health care access that related to ability to afford coverage, it would not solve those problems resulting from racial bias itself.³¹¹ Health care spending comprises fourteen percent of the gross domestic product of the United States; government funds are poured into construction capital for hospitals, reimbursement payments for Medicare and Medicaid programs, biotechnological and biomedical research, and a myriad of other health care interests.³¹² Despite the enormity of federal assistance, there is little adequate enforcement of civil rights.³¹³ Many claimants have resorted to Title VI actions, but the statistical evidence necessary

under Title VI: Discrimination, By Any Other Name, Will Still Have the Same Impact, 15 St. Louis U. Pub. L. Rev. 237, 253-55 (1996).

309. In one case, an obese man weighing 475 pounds was denied a CT scan; this denial was particularly egregious given that the gentleman had a history of Hodgkin's Lymphoma. Many obese people suffer from these sorts of denials; the plight of the obese in acquiring health care access often results in a feeling of being abandoned by society, discarded for being too burdensome: "we are left to die slowly without health care because it costs so much money and we are denied insurance." Rose DeWolf, *More Bias Against Obese: Denial of Medical Care to Overweight is Legal*, Philadelphia Daily News, Aug. 8, 2002.

310. While much has been made of socioeconomic status and health care disparities, it is rarely linked to race. One commentator notes that racial issues have received less attention because the United States has a "national tolerance for socioeconomic inequality as a factor in disparities we deem unacceptable when they result purely and simply from racial bias." Bobinski, *supra* note 48, at 380.

311. Medicare statistics evince this notion. Black beneficiaries of Medicare receive heart bypass surgery only one-quarter as often as white Medicare recipients. White Medicare patients are also seven times more likely to have surgery than their black counterparts similarly situated. Lado, *supra* note 299, at 6.

312. *Id.* at 27-28. Studies show that minorities, African-Americans as well as women, are grossly under represented in biomedical research and that diseases disproportionately affecting blacks and women receive much lower research funding. Noah, *supra* note 56, at 153-54.

313. The United States Department of Health and Human Services distributes more than \$224 billion in federal funds to over 700,000 recipients, but relegates civil rights enforcement over these entities to the underfunded, understaffed, ineffectual Office of Civil Rights. Lado, *supra* note 299, at 28.

to prove a claim of disparate impact is often lost in the bureaucratic shuffle.³¹⁴ As with the obesity epidemic, the health care disparity could be partially ameliorated by addressing the issue through Title VI claims; a better solution, and a more holistic one, would be a multi-faceted approach.

In 1994, President Clinton issued an Executive Order to address the issue of environmental justice and the disproportionate affect of hazardous waste siting on African-Americans.³¹⁵ This Order created an interagency group designed to guide federal agencies in implementing strategies to remedy environmental justice.³¹⁶ This same approach could be taken in the realm of health care as it relates to obesity prevention and treatment. Legislative action has already been effective in some areas involving health care disparities.³¹⁷ Public education is another goal that would be well served by the institution of legislative action.³¹⁸ The importance of information, awareness, and education is often underestimated; the utility of education, in particular, is taken for granted or forgotten because of the almost reflexive and rote use of the term. The role of education in personal autonomy is invaluable. Education is not merely the perfunctory answer to the perfunctory political question of how the world can be changed; it is the self-determining key to individual and societal betterment. A lack of education is a lack of power.³¹⁹ This is particularly true in the case of organ donation where rumors and misinformation run rampant. Many commentators speculate that the reason behind the overwhelming reluctance of African-Americans to become organ donors is a firmly entrenched distrust of the medical

314. Failure to maintain proper data is a problem for many entities receiving federal funds and can be a death knell for a disparate impact claim. *Id.* at 36-37.

315. Noah, *supra* note 56, at 176.

316. *Id.*

317. This is true in the case of bone marrow transplants. Statistics show that seventy-five percent of white individuals in need of bone marrow transplants find donors with matching antigens in the National Bone Marrow Program while fewer than twenty percent of black patients do. Lado, *supra* note 299, at 9. In 1989, the National Bone Marrow Donor Registry increased efforts to reach out to under represented groups; this is largely a result of the efforts of the family of JoAnne Johnson, a black teenager who died of leukemia after no match could be found. *Reauthorization of the National Bone Marrow Registry: Hearing before the Committee on Labor and Human Resources*, 101st Cong. 21, 123 (1990).

318. One effective method in increasing public awareness, undertaken by private entities, was an ad campaign launched by Wrigley Corp and Health Watch, a health advocacy group, to encourage African-Americans to seek preventive care. *Wrigley Ads to Focus on Minority Health*, Wall St. J., June 4, 1997, at B1.

319. A lack of power leads to frustration, which in turn creates malcontents and, as the poet Marge Piercy once wrote, a malcontent is "a bill that will come due in twenty years with interest." Ultimately, it is society that foots the bill in terms of increased crime, poverty and violence.

community.³²⁰ This distrust is not unfounded. From the Tuskegee syphilis studies to the pharmaceutical studies on prisoners, African-Americans have suffered at the hands of biomedical researchers.³²¹ This pervasive fear and distrust also extends to public hospitals and the AIDS epidemic.³²² The AIDS epidemic is sometimes touted by many conspiracy theorists as a genocidal plot.³²³ African-Americans are also wary of agreeing to donate organs at death; rumors circulate in the black community that white doctors prematurely declare black patients dead so that their organs can be harvested for white use.³²⁴ Distrust also abounds for conventional medical treatments.³²⁵ In this convoluted and complicated quagmire of fear and distrust, litigation

320. Lado, *supra* note 299, at 11-12.

321. Much of the experimental research performed on non-consenting African-Americans is well documented. In 1963, for example, the United States Public Health Service and the American Cancer Society gave funding to a study conducted by the Jewish Chronic Disease Hospital in Brooklyn. This study involved the injection of live cancer cells into unsuspecting black patients. In 1972, abortions using a device called the Super Coil, which had been specifically noted as dangerous and ineffective by the medical community for these procedures, were performed on several black and Latino women. As a result, many of the women hemorrhaged and required hysterectomies. Fauci, *supra* note 53, at 47-48. Experiments on unconsenting African-Americans continue to occur. In the mid-1990s, the New York State Psychiatric Institute injected 100 black and Latino boys with intravenous doses of fenfluramine. They theorized that the drug, which is now banned due to the deadly vascular problems it can precipitate, would help predict violent tendencies. This research on human subjects, which was dangerous and offered no countervailing medical benefit, is the reason why many African-Americans are uncomfortable with the medical community. Philip Hilts, *Experiments on Children are Reviewed*, N.Y. Times, Apr. 15, 1998, at B3.

