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Weight Discrimination: One Size Fits All Remedy?

ABSTRACT. Being fat is one of the most devastating social stigmas today. In seeking a legal remedy, commentators and advocates appeal to existing models of employment discrimination: disability, race, sex, and more recently, appearance. Fat people do face discrimination along these fronts. Weight discrimination, however, is a distinct form of discrimination. Weight discrimination blames fat people for their excess weight. Commentators fail to address the central problem when they ignore this unique psychological mechanism. More broadly, commentators miss the boat by focusing entirely on weight discrimination in employment. To really aid fat people, commentators and advocates should begin with an even more harmful area of weight discrimination: health care and health insurance.

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INTRODUCTION

Being fat is one of the most devastating social stigmas today.[1] Fat people are openly stereotyped as "mean, stupid, ugly, unhappy, less competent, sloppy, lazy, socially isolated, and lacking in self-discipline, motivation, and personal control."[2] Respondents to one survey said they would give up a year of their life or even a limb to avoid being fat.[3]

The health consequences of excess weight are well known, but little attention is paid to the social consequences of weight discrimination. Fat people are rejected for jobs, passed over by educators, maltreated by health care professionals, and denied equal access to health insurance.[4] As fat advocate Carol A. Johnson writes, "Weight discrimination can have an omnipresent and lasting impact on the life of an overweight person. It can be much more limiting on that person's life than the excess weight itself."[5] Yet weight discrimination remains one of the most socially acceptable forms of discrimination.[6]

Recently, legal commentators and fat-rights activists have begun advocating for antidiscrimination protection for fat people. The movement's rhetorical strategy analogizes weight discrimination to more familiar forms of discrimination. This Note argues that the strategy is misguided in two ways.

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1. The term "fat" has been reclaimed by activists and commentators. Kelly D. Brownell, *Introduction: The Social, Scientific, and Human Context of Prejudice and Discrimination Based on Weight*, *in* WEIGHT BIAS: NATURE, CONSEQUENCES, AND REMEDIES 1, 9 (Kelly D. Brownell et al. eds., 2005) [hereinafter WEIGHT BIAS] ("The term *fat* came into vogue because negative connotations attached to the word *obese* (as a condition) are applied to people who have the condition. It also attempts to remove the stigma from the word *fat* by using it in an open and forthright way.").

2. Rebecca M. Puhl & Kelly D. Brownell, *Confronting and Coping with Weight Stigma: An Investigation of Overweight and Obese Adults*, 14 OBESITY 1802, 1802 (2006).

3. Jacqueline Weaver, Some People Would Give Life or Limb Not To Be Fat (May 18, 2006), *available at* http://www.innovations-report.com/html/reports/studies/report-59189.html (reporting on an online study conducted by the Yale University Rudd Center for Food Policy and Obesity).

4. *See generally* WEIGHT BIAS, *supra* note 1 (surveying evidence of various sources of discrimination).

5. Carol A. Johnson, *Personal Reflections on Bias, Stigma, Discrimination, and Obesity*, *in* WEIGHT BIAS, *supra* note 1, at 175, 190.

6. *See, e.g.*, Am. Obesity Ass'n, Discrimination, http://obesity1.tempdomainname.com/discrimination/educa.shtml (last visited Apr. 12, 2008); Yale Univ. Rudd Ctr. for Food Policy & Obesity, Current Initiatives, http://www.yaleruddcenter.org/what/bias/Initiative.html (last visited Apr. 12, 2008) ("Because weight bias remains socially acceptable—it usually goes unchallenged and unpunished . . . .").

First, the strategy perpetuates confusion about the very concept of weight discrimination. Fat people face discrimination along many different dimensions. What exactly are we talking about when we say that fat people deserve protection from discrimination? This Note argues that fat people face discrimination primarily because society blames them for their weight. People believe that fat people "really could lose weight if [they just] settled down and stopped being such . . . fat slob[s]."[7] In reality, however, the science of fat is more complicated. Personal choice is a significant, but not the predominant, determinant of weight. Weight discrimination is, therefore, the result of causal misattribution.

Of course, fat people face discrimination for reasons other than causal misattribution. Some fat people face discrimination when public venues refuse to make accommodations for their size. Others face discrimination when their employers assume that they lack adequate physical capacities. Fat women may face differential weight standards from men. All fat people face society's harsh judgment that fat is ugly. Each of these examples illustrates a different rationale for discrimination: actual disability, perceived disability, sex, and appearance. While these are serious problems in their own right, they do not account for the type of discrimination that fat people are most likely to encounter. Laws directed at these types of discrimination will not solve the independent problem of weight discrimination because weight discrimination operates under a unique psychological rationale. Unlike the paradigmatic case of race discrimination, the logic of weight discrimination is explanatory, not descriptive. In other words, nobody believes that being lazy makes you African American. But people do believe that being lazy makes you fat. An effective legal strategy must address the distinctive logic of weight discrimination. By relying on inappropriate analogies, commentators fail to identify the relevant theory of discrimination.

Second, the current strategy unnecessarily restricts its focus to employment discrimination. The workplace is the familiar context of antidiscrimination regulation. Analogizing to traditional forms of discrimination naturally leads commentators to adopt an employment focus. A more effective strategy, however, begins with the source of discrimination that inflicts the greatest harm. For fat people, that source is not employment, but health care.

Thus, the current strategy neglects the pressing problem of health care discrimination, i.e. discrimination by physicians against fat patients. Health care discrimination poses new problems for antidiscrimination law. The

7. GINA KOLATA, RETHINKING THIN: THE NEW SCIENCE OF WEIGHT LOSS—AND THE MYTHS AND REALITIES OF DIETING 70 (2007) (quoting obesity researcher Mickey Stunkard).

physician-patient relationship differs significantly from that of employer-employee. Consequently, traditional antidiscrimination litigation is unlikely to alter physician behavior. This Note suggests an alternative strategy that targets weight discrimination indirectly through the mechanism of health care insurance.

Part I of this Note explains the current scientific understanding of fat. Part II presents evidence of weight discrimination. Part III argues that weight discrimination deserves legal attention. Part IV argues that existing employment discrimination frameworks cannot remedy weight discrimination. Part V advocates a new focus on health care.

I. THE SCIENCE OF FAT

Everyone knows that being fat is, all things considered, less healthy than maintaining a normal weight. As the Centers for Disease Control and Prevention explain, "Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height."[8] Beyond this baseline, however, the lay understanding of fat diverges greatly from the scientific understanding.[9] This Part will provide background on the prevalence of overweight and obesity, their costs, causes, and treatments.

Health professionals define levels of risk by Body Mass Index (BMI), a measurement based upon an individual's weight-to-height ratio.[10] For adults, a BMI of below 18.5 is considered underweight; a BMI of 18.5 to 24.9 is considered healthy; a BMI of 25 or higher is considered overweight; and a BMI of 30 or higher is considered obese. A BMI of 40 or higher is considered

8. Ctrs. for Disease Control & Prevention, Defining Overweight and Obesity, http://www.cdc.gov/nccdphp/dnpa/obesity/defining.htm (last visited Apr. 12, 2008); *see also* Jonathan Q. Purnell, *Obesity*, *in* 1 ACP MEDICINE 714, 714 (David C. Dale & Daniel D. Federman eds., 3d ed. 2007) ("Obesity is an abnormal accumulation of body fat in proportion to body size."); Enrique Saez & Yaacov Barak, *Obesity, Genetics*, *in* 6 ENCYCLOPEDIA OF HUMAN BIOLOGY 391, 391 (Renato Dulbecco ed., 2d ed. 1997) ("Excessive accumulation of adipose tissue results in obesity.").