322. Many African-Americans in New York fear going to public hospitals, having heard rumors of people being misplaced and lost inside. There is also the belief that, rather than help patients, "they kill people there." Lado, *supra* note 299, at 13.

323. In fact, the idea is often circulated at AIDS forums that the disease was purposefully administered to the black population. At a 1998 AIDS forum in Harlem, many speakers expressed the belief that the disease was spread to the black population through childhood vaccines orchestrated by the World Health Organization. Given the already elevated infant mortality level in the black community, the suggestion that childhood immunizations should be avoided is a deadly one. David France, *Challenging the Conventional Stance on AIDS*, N.Y. Times, Dec. 22, 1998, at F6.

324. Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience*, 82 Minn. L. Rev. 1015, 1029 (1998).

325. One black commentator and nature healer, Brother Phillip Valentine, blames western medicine, particularly chemotherapy, for the demise of black activist Stokely Carmichael. Incidentally, he also claims that AIDS facts given the black community are really myths "purposely put there by the propaganda machinery of the Centers for Disease Control and the pharmaceutical companies." Peter Noel, *We're Saving our Own Lives*, The Village Voice, Dec. 22, 1998, at 51.

may force the hand but the ultimate tool for change will be increased awareness, better education, and a purposeful inclusion of African-Americans in the health care field.

2. Title VI and Insurance: Confronting the Zero-Sum Game

Where insurance and obesity meet, the possibility that African-Americans would be disproportionately affected is great. It is typical of insurance companies to either deny overweight people coverage or deny coverage for obesity and obesity-related problems.³²⁶ Allegedly discriminatory insurance practices, which disproportionately disadvantage African-Americans, have previously been addressed using the disparate impact analysis. In one Ohio case involving a disparate impact claim against insurers, *Toledo Fair Housing Center v. Nationwide Mutual Insurance Company*,³²⁷ the court outlined the necessary elements of a *prima facie* case of discrimination based on a disparate impact theory. *Toledo* dealt with homeowner insurance, and a commonly practiced policy of insurance companies to exclude houses in predominately African-American neighborhoods by limiting coverage benefits based on the age of the domicile. In *Toledo*, the houses of the African-American claimants were excluded from coverage due to this facially neutral standard, as were the houses of almost all the African-American members of the community, who primarily lived in the older, poorer sections of town. The court in *Toledo* established that the plaintiff in a disparate impact case has the burden of showing a *prima facie* case of discrimination. The three necessary elements, as outlined by the court, are identification, impact, and causation.³²⁸ To satisfy the first element, the plaintiff must identify the practice or policy that is allegedly discriminatory.³²⁹ In satisfying the second requirement, the plaintiff must show a disparate impact on the affected class.³³⁰ Finally, the plaintiff must show how the practice or policy identified caused the disparate impact.³³¹ After a *prima facie* case of discrimination is made, the burden shifts to the defendant to show that a business necessity precipitated the differential impact.³³² If a business necessity exists,

326. Puhl & Brownell, *supra* note 8, at 795.

327. 704 N.E.2d 667 (Ohio Ct. Com. Pl. 1997).

328. *Id.* at 673.

329. *Id.*

330. The court asserted that such a disparate impact could be shown by sophisticated statistical analysis but that such a statistical showing was not necessary. *Id.*

331. *Id.*

332. *Id.*; see also *Mountain Side Mobile Estates P'ship v. Sec'y of Hous. & Urban Dev.*, 56 F.3d 1243, 1254 (10th Cir. 1995); *Fitzpatrick v. City of Atlanta*, 2 F.3d 1112, 1117 (11th Cir. 1993); *Pumphrey v. City of Coeur D'Alene*, 17 F.3d 395

the policy is justifiable unless the plaintiff can show a less discriminatory alternative to achieve the same end. *Toledo* involved a class action claim against a national insurance company that allegedly maintained underwriting guidelines that disproportionately affected black neighborhoods.³³³ The plaintiffs, African-American homeowners, produced evidence that demonstrated that eighty-two and nine-tenths of homeowners in black neighborhoods were excluded by the insurance company guidelines, while only thirty-one percent of homeowners in white neighborhoods were excluded.³³⁴ The court in *Toledo* denied Nationwide Mutual Insurance's motion for summary judgment, and the case eventually settled.³³⁵ The sufficiency of the established impact was never addressed nor were the possibilities of a less discriminatory alternative.³³⁶

3. *Griggs and Title VII: Discrimination in Operation*

In the seminal case involving the disparate impact theory, *Griggs v. Duke Power Company*,³³⁷ the Supreme Court addressed the issue of facially race-neutral tests in the context of employment discrimination. In *Griggs*, the defendant company instituted a policy that allowed promotions only after two general intelligence tests were sufficiently passed.³³⁸ The plaintiffs in *Griggs* alleged that this policy resulted in a disproportionate number of African-Americans being excluded from employment promotion and disqualified for several jobs.³³⁹ The Court identified the central issue as whether Title VII of the Civil Rights Act of 1964 prohibited employers from requiring the passing of a standardized intelligence test when it was not related to job performance, and it disproportionately affected black employees.³⁴⁰ Under the Civil Rights Act, employment practices and procedures that are neutral on their face and even in terms of intent cannot be maintained if they operate to "freeze the status quo."³⁴¹ The Court held that the Civil Rights Act "proscribes not only overt discrimination but also practices that are fair in form, but

(9th Cir. 1994) (unpublished table decision).

333. 704 N.E.2d at 669.

334. *Id.* at 674.