9. *See* ANNA KIRKLAND, FAT RIGHTS: DILEMMAS OF DIFFERENCE AND PERSONHOOD 109-10 (2008) (discussing the divergence between professional and common sense understandings of fat).

10. To calculate one's BMI, see Nat'l Heart, Lung & Blood Inst., Calculate Your Body Mass Index, http://www.nhlbisupport.com/bmi (last visited Apr. 12, 2008).

severely obese (or morbidly obese).[11] This Note uses the term "fat" to encompass overweight, obese, and morbidly obese, while using the term "obese" to refer only to obese and morbidly obese.

Currently, 66.3% of American adults are overweight, including 32.2% who are obese and 4.8% who are morbidly obese.[12] In general, racial minorities and the poor are at a higher risk for obesity.[13] Women with income less than or equal to 130% of the poverty threshold, for example, are about 50% more likely to be obese than women with higher incomes.[14] Similarly, African American and Mexican American women are more likely to be overweight than their Caucasian counterparts.[15]

In total, direct health costs of overweight and obesity account for $78.5 billion annually, or nine percent of the total U.S. medical expenditure.[16] These expenditures include preventative, diagnostic, and treatment services. Medicaid and Medicare pay for roughly half of the medical expenditures caused by being

11. Cynthia L. Ogden et al., *Prevalence of Overweight and Obesity in the United States, 1999-2004*, 295 J. AM. MED. ASS'N 1549, 1550 (2006); Ctrs. for Disease Control & Prevention, *supra* note 8.

12. Ogden et al., *supra* note 11, at 1553 tbl.4; *see also* CYNTHIA L. OGDEN ET AL., NAT'L CTR. FOR HEALTH STATISTICS, NCHS DATA BRIEF NO. 1, OBESITY AMONG ADULTS IN THE UNITED STATES—NO STATISTICALLY SIGNIFICANT CHANGE SINCE 2003-2004 (2007), *available at* http://www.cdc.gov/nchs/data/databriefs/db01.pdf (reporting "no significant change in obesity prevalence . . . between 2003-2004 and 2005-2006"). For a graphical representation of U.S. trends in obesity, see Ctrs. for Disease Control & Prevention, U.S. Obesity Trends 1985-2006, http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/ (last visited Apr. 12, 2008). For a comparison, the morbidly obese population alone is greater than the total population of Pennsylvania. U.S. Census Bureau, Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2007 (Dec. 27, 2007), *available at* http://www.census.gov/popest/states/NST-EST2007-01.xls.

13. Albert J. Stunkard & Thorkild I.A. Sørensen, *Obesity and Socioeconomic Status—A Complex Relation*, 329 NEW ENG. J. MED. 1036, 1036 (1993) (concluding that there is evidence that socioeconomic status influences obesity and vice versa).

14. U.S. Dep't of Health & Human Servs., The Surgeon General's Call to Action To Prevent and Decrease Overweight and Obesity (Jan. 1, 2007), http://www.surgeongeneral.gov/topics/obesity/calltoaction/1_5.htm (citing 2 U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010 § 19-12 (2000)).

15. NAT'L CTR. FOR HEALTH STATISTICS, NCHS DATA ON RACIAL AND ETHNIC DISPARITIES 2 (2005), http://www.cdc.gov/nchs/data/factsheets/racialandethnic.pdf; Ogden et al., *supra* note 11, at 1554 tbl.5.

16. Ctrs. for Disease Control & Prevention, Overweight and Obesity: Economic Consequences, http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm (last visited Apr. 12, 2008).

overweight and obese.[17] The rest of the cost is borne either out-of-pocket or by private insurance.[18]

In addition to these direct medical expenditures, the indirect economic costs of obesity include morbidity costs (the value lost from decreased productivity, restricted activity, absenteeism, and bed days) and mortality costs (the value of future income lost by premature death).[19] Finally, there are also psychological costs to being overweight or obese.

While the escalating rate of obesity is well known, the exact causes of obesity are not completely understood. As the National Institutes of Health (NIH) explains, "Obesity is a . . . multifactorial disease that develops from the interaction between genotype and the environment."[20] The biological pathways of obesity-related genes are still poorly understood.[21] Studies show, however, that people are genetically predisposed to respond differently to energy

17. *Id.* Overweight and obese people have greater health care costs than their normal-weighted counterparts at any given age. The overall lifetime impact of overweight and obesity on health care costs depends, however, on whether these costs are offset by fat people's shorter life expectancy. Several studies have attempted to estimate this tradeoff with respect to obesity. These studies have produced differing estimates depending on choice of model and underlying data. *See, e.g.*, David B. Allison, Raffaella Zannolli & K.M. Venkat Narayan, *The Direct Health Care Costs of Obesity in the United States*, 89 AM. J. PUB. HEALTH 1194, 1198 (1999) (estimating that treating obesity would produce small overall cost savings); Pieter H.M. van Baal et al., *Lifetime Medical Costs of Obesity: Prevention No Cure for Increasing Health Expenditure*, 5 PLOS MEDICINE 242 (2008) (estimating that obesity prevention would lead to overall increased costs). All of these estimates focus on the cost of obesity, not overweight and obesity. Furthermore, they focus only on the direct health costs. None take into consideration the increased economic productivity and personal well-being of a healthy population.

18. Ctrs. for Disease Control & Prevention, *supra* note 16.

19. *Id.*

20. N. AM. ASS'N FOR THE STUDY OF OBESITY, NAT'L INSTS. OF HEALTH, THE PRACTICAL GUIDE: IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT AND OBESITY IN ADULTS 5 (2000) [hereinafter PRACTICAL GUIDE].

21. Over six hundred obesity-related genetic markers have been studied. Purnell, *supra* note 8, at 715. For recent explorations of obesity-related genes, see, for example, Peter Arner, *Obesity—A Genetic Disease of Adipose Tissue?*, 83 BRIT. J. NUTRITION S9 (2000); Alan Herbert et al., *A Common Genetic Variant Is Associated with Adult and Childhood Obesity*, 312 SCIENCE 279 (2006); and Gabriele E. Sonnenberg et al., *Genetic Determinants of Obesity-Related Lipid Traits*, 45 J. LIPID RES. 610 (2004). For a discussion of the difficulties in locating the genetic determinants of such a complex disease, see R. Rosmond, *Association Studies of Genetic Polymorphisms in Central Obesity: A Critical Review*, 27 INT'L J. OBESITY 1141 (2003).

imbalances.[22] In all, genetic factors play a significant causal role, explaining roughly seventy percent of individual variation in BMI.[23]

The dominant theory of how genetic predisposition works is the "set point" theory of obesity.[24] Set point theory posits that genetic determinants set a target weight around which the body will establish an equilibrium. Biological processes, including metabolism and hormonal signaling, significantly impede people from altering their weight.[25] Individuals can still exert reasonable control over their weight within a certain range of their natural set point. Outside this range, however, it is extremely difficult to maintain weight changes.