335. *Id.* at 677.

336. *Id.* at 675.

337. 401 U.S. 424, 91 S.Ct. 849 (1971).

338. Both tests, the Wonderlic Personnel Test and the Bennett Mechanical Comprehension Test, purported to measure general intelligence. *Id.* at 428, 91 S. Ct. at 852.

339. *Id.* at 426, 91 S. Ct. at 851.

340. *Id.*

341. *Id.* at 430, 91 S. Ct. at 853.

discriminatory in operation.”³⁴² The evidence in *Griggs* showed that employees who had not completed high school or taken the requisite tests performed satisfactorily and progressed in those departments that were newly requiring tests.³⁴³ Since the Court found that the “touchstone is business necessity,”³⁴⁴ the defendants could not defend their policy since evidence demonstrated that it was unnecessary and unrelated to the jobs it purported to screen for. The Court dismissed the notion of discriminatory intent, stating that “good intent or absence of discriminatory intent does not redeem employment procedures or testing mechanisms that operate as ‘built-in headwinds’ for minority groups and are unrelated to measuring job capability.”³⁴⁵ Finally, in interpreting the Title VII of the Civil Rights Act of 1964, the Court reiterated that what Congress “has commanded is that any tests used must measure the person for the job and not the person in the abstract.”³⁴⁶

4. Obesity Regulations under the Civil Rights Act of 1964: Effects

Given the substantial nexus between federal involvement and obesity regulations under insurance policy coverage decisions, hospital refusals to treat obese patients, and denials to obese employees of health benefits, the likelihood of litigation under either Title VI or VII of the Civil Rights Act of 1964 is considerable. Employer-related discrimination is addressed under Title VII; discrimination by entities receiving federal funding, e.g., Medicaid, Medicare, the majority of hospitals (through receipt of federal construction grants or acceptance of reimbursement by federal government benefits), falls under the purview of Title VI. Federal funds pour into the health care sector, triggering Title VI scrutiny and granting greater access to federal redress to those disproportionately burdened individuals. The key factors, and those that remain questionable, are the statistical sufficiency of the actual disparate impact of obesity disincentives on African-Americans and the business necessity justifying the impact. The gap in obesity rates between white and black Americans is constantly increasing. The most recent statistics reveal that African-American women are twice as obese as white women.³⁴⁷ The great majority of people affected by

342. *Id.* at 431, 91 S. Ct. at 853.

343. *Id.* at 431-32, 91 S. Ct. at 854.

344. *Id.* at 431, 91 S. Ct. at 853.

345. *Id.* at 432, 91 S. Ct. at 854.

346. *Id.* at 436, 91 S. Ct. at 856.

347. Of white women, twenty and five-tenths percent are considered obese. Hispanic women fall in the middle, with twenty-six and one-tenth percent of Latino

insurance denials, refusals of coverage, and insurance premium surcharges would be black women. This is particularly deleterious to the health interests of black women given that their health status, plagued with increasing rates of diabetes and breast cancer, is already poor. Business necessity, in this context, is not quite a foregone conclusion. The need for cost-containment in health care is not the final inquiry nor a death knell showing of justified impact. Many studies show that increasing coverage benefits at the outset for treatment of obesity actually decreases insurance losses incurred for obesity-related complication in the long-run, such as hypertension, diabetes, cancer, and cardiovascular incidents. Louisiana is currently implementing an experiment of this nature in the state employee benefits program. The state is offering gastric bypass surgery to a select few morbidly obese state employees, in the hopes that the initial outlay for the surgery will result in long term savings attributable to the decreased presence of obesity-related disabilities. The net benefit of treating obesity, as opposed to treating its complications, may soon be evident. Furthermore, current federal legislative proposals that would prohibit genetic discrimination in insurance and employment may have a profound effect on obesity discrimination. A large number of scientists and medical researchers believe that susceptibility to obesity is often a genotypic manifestation that is exacerbated by external stimuli. In some instances, discrimination against the obese would be discrimination based on genomics and, under the current proposal, would be illegal.

C. An ADA Perestroika: The Obesity as Disability Conundrum

The Americans with Disabilities Act, which was passed in 1990, extends the protections of the Civil Rights Act of 1964 to all those individuals qualifying under it as disabled.³⁴⁸ The ADA, like the Civil Rights Act, guarantees those it protects access to public facilities, employment, or communication services. The ADA has two primary goals: 1) to eliminate simple discrimination and 2) to provide reasonable accommodations for individuals falling within its scope.³⁴⁹ The first component is a matter of preventing differential treatment among individuals alike in all relevant ways; the second component is a more complicated matter, drawing in a number of factors like policy balancing and cost concerns. Essentially, an exclusion or denial of equal work or equal benefits to an otherwise

women classified as obese. Rates of obesity for black women far exceed these numbers, with forty and four-tenths percent of black women considered obese. Nat'l Ctr. For Health Stat., *supra* note 69, at 32, fig. 6.3.

348. Americans with Disabilities Act, 42 U.S.C. §§ 12101-12213 (2000).

349. *Id.*

qualified person because of their known disability is a violation of the Act.³⁵⁰ It is unlawful for an employer to use standards, criteria, or methods of administration which are not job-related and consistent with business necessity, and which have the effect of discriminating on the basis of disability.³⁵¹ The Act also proscribes the process of segregating, limiting, or classifying job applicants or employees in a manner that adversely affects their employment opportunities or status on the basis of their disability.³⁵²

There are several defenses available to the employer against whom a violation of the Act is alleged. In order to rebut a claim of disparate treatment, the employer could assert that the challenged action is justified by a legitimate, nondiscriminatory reason, i.e., that the action is job-related and consistent with business necessity. There is also the potentiality for a defense premised on the notion of direct threat: the disabled individual cannot be allowed to pose a direct threat to the health or safety of others in the workplace. Against a disparate impact claim, the employer would have to maintain that the criteria used was uniformly applied, job-related and consistent with business necessity; also, the end sought with the criteria must not be accomplishable with reasonable accommodation.³⁵³ Both goals of the ADA hinge upon a question of disability, i.e., who is disabled, what impairments constitute a disability, and how should the disability (and the disabled person) be treated. For obesity to be a protected disability under the ADA, it would have to meet certain qualifications as prescribed by the Act

1. A Statutory Overview: Defining Disability Under the ADA

Under the purview of the Act, a disability is a “physical or mental impairment that substantially limits one or more of the major life activities” of the individual affected; a disability can also be a record of such an impairment or being regarded as having such an impairment.³⁵⁴ Major life activities, such as walking, seeing, hearing,

350. 29 C.F.R. § 1630.8 (2004). It is unlawful for a covered entity to discriminate on the basis of disability against a qualified person with a disability in regard to “recruitment, job application procedures, hiring, promotion, tenure, demotion, transfer, layoff, rehiring, job assignments, job classifications, seniority lists, leaves of absence, sick leave, fringe benefits available by virtue of employment whether or not administered by the covered entity, selection and financial support for training, activities sponsored by covered entity like social and recreational programs, and any other term, condition or privilege of employment.” *Id.* § 1630.4.

351. *Id.* § 1630.7

352. *Id.* § 1630.5.

353. *Id.* § 1630.15.

354. *Id.* § 1630.2(g). Under the ADA, a physical or mental impairment means

or speaking,³⁵⁵ are substantially limited when the individual is unable to perform them or is significantly restricted in the condition, manner, or duration of the performance as compared to the average person.³⁵⁶ Several factors are used to determine whether the individual is so limited: the nature and severity of the impairment, the duration or expected duration of the impairment, and the permanent or long term impact or expected long term impact of such impairment.³⁵⁷

The existence of a disability under the ADA is determined on a case-by-case basis.³⁵⁸ Questions of physiology, permanency, voluntariness, and mutability all factor into the disability calculus. HIV is a physical impairment under the ADA from the very moment of infection as it constitutes a physiological disorder with constant and detrimental effects on the blood and lymph systems of the infected individual.³⁵⁹ Recovering heroin addicts also qualify as disabled individuals under the Act because their addiction is a long term, permanent problem that continually affects their work, parenting, and life relationships.³⁶⁰ Notwithstanding these actual disabilities, the ADA also provides for protection of those individuals who are regarded as having a disability. An individual is regarded as disabled if an employer or other covered entity mistakenly believes that the individual's actual, non-limiting impairment substantially limits one or more major life activities.³⁶¹

Obesity is not a physical impairment under the ADA except where it has been found to relate to a physiological disorder.³⁶² Obesity alone will not trigger the application of the ADA.³⁶³ Federal regulations stipulate that obesity is generally not considered a disabling impairment except in rare circumstances, but fail to define

“(1) Any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory, cardiovascular, reproductive, digestive, genito-urinary, hemic and lymphatic, skin, and endocrine, or (2) Any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.” *Id.* § 1630.2(h).

355. Also included in the list of major life activities are caring for oneself, performing manual tasks, breathing, learning, and working. *Id.* § 1630.2(i).

356. *Id.* § 1630.2(j).

357. *Id.* § 1630.2(j)(2).

358. *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 556, 119 S. Ct. 2162, 2169 (1999).

359. *Bragdon v. Abbott*, 524 U.S. 624, 637, 118 S. Ct. 2196, 2201 (1998).

360. *MX Group, Inc. v. City of Covington*, 106 F. Supp. 2d 914, 918 (E.D. Ky. 2000), *aff'd* 293 F.3d 326 (6th Cir. 2002).

361. *Murphy v. United Parcel Servs., Inc.*, 527 U.S. 516, 521-22, 119 S. Ct. 2133, 2137 (1999).

362. *Francis v. City of Meriden*, 129 F.3d 281, 286 (2d Cir. 1997).

363. *Fredregill v. Nationwide Agribusiness Ins. Co.*, 992 F. Supp. 1082, 1088-89 (S.D. Iowa 1997).

those circumstances.³⁶⁴ Also, as corrective and mitigating measures should be considered when determining the existence of a disability under the ADA, obesity would not be a disability if its effects could be mitigated.³⁶⁵ Many conditions may be substantially limiting, but are not covered under the Act because they are correctable or because they do not stem from physiological origins. Pregnancy, for instance, is substantially limiting and affects nearly all bodily systems, but is not an impairment under the Act because it is not the result of a physiological condition or disorder; also, it is a temporary state.³⁶⁶ The implication is that obesity, in order to qualify as a disability under the ADA, must not only affect bodily systems but must result from a physiological condition.³⁶⁷ Another factor that is problematic in the obesity question is the notion that obesity is both a voluntary and mutable condition, and therefore should not be protected under the Act.³⁶⁸

2. *Bragdon v. Abbott: Obesity and the Physiological Effects Theory*

In *Bragdon v. Abbott*, a patient with seemingly asymptomatic HIV brought an action under the ADA against a dentist who refused to treat her in his office.³⁶⁹ Some question existed as to whether HIV could be considered an impairment before it became symptomatic or

364. 29 C.F.R. PT 1630, App. § 1630.2(j) (2004).

365. See *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 482, 119 S. Ct. 2139, 2146 (1999).

366. 29 C.F.R. pt. 1630, App. § 1630.2(h) (2004). Physiology is the biological science of essential and characteristic life processes, and refers to those activities and functions that are vital processes of an organism. *The American Heritage Dictionary* (2d ed. 1985).

367. See *Andrews v. Ohio*, 104 F.3d 803, 808 (6th Cir. 1997) (finding physical characteristics that are not the result of physiological disorders are not considered impairments for purposes of determining either actual or perceived disability); *Francis v. City of Meriden*, 129 F.3d 281, 286 (2d Cir. 1997) (finding obesity except where it relates to physiological disorder not a physical impairment under the ADA); *Cook v. Rhode Island*, 10 F.3d 17, 24 (1st Cir. 1993) (where evidence of metabolic dysfunction could lead to obesity being considered impairment under the ADA).