That is not to say, however, that the set point theory denies individual variation. There is no single genetic determinant of weight. Hundreds of specific genes have already been studied,[26] and researchers estimate that thousands of genes may ultimately influence one's genetic predisposition.[27]

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22. R.J.F. Loos & C. Bouchard, *Obesity—Is It a Genetic Disorder?*, 254 J. INTERNAL MED. 401 (2003) (reviewing various studies on the genetic disposition toward obesity).

23. Hermine H.M. Maes, Michael C. Neale & Lindon J. Eaves, *Genetic and Environmental Factors in Relative Body Weight and Human Adiposity*, 27 BEHAV. GENETICS 325, 325 (1997) (reviewing various methodologies and reporting that an integrated model estimates a genetic contribution of sixty-seven percent); Jack A. Yanovski & Susan Z. Yanovski, *Recent Advances in Basic Obesity Research*, 282 J. AM. MED. ASS'N 1504 (1999). For early and influential studies, see Albert J. Stunkard et al., *An Adoption Study of Human Obesity*, 314 NEW ENG. J. MED. 193 (1986); and Albert J. Stunkard et al., *The Body-Mass Index of Twins Who Have Been Reared Apart*, 322 NEW ENG. J. MED. 1483 (1990).

24. *See, e.g.*, Rudolph L. Leibel, *Is Obesity Due to a Heritable Difference in 'Set Point' for Adiposity?*, 153 W.J. MED. 429, 429 (1990); Purnell, *supra* note 8, at 716; Corri Wolf & Michael Tanner, *Straight to the Point: Obesity*, 176 W.J. MED. 23, 23 (2002); Shawna Vogel, *Why We Get Fat*, DISCOVER, Apr. 1999, at 94, 98. *But see* Roland L. Weinsier, *Do Adaptive Changes in Metabolic Rate Favor Weight Regain in Weight-Reduced Individuals? An Examination of the Set-Point Theory*, 72 AM. J. CLINICAL NUTRITION 1088 (2000) (rejecting the theory that metabolic rates determine weight, one version of the set point theory). *See generally* KOLATA, *supra* note 7 (exploring the history of obesity research).

25. For recent research on hormonal signaling, see, for example, Birgitte Holst & Thue W. Schwartz, *Constitutive Ghrelin Receptor Activity as a Signaling Set-Point in Appetite Regulation*, 25 TRENDS PHARMACOLOGICAL SCI. 113 (2004); Barry E. Levin, *Factors Promoting and Ameliorating the Development of Obesity*, 86 PHYSIOLOGY & BEHAV. 633 (2005); Vera Popovic & Leonidas H. Duntas, *Brain Somatic Cross-Talk: Ghrelin, Leptin and Ultimate Challengers of Obesity*, 8 NUTRITIONAL NEUROSCIENCE 1 (2005). For an overview of the biological mechanism underlying obesity, see George A. Bray, *Obesity*, *in* 6 ENCYCLOPEDIA OF HUMAN BIOLOGY, *supra* note 8, at 385, 387.

26. For a survey of studies, see Tuomo Rankinen et al., *The Human Obesity Gene Map: The 2005 Update*, 14 OBESITY 529 (2006).

27. One study, for example, estimates that up to six thousand genes influence genetic predisposition for weight. Danielle R. Reed, Maureen P. Lawler & Michael G. Tordoff,

The process of maintaining homeostatic equilibrium certainly differs between individuals. Some people will have strong homeostatic regulation around their set point whereas others may have very weak regulation.[28] That is, although genetic variation explains seventy percentage of weight variation, genes may be more or less determinative for any particular individual.

While the causes of obesity are still obscure, the effects of obesity are well documented. Obesity increases one's risk for a variety of comorbid conditions, including "insulin resistance, diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, gallstones and cholecystitis, sleep apnea and other respiratory dysfunction, and . . . certain cancers."[29] Yet historically, both overweight and obesity have been undertreated by physicians.[30]

The NIH[31] and the National Institute for Health and Clinical Excellence (NICE)[32] in the U.K. have similar guidelines for treating obesity. Broadly speaking, physicians have three treatment options: behavioral, pharmacological, and surgical. The appropriate medical intervention depends on the patient's BMI and the existence of comorbid conditions.

Behavioral interventions include reduced caloric intake, increased physical activity, and behavioral therapies such as stimulus control, stress management, cognitive restructuring, and social support.[33] Pharmacological interventions include Orlistat, a fat absorption blocker, and Sibutramine, an appetite suppressant. Drug therapy produces moderate weight loss of on average 4.4 to 22 pounds.[34] Studies show that obesity drugs are also effective in treating diabetes, liver disease, and heart disease in obese patients.[35]

Reduced Body Weight Is a Common Effect of Gene Knockout in Mice, BMC GENETICS, Jan. 8, 2008, http://www.biomedcentral.com/1471-2156/9/4.

28. Loos & Bouchard, *supra* note 22, at 401 (describing four degrees of genetic influence).

29. F. Xavier Pi-Sunyer, *The Medical Risks of Obesity*, 2002 OBESITY SURGERY 6S; *see also* Ctrs. for Disease Control & Prevention, Overweight and Obesity, http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm (last visited Apr. 12, 2008) (reviewing recent trends in obesity in the American population). On the other hand, it is unclear whether being merely overweight carries negative health risks. Katherine M. Flegal et al., *Excess Deaths Associated with Underweight, Overweight, and Obesity*, 293 J. AM. MED. ASS'N 1861 (2005).

30. PRACTICAL GUIDE, *supra* note 20, at vi.

31. *Id*.

32. NAT'L INST. FOR HEALTH & CLINICAL EXCELLENCE, OBESITY: GUIDANCE ON THE PREVENTION, IDENTIFICATION, ASSESSMENT AND MANAGEMENT OF OVERWEIGHT AND OBESITY IN ADULTS AND CHILDREN (2006) [hereinafter NICE GUIDELINES].

33. PRACTICAL GUIDE, *supra* note 20, at 2-3.

34. *Id.* at 35-36.

35. Sheridan Henness & Caroline M. Perry, *Orlistat: A Review of Its Use in the Management of Obesity*, 66 DRUGS 1625, 1627, 1645 (2006).

Surgical interventions include various types of gastric bypass, which restricts the patient's gastric volume. Most patients who undergo these surgeries "fare remarkably well with reversal of diabetes, control of hypertension, marked improvement in mobility, return of fertility, cure of pseudo-tumor cerebri, and significant improvement in quality of life."[36] Contrary to public perception, the mortality rate of gastric surgery is less than one percent.[37] Furthermore, the procedure is extremely cost efficient by industry standards.[38] In fact, because gastric bypass alleviates many costly comorbid conditions, it saves money in the long run.[39]

Obesity treatment is not just for removing excess fat. Obesity treatment is an effective treatment (sometimes the only effective treatment) for obesity-related comorbid conditions. One newly published study shows that obesity surgery is much more effective in treating Type 2 diabetes among obese patients than traditional diabetes treatments.[40] Among those who underwent obesity surgery, seventy-three percent saw complete remission of their diabetes.[41] In comparison, among those who underwent traditional diabetes

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36. PRACTICAL GUIDE, *supra* note 20, at 38.