368. See *Tudyman v. United Airlines*, 608 F. Supp. 739, 746 (C.D. Cal. 1984) (weight of bodybuilder who failed to meet height/weight requirements of airline was not the result of a physiological disorder but self-imposed and voluntary; distinguished from situation where weight was involuntary, like glandular disorder); see also *Greene v. Union Pacific Railroad Co.*, 548 F. Supp. 3, 5 (W.D. Wash. 1981) (where railroad employee challenged denial of transfer to fireman job category by employer as discrimination due to morbid obesity and court held that it was not handicap under Washington's handicap discrimination laws because obesity was not an immutable condition like blindness or lameness).

369. 524 U.S. 624, 118 S. Ct. 2196 (1998).

outwardly expressed its presence in the individual's body. The Supreme Court of the United States held that even asymptomatic HIV is a disability under the Act, despite the absence of notable impairments, because it limits reproduction—which is a major life activity as defined by the ADA.³⁷⁰ The Court began with an inquiry into whether the infection itself was a physical impairment. Finding that it was, the Court went on to find that the infection, even in its asymptomatic phase, substantially limited a major life activity of the individual who was host to it.³⁷¹ The Court cited federal regulations which classify various physical impairments, like orthopedic disorders, cancer, heart disease, mental retardation, emotional illness, drug addiction, and alcoholism, as disabilities that warrant the protection of the Act.³⁷² The Court also pointed out that the notion of an asymptomatic phase with regard to HIV was a misnomer.³⁷³ From the moment of infection, the virus begins to damage white blood cells, impair the immune system, and affect the health of the host individual.³⁷⁴ The Court found that the physiological effects of the impairment began even before the physical manifestations of the disease appeared; hence, the physiological effects were enough to constitute a disability under the ADA.

Obesity, as has been previously illustrated in this comment, is a dangerous and debilitating condition. Research has shown that obesity is very often related to a genetic component and is usually immutable and sometimes involuntary; it is also a physiological condition. The effects of obesity begin to manifest in the individual's bones, pancreas, vascular system, and heart long before the co-morbid conditions so often associated with obesity, like hypertension, diabetes and heart disease, appear.³⁷⁵ The pancreas of an obese individual begins to manufacture the overabundance of insulin that will inevitably lead to insulin resistance long before diabetes is present. The arterial plaque precipitated by the excess adipose tissue builds over a period of years, slowly forming the blockage that may one day stop the flow of blood to the heart or break loose to cause a stroke elsewhere in the body. The bones of the obese person weaken and become arthritic, the metabolic functions become defunct, and a variety of bodily systems shut down or become dysfunctional. The

370. *Id.*

371. *Id.* at 631-37, 118 S. Ct. at 2202-05.

372. *Id.* at 633, 118 S. Ct. at 2202 (citing 42 Fed. Reg. 22,685 (1977)).

373. *Id.* at 635, 118 S. Ct. at 2204.

374. *Id.* at 637, 118 S. Ct. at 2204.

375. One example of this that is particularly disturbing is the study conducted in Bogalusa, Louisiana which revealed the presence of arterial plaque in the arteries of toddlers. Maryann Napoli, *The Bogalusa Heart Study of 14,000 Children*, Healthfacts, Aug. 1998.

obese person suffers the physiological effects of their obesity long before those effects become apparent to the outside world.

The ADA attempts to protect marginalized individuals from social segregation. This is why individuals with temporary illnesses are excluded from its breadth. An individual with the flu is not a member of a marginalized or vilified social group because everyone has, at some point, been sick. As the person with the flu will usually get well, there is no need to ensure their protection and inclusion in the world and the marketplace. Federal regulations specify that the duration, long term impact and permanence of an ailment is crucial to the determination of its substantially limiting effects.³⁷⁶ Obesity, as nearly all of the research relating to it shows, is for all intents and purposes an immutable characteristic which has a serious long-term impact on the health and well-being of individuals suffering from it. The contention that obesity is both immutable and permanent is buttressed by the statistical studies which show the substantial failure rates of various control methods intended to remedy the obesity problem.

3. *To Mitigate or Not to Mitigate, That is the Question*

In 1999, the Supreme Court of the United States handed down three decisions that severely limited the scope of the ADA.³⁷⁷ These cases narrowed the class of people who qualify under the ADA as disabled, squeezing out a wide range of individuals with profoundly limiting impairments such as hypertension, myopia, and diabetes. These individuals, who can function in society with the help of medicines or aids but whose impairments still make them ineligible for certain jobs, were no longer classified as disabled under the Act. In essence, these individuals were disabled enough to be denied employment but not disabled enough to seek protection under ADA. This jurisprudential catch twenty-two prevents many previously qualified individuals from seeking redress under the Act.

In *Sutton v. United Air Lines, Inc.*, severely myopic twin sisters filed suit under the ADA against a commercial airline who denied them employment due to their visual acuity or lack thereof.³⁷⁸ The Supreme Court of the United States held that the sisters were not disabled within the meaning of the ADA because the existence of mitigating measures, like contacts or eyeglasses, were available to

376. 29 C.F.R. § 1630.2(j)(2) (2000).

377. See *Murphy v. United Parcel Servs., Inc.*, 527 U.S. 516, 119 S. Ct. 2133 (1999); *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 119 S. Ct. 2139 (1999); and *Albertson's, Inc. v. Kirkingburg*, 527 U.S. 555, 119 S. Ct. 2162 (1999).