37. Yale D. Podnos et al., *Complications After Laparoscopic Gastric Bypass: A Review of 3464 Cases*, 138 ARCHIVES SURGERY 957, 958 (2003) (reviewing studies of complication rates for both types of obesity surgery and finding a mortality rate of under one percent for both); Mayo Clinic, Gastric Bypass Surgery: What Can You Expect? (Oct. 5, 2007), http://www.mayoclinic.com/health/gastric-bypass/HQ01465.

38. In technical terms, obesity surgery has a low cost per Quality-Adjusted Life Year (QALY) gained. A QALY is a measurement of the benefit of a medical procedure in terms of how much it improves the quality and quantity of life lived. *See, e.g.*, A. Clegg et al., *Clinical and Cost Effectiveness of Surgery for Morbid Obesity: A Systematic Review and Economic Evaluation*, 27 INT'L J. OBESITY 1167 (2003) (finding obesity surgery to be cost effective at £11,000 per QALY); Benjamin M. Craig & Daniel S. Tseng, *Cost-Effectiveness of Gastric Bypass for Severe Obesity*, 113 AM. J. MED. 491 (2002) (finding obesity surgery cost effective at between $5000 and $35,600 per QALY). Health interventions below $50,000 per QALY are generally accepted as cost effective. Craig & Tseng, *supra*, at 494. Similarly, NICE considers procedures between £20,000 and £30,000 per QALY cost effective. Nancy Devlin & David Parkin, *Does NICE Have a Cost-Effectiveness Threshold and What Other Factors Influence Its Decisions? A Binary Choice Analysis*, 13 HEALTH ECON. 437 (2004).

39. *See, e.g.*, Scott F. Ghallagher et al., *The Impact of Bariatric Surgery on the Veterans Administration Health-Care System: A Cost Analysis*, 13 OBESITY SURGERY 245 (2003); John S. Sampalis et al., *The Impact of Weight Reduction Surgery on Health-Care Costs in Morbidly Obese Patients*, 14 OBESITY SURGERY 939 (2004); W.G. van Gemert et al., *A Prospective Cost-Effectiveness Analysis for Vertical Banded Gastroplasty for the Treatment of Morbid Obesity*, 9 OBESITY SURGERY 484 (1999).

40. John B. Dixon et al., *Adjustable Gastric Banding and Conventional Therapy for Type 2 Diabetes: A Randomized Controlled Trial*, 299 J. AM. MED. ASS'N 316 (2008).

41. *Id.*

treatment, only thirteen percent saw complete remission.[42] The study reflects an increasing interest in the efficacy of weight-loss treatment for chronic conditions among obese patients, even for those who are not morbidly obese.[43]

Currently, the NIH recommends pharmacological therapy if six months of behavioral therapy has failed to promote weight loss.[44] The NIH also recommends surgery for patients with a BMI of at least 40 or a BMI of at least 35 with serious comorbid conditions, and for whom other therapies have failed.[45] For patients with a BMI of at least 50, however, NICE recommends surgery as the "first-line option (instead of lifestyle interventions or drug treatment . . .)."[46]

In sum, being fat is not just a matter of personal choice. Just like other chronic diseases, fatness results from the interaction between genes, environment, and personal choice. Moreover, being fat is not just a personal problem. Ultimately, society suffers from fat in terms of increased health care costs and lost productivity.

II. WEIGHT DISCRIMINATION

Fat people suffer from a chronic illness that is not predominantly within their control. Instead of supporting medical care and treatment, however, society blames fat people for their bad fate. Section A of this Part will survey the various sources of weight discrimination in society. Section B will explore why people discriminate against fat people and how discrimination harms fat people.

A. The Reality of Weight Discrimination

Weight discrimination is pervasive, beginning in childhood and affecting every area of one's personal and professional life. In an iconic 1960s study, children aged ten to eleven evaluated line drawings of other children. The drawings depicted one overweight child, four children with various physical disabilities, and one able-bodied child of normal weight. Children overwhelmingly ranked the overweight child least likable, behind every

42. *Id.*

43. Denise Grady, *Diabetes Study Favors Surgery To Treat Obese*, N.Y. TIMES, Jan. 23, 2008, at A1.

44. PRACTICAL GUIDE, *supra* note 20, at 3-4.

45. *Id.* at 4.

46. NICE GUIDELINES, *supra* note 32, at 11.

disabled child and far behind the normal-weighted child.[47] At school, discrimination comes not only from peers, but also from teachers and even from parents.[48] Ultimately, fat high school students have lower college acceptance rates despite having comparable academic performance.[49]

On the job market, fat applicants with similar or identical credentials are less likely to be hired than thin applicants.[50] Fat candidates are evaluated as less competent, productive, industrious, organized, decisive, and successful.[51] Even after being hired, fat employees suffer from worse treatment[52] and receive

47. Stephen A. Richardson et al., *Cultural Uniformity in Reaction to Physical Disabilities*, 26 AM. SOC. REV. 241, 244 (1961). Discrimination among children has only increased since then. Janet D. Latner & Albert J. Stunkard, *Getting Worse: The Stigmatization of Obese Children*, 11 OBESITY RES. 452 (2003).

48. *See, e.g.*, Christy Greenleaf & Karen Weiller, *Perceptions of Youth Obesity Among Physical Educators*, 8 SOC. PSYCHOL. OF EDUC. 407 (2005) (finding anti-fat bias among physical educators). One study found that fat daughters receive less financial support for college from their parents than thin daughters. Christian S. Crandall, *Do Parents Discriminate Against Their Heavyweight Daughters?*, 21 PERSONALITY & SOC. PSYCHOL. BULL. 724 (1995).

49. Helen Canning & Jean Mayer, *Obesity—Its Possible Effect on College Acceptance*, 275 NEW ENG. J. MED. 1172-74 (1966) (finding lower college acceptance rates for obese students even controlling for social economic status). Today, obese students still have lower levels of college matriculation. *See, e.g.*, Robert Crosnoe, *Gender, Obesity, and Education*, 80 SOC. OF EDUC. 241 (2007) (finding that intensity of stigma contributes to lower matriculation rates).

50. *See, e.g.*, Regina Pingitore et al., *Bias Against Overweight Job Applicants in a Simulated Employment Interview*, 79 J. APPLIED PSYCHOL. 909 (1994); *see also* Eugene J. Kutcher & Jennifer DeNicolis Bragger, *Selection Interviews of Overweight Applicants: Can Structure Reduce the Bias?*, 34 J. APPLIED PSYCHOL. 1993 (2004) (finding bias against fat applicants but also finding that bias was lower when interviews were highly structured). For a survey of this research, see Janna Fikkan & Esther Rothblum, *Weight Bias in Employment*, *in* WEIGHT BIAS, *supra* note 1, at 15.

51. Judith Candib Larkin & Harvey A. Pines, *No Fat Person Need Apply: Experimental Studies of the Overweight Stereotype and Hiring Preference*, 6 SOC. WORK & OCCUPATIONS 312, 315-16 (1979); *see also* Cynthia R. Jasper & Michael L. Klassen, *Perceptions of Salespersons' Appearance and Evaluation of Job Performance*, 71 PERCEPTUAL & MOTOR SKILLS 563 (1990) (discussing stereotypes among salespeople).

52. *See, e.g.*, Joseph A. Bellizzi & Ronald W. Hasty, *Territory Assignment Decisions and Supervising Unethical Selling Behavior: The Effects of Obesity and Gender as Moderated by Job-Related Factors*, 18 J. PERS. SELLING & SALES MGMT. 35 (1998) (finding that fat salespeople were disciplined more harshly than thin salespeople for ethics violations).

lower pay.[53] Recent analysis suggests that wage discrimination is still increasing even as the population becomes increasingly obese.[54]

Finally, fat people suffer from discrimination in health care treatment and health insurance. While one might expect physicians, of all people, to treat patients in an impartial fashion, in fact, health care professionals share the same prejudices against fat people as the general public.[55] According to one survey, physicians are among the most common sources of stigmatizing experiences for fat people.[56] Perhaps most detrimental for the patient, physicians respond with less patient time.[57]

Equally important, physicians simply fail to treat obese patients' underlying medical condition—their obesity. In one study, fifty percent of respondents reported that their physician had not suggested any of the common methods of weight management.[58] Despite the fact that obesity is a leading cause of preventable death,[59] obesity is "not receiving the attention [it] deserve[s] from primary care practitioners."[60] Thus, even patients who want to

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53. *See, e.g.*, Charles L. Baum II & William F. Ford, *The Wage Effects of Obesity: A Longitudinal Study*, 13 HEALTH ECON. 885 (2004) (finding wage disparities among both men and women).

54. David Lampert, *Women's Increasing Wage Penalties from Being Overweight and Obese* (U.S. Bureau of Labor Statistics, Working Paper No. 414, 2007), http://www.bls.gov/ore/pdf/eco70130.pdf (finding increasing wage discrimination among overweight white women).

55. *See, e.g.*, Garry D. Foster et al., *Primary Care Physicians' Attitudes About Obesity and Its Treatment*, 11 OBESITY RES. 1168 (2003); George L. Maddox & Veronica Liederman, *Overweight as a Social Disability with Medical Implications*, 22 J. MED. EDUC. 214 (1969). *See generally* Kelly D. Brownell & Rebecca Puhl, *Stigma and Discrimination in Weight Management and Obesity*, 7 PERMANENTE J. 21 (2003) (surveying research on the stigmatization of fat patients by various physicians, nurses, and medical students); Anthony N. Fabricatore, Thomas A. Wadden & Gary D. Foster, *Bias in Health Care Settings*, *in* WEIGHT BIAS, *supra* note 1, at 29 (surveying similar research).

56. Puhl & Brownell, *supra* note 2, at 1811.

57. M.R. Hebl & J. Xu, *Weighing the Care: Physicians' Reaction to the Size of a Patient*, 25 INT'L J. OBESITY 1246 (2001) (finding that physicians ordered more tests for overweight and obese patients but actually spent less time with them per visit).

58. Thomas A. Wadden et al., *Obese Women's Perceptions of Their Physicians' Weight Management Attitudes and Practices*, 9 ARCHIVES FAM. MED. 854, 858 (2000).

59. Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 J. AM. MED. ASS'N 1238, 1240 (2004) (listing "poor diet and physical inactivity" as the second leading cause of death). There have been recent disputes over the methodology of calculating deaths due to obesity. For a more conservative calculation of obesity deaths in the same year, see Flegal et al., *supra* note 29, at 1863, who report deaths due to obesity at approximately 111,000 per year.

60. PRACTICAL GUIDE, *supra* note 20, at vi.

improve their weight management find it difficult to get adequate medical support and guidance from their physician.

Exacerbating the problem, patients face many obstacles to obtaining health care coverage for obesity treatment. While most public insurers are increasing coverage for obesity,[61] private health insurance providers are reducing coverage.[62] Many large insurance providers have recently made highly publicized decisions to drop coverage for obesity surgery.[63] According to a 2004 survey, only forty-eight percent of employers now cover obesity surgery.[64] Another study found that even children for whom obesity treatment was a "medical necessity" were denied coverage in thirty-five percent of cases.[65] As Part I discussed, risk and cost rationales do not justify restrictions in coverage. Nonetheless, insurance providers refuse to provide coverage for obesity as they do for other chronic illnesses.

Thus, not only does societal discrimination punish fat people with fewer opportunities, it also subjugates fat people by refusing them the medical and

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61. Traditionally, Medicare excluded coverage of obesity-related treatment. In 2004, the Centers for Medicare and Medicaid Services changed this policy by removing language from its manual stating, "[o]besity is not an illness." Press Release, U.S. Dep't of Health & Human Servs., HHS Announces Revised Medicare Obesity Coverage Policy: Policy Opens Door to Coverage Based on Evidence (July 15, 2004), *available at* http://www.dhhs.gov/news/press/2004pres/20040715.html. Similarly, a few state courts have begun mandating coverage of obesity-related treatment under the "medically necessary" standard governing Medicaid. McCoy v. Idaho Dep't of Health & Welfare, 907 P.2d 110 (Idaho 1995) (gastric bypass); Morgan v. Idaho Dep't of Health & Welfare, 813 P.2d 345 (Idaho 1991) (same); Holman v. Ohio Dep't of Human Servs., 757 N.E.2d 382 (Ohio Ct. App. 2001) (abdominoplasty). Finally, the Internal Revenue Service has also begun allowing tax deductions for out-of-pocket expenses for medically necessary weight-loss treatment. Rev. Rul. 2002-19, 2002-1 C.B. 778.

62. W. Wayt Gibbs, *Treatment That Tightens the Belt: Is Insurance Part of America's Obesity Problem?,* SCI. AM., Mar. 1995, at 3; *see also* Morgan Downey, *Insurance Coverage for Obesity Treatments*, *in* EVALUATION & MANAGEMENT OF OBESITY 139, 139 (Daniel H. Bessesen & Robert Kushner eds. 2002) (discussing the difficulties of getting coverage); Walter Lindstrom, Jr., *Maximizing Your Chances of Getting an Insurance Approval the First Time*, 7 OBESITY SURGERY 449, 449 (1997) (same).

63. Bassem Y. Safadi, *Trends in Insurance Coverage for Bariatric Surgery and the Impact of Evidence-Based Reviews*, 85 SURGICAL CLINICS N. AM. 665, 667-69 (2005); Kathryn Hinton, Note, *Employer by Name, Insurer by Trade: Society's Obesity Epidemic and Its Effects on Employers' Health-Care Costs*, 12 CONN. INS. L.J. 137, 149 (2005) (listing insurance companies that have recently dropped coverage of gastric bypass).

64. Leslie Gross Klaff, *Weighing the Pros and Cons of Paying for Gastric Bypass Surgery*, WORKFORCE MGMT., June 1, 2004, at 88, 88.

65. Andrew M. Tershakovec et al., *Insurance Reimbursement for the Treatment of Obesity in Children*, 134 J. PEDIATRICS 573, 576-77 (1999).

financial support that would help them to improve their weight management: "It's kind of a double punishment."[66]

Even though mistreatment of fat people is commonplace, the negative impact of such discrimination remains largely misunderstood. There is a widely shared misconception that making people feel bad about their weight is an "effective . . . form of motivation to lose weight."[67]

This incentive rationale is suspect to begin with; for no other chronic illness do we encourage discrimination as an incentive. There are no campaigns, for example, to stigmatize people with heart disease or high cholesterol. Heart disease is the number one killer in the United States.[68] As with obesity, personal choice plays a role in prevention and management of heart disease. Unhealthy lifestyles are indeed a serious problem, but not one unique to obesity.