378. *Sutton*, 527 U.S. 471, 119 S. Ct. 2139.

remedy the impairment.³⁷⁹ The Court specifically refused to apply the EEOC guidelines which stated that a disability determination must be made on an individual basis without regard to mitigating measures, like prosthetic devices or medication.³⁸⁰ The Court reasoned that a failure to consider mitigating measures would lead to an overinclusiveness of the Act; that is, the Act would encompass too many people.³⁸¹ The dissent in *Sutton* emphatically disagreed, stating that individuals should not be precluded from statutory protection simply because a medication or prosthesis has restored their ability to perform major life activities.³⁸² In pointing out the fallaciousness of the majority opinion, the dissent notes that Subsection B of the Act's definitions states that an individual who previously had a serious hearing impairment which has subsequently been cured would still be covered by the Act; the majority opinion suggests that an individual with a continuing hearing impairment who wears a hearing aid would not be covered.³⁸³ To remedy this cognitive dissonance between fully cured but protected impairments and temporarily treated but unprotected impairments, the dissent suggests that the Act should apply to the existence of an impairment—present or past—that substantially limits or did substantially limit the individual before it was corrected or mitigated. This reading avoids “counterintuitive conclusion that the ADA’s safeguards vanish when individuals make themselves more employable by ascertaining ways to overcome their physical or mental limitations.”³⁸⁴

The issue of mitigation and correction is tricky in relation to obesity as the condition itself is highly variable. Some noninvasive treatments for obesity enjoy a small success rate. Other treatments continue to prove ineffective and futile, and often result in habitual, dispiriting relapse. The measures that enjoy the greatest success are often extreme, e.g., gastric bypass surgery. When the mitigating or correcting measure has the potentiality to be as detrimental as the condition itself, the negative effects of that measure must be taken into account. An obese person may be able to slim down by embracing a starvation diet or saying goodbye to a large portion of their stomach, but, in doing so, they may more severely impair

379. *Id.* at 475, 119 S. Ct. at 2143.

380. *Id.* at 472, 119 S. Ct. at 2141-42 (referring to 29 C.F.R. pt. 1630, App. § 1630.2(j)).

381. By way of example, the Court noted that more than 100 million people need corrective lenses to see properly, and fifty million Americans have high blood pressure. *Id.* at 487, 119 S. Ct. at 2149.

382. *Id.* at 498, 119 S. Ct. at 2154.

383. This conundrum led the dissent to question why fully cured impairments are covered, as the Act itself states, but not merely treatable ones, as the majority opinion provides. *Id.* at 498-99, 119 S. Ct. at 2154.

384. *Id.* at 499, 119 S. Ct. at 2154.

themselves in the long run. The question of mutability is not merely tangential in the consideration of mitigating factors; rather, it is crucial. If obesity is mutable, then logically the ADA should not extend to protect those individuals who have the opportunity and capacity to change their impaired state. However, if the condition is immutable, then anti-discrimination legislation would be justified in protecting those individuals who suffer its effects.

4. *The High Price of Mutability: Cook v. State of Rhode Island*

The Rehabilitation Act of 1973, much like the ADA, attempts to ensure the full inclusion of disabled people into the economic, political, social, cultural, and educational mainstream of America. The Rehabilitation Act protects disabled people from discrimination at the hands of the federal government, federal contractors, and recipients of federal funds.³⁸⁵

In *Cook v. State of Rhode Island, Dept. Of Mental Health, Retardation, and Hospitals*, a five-foot two-inch, 320 pound woman who was denied employment at a mental institution (where she had previously worked and then voluntarily left, leaving behind a spotless work record) filed suit against the institution under the Rehabilitation Act of 1973.³⁸⁶ The mental institution claimed that Cook's morbid obesity compromised her ability to properly evacuate patients; they also alleged that her obesity, which put her at risk for developing serious ailments, would lead to increased absenteeism and claims for worker's compensation.³⁸⁷ Cook bore the burden of proving that the federally funded program refused to hire her because she had a disability; she also had the burden of showing that she was, despite her disability, qualified for the position.³⁸⁸

Initially, Cook proceeded on a perceived disability theory, alleging that the institution regarded her impairment as a disability when, in reality, it was not.³⁸⁹ The court in *Cook* denied summary judgment to the defendants, stating that a jury could plausibly find that Cook had an actual physical impairment based on the evidence presented.³⁹⁰ In the alternative, the court held that a jury could reasonably find that Cook was not actually impaired, but that the

385. 29 U.S.C.A. § 701, annotations (West 2000).

386. 10 F.3d 17 (1st Cir. 1993).

387. *Id.* at 21.

388. *Id.* at 22.

389. *Id.*

390. Cook presented evidence that her morbid obesity was a physiological disorder involving the dysfunction of both her metabolic system and neurological appetite-suppressing signal systems which caused adverse affects on her musculoskeletal, respiratory, and cardiovascular systems. *Id.* at 23.

institution regarded her as such.³⁹¹ The court scoffed at the institution's contention that obesity was a mutable condition, i.e., Cook could simply lose weight and thereby rid herself of the disability.³⁹² In response to this claim, the court noted that evidence of metabolic dysfunction lingers even after the weight is lost, and, though obesity may be treated by fasting or perennial under-eating, the dysfunction is permanent.³⁹³ The institution contended that Cook's voluntary conduct, i.e., overeating, caused her disability, and alleged that voluntarily-acquired disabilities are not covered under the Rehabilitation Act. The court summarily rejected this notion, stating that the Rehabilitation Act indisputably covered many conditions that are caused or exacerbated by personal conduct, such as alcoholism, AIDS, diabetes, and cancer from cigarette smoking.³⁹⁴ In rendering their judgment, the court took special note of the discrimination and social barriers that obese people face.³⁹⁵ Most notably (and most relevant in regard to the purposes of this comment), the court in *Cook* specifically rejected the contention that obesity is mutable and dismissed the notion that voluntarily-acquired or exacerbated disabilities are outside of the scope of anti-discrimination Law.³⁹⁶

IV. PROPOSALS FOR A NON-ZERO SUM GAME

The notion that some must lose in order for others to win is deeply and firmly entrenched in the American psyche. This crude teleological philosophy that willingly sacrifices the few for the good of the whole applies with particular relevance to obesity regulation. In suffering the economic disincentives of obesity regulations as well as the noneconomic disincentives like denials of insurance, obese people clearly lose; presumably, this is a good thing as the obese are forced to ameliorate the damage they have ostensibly committed against society, e.g., higher health care costs. If the

391. *Id.*

392. The court actually stated that the contention that Cook could simply lose weight was "as insubstantial as a pitchman's promise." *Id.* at 23.

393. *Id.* at 24.

394. *Id.*

395. "In a society that all too often confuses 'slim' with 'beautiful' or 'good,' morbid obesity can present formidable barriers to employment." *Id.* at 28.