Therefore, if society singles out obesity for discrimination, it should only do so if fat people are unmotivated by health benefits and if discrimination actually produces more weight loss. Both hypotheses are false. Fat people do respond to health incentives. Even today, the most common motivation for losing weight is health, not appearance.[69] Thus, if society stopped discriminating, fat people would not give up on weight loss.

Assuredly, there are people at the margin for whom greater incentives would make a difference.[70] If the goal is to incentivize healthy weight loss, however, weight discrimination is counterproductive. Denigrating fat people does not help them lose weight. Instead, weight discrimination triggers unhealthy eating behaviors.[71] Similarly, fear of weight-related teasing is a major reason that students do not participate in physical education classes in

66. KOLATA, *supra* note 7, at 70 (quoting obesity researcher Kelly Brownell).

67. Rebecca M. Puhl & Kelly D. Brownell, *Wrong Way To Fight Fat*, WASH. POST, Nov. 2, 2006, at A17; *see also* KIRKLAND, *supra* note 9, at 10 (discussing the incentive rationale).

68. Mary Carter, *Heart Disease Still the Most Likely Reason You'll Die*, CNN.COM, Nov. 1, 2006, http://www.cnn.com/2006/HEALTH/10/30/heart.overview/index.html.

69. Lawrence J. Cheskin & Laurie Friedman Donze, *Appearance vs. Health as Motivators for Weight Loss*, 286 MED. STUDENT J. AM. MED. ASS'N 2160 (2001).

70. One recent pilot study, for example, found that small monetary incentives have some impact on weight loss. Eric A. Finkelstein et al., *A Pilot Study Testing the Effect of Different Levels of Financial Incentives on Weight Loss Among Overweight Employees*, 49 J. OCCUPATIONAL & ENVTL. MED. 981, 981 (2007).

71. Puhl & Brownell, *supra* note 2, at 1803. For example, more people respond to stigmatizing experiences by giving up dieting than by taking up dieting. *Id.* at 1807.

school.[72] Furthermore, weight-related teasing in childhood leads to binge eating,[73] eating disorders,[74] and other eating disturbances later in life.[75] Ultimately, it is those who start with a positive self-image that are more likely to be successful at weight loss than those who start with a negative self-image.[76] Thus, weight discrimination only furthers a vicious cycle that perpetuates obesity.[77]

More broadly, weight discrimination harms the health and wealth of its victims. Discrimination within education and employment naturally reduces chances of economic success in life. One study found that "women who had been fat in adolescence (unlike those with other chronic conditions) completed fewer years of schooling, . . . had lower household incomes, and higher rates of household poverty than women who had not been fat."[78] Thus, not only does being poor increase your chances of becoming fat,[79] being fat also increases your chances of becoming poor.[80]

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72. Katherine W. Bauer, Y. Wendy Yang & S. Bryn Austin, *"How Can We Stay Healthy When You're Throwing All of This in Front of Us?": Findings from Focus Groups and Interviews in Middle Schools on Environmental Influences on Nutrition and Physical Activity*, 31 HEALTH EDUC. & BEHAV. 34, 34 (2004); Myles S. Faith et al., *Weight Criticism During Physical Activity, Coping Skills, and Reported Physical Activity in Children*, 110 PEDIATRICS e23 (2002).

73. Jess Haines et al., *Weight Teasing and Disordered Eating Behaviors in Adolescents: Longitudinal Findings from Project EAT (Eating Among Teens)*, 117 PEDIATRICS e209, e209 (2006).

74. Christopher G. Fairburn et al., *Risk Factors for Binge Eating Disorder*, 55 ARCHIVES GEN. PSYCHIATRY 425 (1998).

75. Haines et al., *supra* note 73, at 213-14.

76. Cheskin & Donze, *supra* note 69.

77. Puhl & Brownell, *supra* note 67 ("The data are quite clear: Stigmatizing overweight people contributes to unhealthy behavior that only adds to the problem of obesity.").

78. Fikkan & Rothblum, *supra* note 50, at 23. The study "control[led] for base-line characteristics, including household income, the respondent's educational level, the mother's and father's educational level, the score on the AFQT, the presence of a chronic physical health condition, height, self-esteem, age, and race or ethnic group." Steven L. Gortmaker et al., *Social and Economic Consequences of Overweight in Adolescence and Young Adulthood*, 329 NEW ENG. J. MED. 1008, 1010 (1993); *see also* SONDRA SOLOVAY, TIPPING THE SCALES OF JUSTICE 26 (2000) (discussing the relationship between obesity and poverty); James D. Sargent & David G. Blanchflower, *Obesity and Stature in Adolescence and Earnings in Young Adulthood: Analysis of a British Birth Cohort*, 148 ARCHIVES PEDIATRICS & ADOLESCENT MED. 681 (1994) (estimating the impact of weight on lifetime earnings).

79. *See supra* note 14 and accompanying text.

80. Fikkan & Rothblum, *supra* note 50, at 23.

In health care contexts, discrimination not only produces poorer quality care, it also discourages patients from seeking further care.[81] Similarly, discriminatory insurance policies force obese people to pay out-of-pocket for their medical expenses, and consequently, obese people are more likely to be priced out of getting adequate care. Thus, weight discrimination independently increases the health risks for fat people.[82]

Discrimination places fat people at greater risk of poverty and poor health, making it even more difficult for them to live healthily. Why does society place these burdens on fat people? As the next Section explains, weight discrimination is the result of intuitive misattribution of the causes of excess weight.

B. The Psychology of Weight Discrimination

Weight discrimination is a unique form of discrimination because it is the product of causal misattribution. Thus, unlike many forms of discrimination, weight discrimination is not due to group conflict. Nor is it the result of evolutionarily ingrained preference. This Section will examine the evidence that causal misattribution is the primary reason that people discriminate against fat people. Thereafter, this Section will distinguish this psychological mechanism from that of race and appearance discrimination.

According to the attribution theory of discrimination, people search for the causes of uncertain outcomes.[83] In particular, people tend to "use[] negative attributions to explain negative life outcomes."[84] When this happens, people blame the victim for being responsible for the victim's own bad fate.

In the case of weight discrimination, having excess body weight is a "negative life outcome." As discussed above, "body weight is determined by a complex interaction of biological and environmental factors."[85] Individual willpower is an important factor, but there is a limit to how much one can reasonably control one's weight. Yet people still tend to believe that body

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81. *See, e.g.*, Kevin R. Fontaine et al., *Body Weight and Health Care Among Women in the General Population*, 7 ARCHIVES FAM. MED. 381, 381 (1998).

82. *See* Brownell, *supra* note 1, at 4. In fact, a recent study suggests that the psychological strain of negative body image causes more health problems than excess fat itself. Peter Meunnig et al., *I Think Therefore I Am: Perceived Ideal Weight as a Determinant of Health*, 98 AM. J. PUB. HEALTH 1 (2008).

83. R.M. Puhl & K.D. Brownell, *Psychosocial Origins of Obesity Stigma: Toward Changing a Powerful and Pervasive Bias*, 4 OBESITY REVIEWS 213, 215 (2003).

84. *Id.*

85. *Id.*

weight is primarily determined by internal, controllable factors. Weight discrimination occurs when people mistakenly attribute a person's excess weight to primarily internal causes, such as lack of self-discipline.[86]

In short, people discriminate because they believe in the myth of controllability. The more one believes that body weight is entirely within one's personal control, the more one is prone to discriminate on the basis of weight.[87] Interestingly, both fat and thin people are prone to the myth of controllability.[88]

Weight discrimination is the result of common mistakes in causal attribution, which stem from shared social ideologies. As such, the psychological mechanism of weight discrimination is fundamentally different from race discrimination, which stems from intergroup conflict.[89]

Although group conflict models of weight discrimination have not been tested, there are strong reasons to doubt that they could account for weight discrimination. To begin with, fat and thin people do not really function as separate, cognizable groups. The "groups" are well integrated into society and with one another.[90] Furthermore, weight discrimination is not solely an in-group preference of thin people for other thin people. Group-based models cannot "account for self-stigma among obese individuals, which would damage their own in-group identity."[91] Finally, if the underlying issue were group tension, increased intergroup interactions should decrease discrimination.[92] Studies show, however, that increasing contact does not decrease weight

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86. *Id.* at 215-16.

87. Christian S. Crandall & April Horstman Reser, *Attributions and Weight-Based Prejudice*, *in* WEIGHT BIAS, *supra* note 1, at 83, 83.

88. Phebe Cramer & Tiffany Steinwert, *Thin Is Good, Fat Is Bad: How Early Does It Begin?*, 19 J. APPLIED DEVELOPMENTAL PSYCHOL. 429 (1998) (finding that fat children are just as likely to ascribe to negative stereotypes about fatness as thin children); Puhl & Brownell, *supra* note 83, at 219 (discussing the lack of in-group preferences among the fat).

89. For a review of intergroup theories of race discrimination by one of the founders of social identity theory, see Henri Tajfel, *Social Psychology of Intergroup Relations*, 33 ANN. REV. PSYCHOL. 1 (1982).

90. Similarly, fat and thin are not usually a core part of one's identity. Fat denotes a deviation from the mean, not a separate social category. As the National Association To Advance Fat Acceptance (NAAFA) Web site states, fat is "an adjective, like short, tall, thin, or blonde." Nat'l Ass'n To Advance Fat Acceptance, NAAFA Information Index, http://www.naafa.org/documents/brochures/naafa-info.html (last visited Apr. 12, 2008).

91. Puhl & Brownell, *supra* note 83, at 219.

92. *Id.*

discrimination.[93] In fact, the people who have the greatest contact with fat people, their own family members, are also the greatest sources of discrimination.[94] Thus, evidence suggests that unlike race discrimination, weight discrimination is not the result of intergroup conflict.

Similarly, weight discrimination is not solely a bias in favor of attractive people. If weight discrimination were just about appearances, discriminators would simply have a visceral reaction against fat people. Experimental research rejects this hypothesis.

In a typical study, two groups of subjects are asked to evaluate obese and nonobese targets performing a task. One group of subjects is told that the obese target has a thyroid condition that causes weight gain, whereas the other group is not told anything. If weight discrimination is merely a visceral reaction to the appearance of fatness, then both groups should have equally negative evaluations of the target. If, however, weight discrimination is about blaming fat people for failing to control their weight, the two should groups should differ. The results support the attribution theory of discrimination: subjects who were not given an external cause for the obese target's weight evaluated her as having less self-discipline and being more self-indulgent (as compared to the nonobese target), whereas those who were told that her weight was due to a medical condition did not.[95]

Studies like this one suggest that people's default assumption is that weight is predominantly internally controllable. When the assumption of internal controllability is removed, so are the negative evaluations. Therefore, weight discrimination is more than a superficial preference for thin people; it is a moral objection to perceived weakness of will. In sum, weight discrimination is a different psychological phenomenon than group-based discrimination or appearance-based discrimination. Any effective legal response must be attuned to this fundamental uniqueness.

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93. *See, e.g.*, Puhl & Brownell, *supra* note 2, at 1808 (reporting that the most frequent source of stigma is family members; the second most frequent source is physicians).

94. *Id.* at 1808.

95. William DeJong, *Obesity as a Characterological Stigma: The Issue of Responsibility and Judgments of Task Performance*, 73 PSYCHOL. REP. 963. 968-9 (1993); *see also* William DeJong, *The Stigma of Obesity: The Consequences of Naive Assumptions Concerning the Causes of Physical Deviance*, 21 J. HEALTH & SOC. BEHAV. 75 (1980) (conducting an earlier version of this experiment with pictures instead of task performance).

III. NEED FOR LEGAL REDRESS

Weight bias is a real phenomenon that causes discrimination in education, employment, and health care. Yet many groups are socially disadvantaged. What makes weight discrimination a harm deserving of a legal remedy?

Commentators generally make fairness arguments for why weight discrimination deserves legal redress.[96] It is fundamentally unfair for society to blame fat people for a condition that is to a great extent outside of their control.

The fairness argument, however, has potential weaknesses. First, the fairness justification is weaker for weight than it is for completely immutable characteristics such as race or national origin. Second, the fairness rationale does not distinguish weight discrimination from other forms of equally unfair inequalities. This Part argues, however, that special legal protections for weight discrimination are justified by utilitarian considerations, in particular, the scope of the harm and its suitability for legal action.

Weight discrimination directly harms a large portion of the population. The obese, who are at greatest risk for discrimination, account for thirty-two percent of the U.S. population.[97] In comparison, racial minorities account for only twenty-five percent of the population,[98] and the disabled account for only nineteen percent of the population.[99] In fact, a recent study found that weight discrimination was the fourth most common form of discrimination experienced by Americans (after gender, age, and race).[100] Among women, weight discrimination was actually reported more frequently than race discrimination.[101] Moreover, weight discrimination has been on the rise in recent decades while race discrimination has been relatively stable.[102]

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96. *See, e.g.*, Elizabeth Kristen, Comment, *Addressing the Problem of Weight Discrimination in Employment*, 90 CAL. L. REV. 57, 108-09 (2002) (arguing that a combination of fairness and equality rationales supports providing legal protection to fat people).

97. *Id.*

98. ELIZABETH M. GRIECO & RACHEL C. CASSIDY, U.S. CENSUS BUREAU, OVERVIEW OF RACE AND HISPANIC ORIGIN: 2000 (2001), *available at* http://www.census.gov/prod/2001pubs/c2kbr01-1.pdf.

99. JUDITH WALDROP & SHARON M. STERN, U.S. CENSUS BUREAU, DISABILITY STATUS: 2000 (2003), *available at* http://www.census.gov/prod/2003pubs/c2kbr-17.pdf.

100. R.M. Puhl, T. Andreyeva & K.D. Brownell, *Perceptions of Weight Discrimination: Prevalence and Comparison to Race and Gender Discrimination in America*, INT'L J. OBESITY (forthcoming 2008) (manuscript at 7, on file with The Yale Law Journal), *available at* http://www.yaleruddcenter.org/news/pdf/IJO2008.pdf.