396. *Id.* at 24. For a combination of ADA and Title VII law that is particularly relevant to obesity employment policies, see *Murray v. John D. Archbold Memorial Hospital, Inc.*, 50 F. Supp. 2d 1368 (M.D. Ga. 1999) (where a job applicant who was disqualified based on a weight policy brought action under the ADA and Title VII, alleging that the policy unlawfully discriminated against her on the basis of disability and race, as it had a disparate impact on black female applicants; the court never reached the merits of the case as the claims under Title VII were barred because the complaint filed with the EEOC failed to specifically allege a disparate impact claim as required by 42 U.S.C. § 2000e-5(e)-(f)).

obese population loses, then society must win. However, regulations that exacerbate poverty by shifting the economic burden onto the income-limited and access-restricted impoverished, increase sickness by denying access to proper health care to those who need it the most but can afford it the least, and generally help to ferment the unhappiness and malcontent of an already stigmatized population group do not constitute a net benefit—not for society and certainly not for the individuals that these regulations affect the most. A healthy population is non-zero sum. The binary option, that is, the option of winners and losers, is not absolute. Conventional game theory, enriched and supported by the Nash equilibrium, suggests that no party benefits by moving unilaterally while all others remain fixed.

There are other options for addressing the obesity epidemic that do not require legislative penalties, carrot-and-stick routines, and economic punishments. First, there is the option of treating obesity at the outset, before the co-morbid conditions that lead to the increased health care expenses become an inevitability.³⁹⁷ Obesity treatments are widely regarded as ineffective, and, as a result, are often excluded from insurance coverage.³⁹⁸ Several institutions and research centers that study obesity are attempting to change this perception.³⁹⁹ There is the option of classifying obesity as a disease category for reimbursement coding and partially or fully covering health care services associated with weight management, including nutrition education and physical activity, in both private sector and public insurance plans. There are less invasive and regressive

397. Intervention to prevent obesity is particularly important for overweight adolescents. Data collected over a ten year period showed that intervention at the adolescent stage can substantially reduce the degree of fatness in adult life. Bray, *supra* note 5, at 157.

398. While many conventional obesity treatments do have a high failure rate, the treatments themselves are not necessarily ineffective. Duration is often crucial and, as many insurers limit the duration of the treatment, relapse is much more likely. Medication and behavioral therapy are effective and the duration of the treatment is the determining factor—as the length of treatment increases, more weight is lost. *Id.* at 169. Behavioral therapy is particularly effective for children. *Id.* at 177. The treatment that resulted in the largest loss and the least weight regain combined exercise, social contact, and therapy. *Id.* at 179.

399. The Pennington Biomedical Research Center recently published a report on the effectiveness and safety of ephedra and caffeine combinations for weight loss treatment. Lilian de Jonge, Madlyn Frisard, Damian Blanchard, & Frank Greenway, *Safety and Efficacy of an Herbal Dietary Supplement Containing Caffeine and Ephedra for Obesity Treatment*, Obesity Res. Program Abstracts, 9 Obesity Res. 184S (2001). In this double-blind study, the researchers found that caffeine and ephedra increased metabolic rate and provided weight loss safely in a three month trial. Other medications, which may prove efficacious for weight loss, are currently in the early stages of development, e.g., leptin peptide and orlistat (xenical). Bray, *supra* note 5, at 266, 268.

legislative remedies that can be employed as well, especially where access to healthy foods and prevention of obesity is concerned.⁴⁰⁰

A. The Fault-Based Paradigm and Other Shell Games for Shifting Obesity Blame

Fat taxes presume that obese people are wholly at fault for their condition.⁴⁰¹ However, much research exists to suggest that obesity is the product of a myriad of factors, not the least of which is heredity. Another idea used to justify taxes and insurance surcharges is the notion that the cost of obesity to society must be offset.⁴⁰² In a tongue-in-cheek response, one commentator debunks this rationale by suggesting that overweight people, like smokers, die earlier and so do not use as much health care in old age or collect as much social security; the financial result of increased obesity might be, in the end, an occasion of breaking even or, as in the case of smokers, taxpayer savings.⁴⁰³ The question then becomes whether the rationale provided is significant enough to justify the disparate impact. In cases such as these, where an already overburdened and underrepresented class is disproportionately affected, a higher standard of justification should be met.⁴⁰⁴

The current insurance solution, which focuses on immediate costs, is myopic. If insurance policies covered obesity treatment and prevention, they would be able to save on health care costs in the long run (by preempting the co-morbid conditions that are the costly

400. Some currently extant examples of such legislation include the National Institute of Health's project to develop awareness of obesity effects and prevention called Sisters Together: Move More, Eat Better. The campaign was originally implemented to encourage black women in Boston to exercise and eat better, and, due to its success, is currently expanding to other cities. Another successful program is the Women, Infants, and Children (WIC) Farmer's Market Nutrition Program which was established by Congress to provide fresh and nutritious food to low income families in the WIC program. Surgeon General's Call to Action, *supra* note 28, at 47-48.

401. The ostensible reason for these taxes is the idea that overweight people respond to price incentives and social stigma. Therefore, their condition is changeable and merely an issue of will. Jacob Sullum, *Weight Problem*, Reason, Sept. 22, 1999.

402. Jacob Sullum, *Thinning the Heard: Is your Weight the Government's Business*, Reason, June 13, 2003.

403. *Id.*

404. A higher standard of justification is necessary because almost any action can be rationalized given the right context. Justice Stone recognized this fact in one opinion, saying, "History teaches us that there have been but few infringements of personal liberty by the state which have not been justified . . . in the name of righteousness and the public good, and few which have not been directed, as they are now, at politically helpless minorities." *Minersville Sch. Dist. v. Gobitis*, 310 U.S. 586, 604, 60 S. Ct. 1010, 1017 (1940).

albatrosses around the neck of the insurance industry) while collecting reasonable insurance premiums from those individuals they allowed to be treated at the outset. Given that many states are now passing laws that prohibit discrimination against the obese in insurance and force insurers to cover obesity and all its effects, such as cardiovascular dysfunction, diabetes, and arthritis, insurance companies may want to implement obesity treatment coverage of their own volition and preempt the exorbitant, long-term costs of treating the effects of obesity as opposed to the obesity itself.

CONCLUSION

Where litigation fails or is ineffective at wholly addressing the complexity of the obesity problem, proactivity and foresight is helpful.⁴⁰⁵ Increasing public awareness of health concerns related to obesity and promoting nutritional education is beneficial, empowering, and grossly underestimated. In some instances, a serious investigation of the food industry might also be merited.⁴⁰⁶ One surveyor of the food industry has suggested that four initiatives be taken to help arrest the obesity problem: 1) eliminate junk food commercials aimed at children, 2) create a federal agency to promote nutrition education, 3) increase government subsidies for healthier foods by adjusting farm supports, and 4) limit campaign contributions from corporate interests involved in food manufacturing.⁴⁰⁷ The idea

405. In Louisiana, one councilwoman is already taking this step. Councilwoman Lori Burgess is participating in a program instituted by the Pennington Biomedical Research Center that aims to introduce nutrition education into the black community. Since obesity is a major concern for black women, the supporters of the program are trying to solicit more money so that the program can be expanded to poor residents in rural areas across the Mississippi Delta. Laurie Anderson, *Rolling Store Seeks to Change Eating Habits*, Baton Rouge Advocate, Apr. 9, 2003, at 1C.

406. The fundamental ingredients in most fast food are subsidized by the government. A growing surplus coupled with falling prices has made these foods easy and cheap to produce. These subsidies, in essence, contribute to the competitive food industry and lead to more questionable advertising and solicitation of consumers. Gregerson, *supra* note 24, at 44. The fast food industry is also invading more and more school cafeterias in an effort to effectively advertise their products, with Domino's Pizza, Taco Bell, and Subway being the most popular brands on school campuses. Lisa Craypo, et al., *Fast Food Sales on High School Campuses: Results from the 2000 California High School Fast Food Survey*, J. of Sch. Health, Feb. 1, 2002, at 78.

407. Gregerson, *supra* note 24, at 44. Food manufacturers gave \$3.3 million to federal campaigns in a recent election cycle. A full eighty-six percent of those donations were made to Republican candidates. Ellen Shell, *The Fat of the Land—It's Tough to Eat Right When We're Deliberately Saturated with the Wrong Food*, Pittsburgh Post-Gazette, Aug. 28, 2003, at D2.

of controlling advertisements of food is not a novel concept.⁴⁰⁸ As has already been discussed, the implementation of greater preventive medical procedures would be enormously helpful in allaying health care costs associated with obesity. Studies suggest that the solution to the problem of cost might be one of simple transposition; perhaps, it is not the unhealthiness that creates the stigma, but the stigma of obesity that leads to the unhealthiness and the enormous medical costs associated therein.⁴⁰⁹ Physicians are not immune from exercising this stigma, nor are nurses.⁴¹⁰ The stigma of obesity filters down to other levels as well. Teachers manifest cultural dislikes that are readily apparent to the children they instruct.⁴¹¹ Despite the obvious and pervasive ignominy that is currently attached to obesity, the idea still persists that not enough stigma exists.⁴¹² More and more, regulations are proposed to more effectively shame obese and overweight individuals into behavioral changes, into adopting a body that is given the cultural seal of approval. Fat taxes, insurance surcharges, obesity coverage limitations, health, life, and disability insurance denials, hospital refusals to treat overweight persons, and rampant suggestions that discrimination is the key to affecting change for these individuals all serve society's mission to firmly entrench overweight people in a veritable subclass prison. These measures, which are often self-righteously and condescendingly praised by the people who propose them as being good for the very people they

408. Indeed, in 1975, the United States Public Health Service proposed this very thing. Dan Beauchamp, who was then an assistant professor of public health at the University of North Carolina and is now a professor at the University of New York at Albany, argued that "the radical individualism inherent in the market model" is the biggest obstacle to improving public health. Jacob Sullum, *What the Doctor Orders*, Reason, Jan. 6, 2001.

409. Obese people are typically reluctant to seek health care. One 1992 National Health Interview Survey revealed that obese women are much less likely to get mammograms, pap smears, and pelvic exams with this reluctance increasing directly proportional to weight. Puhl & Brownell, *supra* note 8, at 793-94.

410. A study of 400 physicians asked the participating doctors to rank those personal characteristics that they found intolerable and repulsive in patients. One-third of the doctors ranked obesity as the fourth most reprehensible characteristic, following drug addiction, alcoholism, and mental illness. In another study, forty-eight percent of nurses reported feeling uncomfortable with obese patients; another thirty-one percent responded that they would rather not care for the obese at all while twenty-four percent said they were repulsed by obese people. *Id.* at 792, 788.

411. Considering that one study revealed that twenty-eight percent of teachers questioned thought that obesity was the worst thing that could happen to a person, it is no wonder that obese children often feel marginalized at school. *Id.* at 788.

412. Of the American tendency of tolerating difference, one British commentator said, "It is the peculiar American genius to take what everyone else would be ashamed of and turn it into a badge of pride. A vice is just a virtue with bad PR. But perhaps the problem is that there is not enough stigma attached to obesity." Macaulay, *supra* note 137, at 20.

injure, continually and steadily chip away at the potentiality of African-Americans in this country to achieve equal achievement. A great deal of evidence suggests that these disproportionate effects might be somewhat mitigated by employing a variety of traditional civil rights actions. This comment maintains that a more holistic approach, seeking to meet the goal of equal possibility irrespective of race or weight, founded in education, awareness, compassion, and access would be more effective and more amenable to the ideals long espoused as peculiarly American: the notion that equity is inviolable, human dignity immutable, and acceptance of difference integral.

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I would like to thank my husband, who endured his wife's monomaniacal fat tax obsession with remarkable forbearance and impeccable grace, for the invaluable gifts of his insight and support. This paper is dedicated to the memory of my grandfather, Ashby Earl Kelley, Sr., who died July 7, 2004, but whose steadfast and unqualified love continues to light my path in life, even in the dimmed world of his absence. *Slán agus beannacht leat, a ghrá mo chroí.*