101. *Id.*

102. Tatiana Andreyeva, Rebecca M. Puhl & Kelly D. Brownell, *Changes in Perceived Weight Discrimination Among Americans, 1995-1996 Through 2004-2006*, 16 OBESITY (forthcoming

Therefore, the class of potential victims of weight discrimination is large enough to deserve legal attention.

Weight discrimination also has a deep impact on each victim, potentially more harmful than disability or race discrimination. As the line-drawing studies show, people dislike fat people more than they dislike disabled people; the fat target is consistently ranked last, behind four targets with various physical disabilities, and the able-bodied thin target.[103] Furthermore, weight discrimination may feel worse than descriptive forms of discrimination. For example, African American adolescent girls who reported both weight and race discrimination experience weight discrimination as "more hurtful" than race discrimination.[104] Therefore, the harm to each individual is severe enough to deserve legal attention.

Furthermore, weight discrimination produces third party costs. As others have argued,[105] discrimination produces inefficient distribution of resources. Weight discrimination prevents the most qualified applicant from getting educational and occupational advancement opportunities. Perhaps more importantly, the public also pays in terms of more obesity. Weight discrimination makes fat people fatter.[106] This is especially true in health care contexts, where discrimination directly impedes fat people from obtaining weight-loss treatment. Therefore, weight discrimination does not just harm its victims; it contributes to the societal obesity epidemic.

Finally, the problem of weight discrimination is particularly well suited to legal intervention. Legal intervention is especially appropriate when there are no corrective social and moral norms.[107] For many forms of discrimination, particularly discrimination based on physical traits, Americans have established antidiscrimination norms. For example, people know that it is wrong to mistreat ugly people just because they are ugly. The ugly even get sympathy in court.[108] In contrast, fat people are continually rejected by courts even when

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May 2008) (manuscript at 3, on file with The Yale Law Journal), manuscript available at http://www.yaleruddcenter.org/news/pdf/Obesity-2008.pdf.

103. Richardson et al., *supra* note 47, at 243-46.

104. Dianne Neumark-Sztainer, Mary Story & Loren Faibisch, *Perceived Stigmatization Among Overweight African American and Caucasian Adolescent Girls*, 23 J. ADOLESCENT HEALTH 264, 269 (1998).

105. *See, e.g.*, Kristen, *supra* note 96, at 71-72.

106. Puhl & Brownell, *supra* note 67.

107. Steven Shavell, *Law Versus Morality as Regulators of Conduct*, 4 AM. L. & ECON. REV. 227, 251-54 (2002).

108. *See, e.g.*, Yanowitz v. L'Oreal U.S.A., 116 P.3d 1123, 1130-35 (Cal. 2005) (ruling that even though discrimination based on unattractiveness was not illegal, it was reasonable for an

they have reasonable legal claims.[109] There is no established social or moral norm against weight discrimination;[110] there may even be a norm favoring weight discrimination.[111] When social and moral norms are counterproductive, legal intervention is needed to regulate behavior and shape future norms.[112]

This Part has argued that weight discrimination is not just a moral injustice; it is a costly social problem. Furthermore, weight discrimination is a problem for which social solutions are unavailing. Therefore, for moral, utilitarian, and practical reasons, society should invest in legal remedies for weight discrimination.

IV. CURRENT LEGAL FRAMEWORKS

Many commentators believe that the proper remedy for weight discrimination is to include it in one of the existing employment antidiscrimination regimes. Current federal antidiscrimination laws, most notably the Americans with Disabilities Act (ADA) and Title VII of the Civil Rights Act of 1964, are designed around the model of disability or race discrimination; these laws do not address the unique problems of weight discrimination. Similarly, new appearance discrimination laws target only a tangential part of the problem of weight discrimination. This Part will argue that all current antidiscrimination laws fail to capture the right theory of weight discrimination.

A. Disability Discrimination: The ADA and the Rehabilitation Act

Is weight discrimination merely disability discrimination? As one commentator puts it, this "is the issue that pits activists against activists and experts against experts. . . . It is possibly the most controversial topic in the fat-rights community."[113] Many fat-rights commentators have pinned their hopes

employee to believe that it was illegal). *But see* May It Please the Court, http://www.mayitpleasethecourt.com/journal.asp?blogid=897 (Aug. 13, 2005, 10:57 PDT) (critiquing *Yanowitz*'s rationale).

109. *See infra* Part IV.

110. *See supra* Section II.A.

111. *See, e.g.*, William Saletan, *Fat Lies: Obesity, Laxity, and Political Correctness*, SLATE, July 26, 2007, http://www.slate.com/id/2171214/nav/tap3/ (advocating more stigmatization of fat people).

112. Shavell, *supra* note 107, at 251-54.

113. SOLOVAY, *supra* note 78, at 129.

on the ADA and the Rehabilitation Act.[114] Both statutes provide protections for discrimination on the basis of a disability, where the two prongs of "disability" are defined as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual, . . . or . . . being regarded as having such an impairment."[115]

The ADA Guidelines state specifically that "except in rare circumstances, obesity is not considered a disabling impairment."[116] As the Department of Justice puts it, it is a "myth" that the ADA protects people who are overweight: "Just being overweight is not enough."[117] Courts have generally followed this rule, recognizing only morbid obesity as a form of disability. This Section argues that while some morbidly obese people are disabled, disability discrimination does not account for the type of stigmatization that most harms fat people.

1. Case Law

Under the first prong of the ADA, conditions that substantially limit a person's major life activities qualify as actual disabilities. In *Cook v. Rhode Island Department of Mental Health, Retardation, and Hospitals*,[118] the First Circuit ruled that morbid obesity can sometimes be sufficiently impairing.[119]

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114. *See, e.g.*, *id.*; Jeffrey Garcia, Note, *Weight-Based Discrimination and the Americans with Disabilities Act: Is There an End in Sight?*, 13 HOFSTRA LAB. & EMP. L.J. 209 (1995); Milena D. O'Hara, Note, *"Please Weight To Be Seated": Recognizing Obesity as a Disability To Prevent Discrimination in Public Accommodations*, 17 WHITTIER L. REV. 895 (1996); Steven M. Ziolkowski, Case Comment, *The Status of Weight-Based Employment Discrimination Under the Americans with Disabilities Act After* Cook v. Rhode Island Department of Mental Health, Retardation, and Hospitals, 74 B.U. L. REV. 667 (1994).

115. 42 U.S.C. § 12,102(2) (2000). Title I of the ADA applies to terms of employment generally, whereas the Rehabilitation Act applies only to federally funded programs. The Rehabilitation Act, however, follows the same standards as the ADA. 29 U.S.C. § 791(g) (2000).

116. 29 C.F.R. § 1630 app. at 368 (2007).

117. U.S. Dep't of Justice, Myths and Facts about the Americans with Disabilities Act, http://www.usdoj.gov/crt/ada/archive/mythfact.htm (last visited Apr. 12, 2008).

118. 10 F.3d 17 (1st Cir. 1993).

119. *See also* Gaddis v. Oregon, 21 Fed. App'x 642, 643 (9th Cir. 2001) (stating that morbid obesity is covered by the ADA); Connor v. McDonald's Rest., No. 02-382, 2003 WL 1343259 (D. Conn. Mar. 19, 2003) (same). Since *Cook*, some courts have added the requirement that plaintiffs must suffer from an underlying "physiological condition" that causes morbid obesity. *See, e.g.*, EEOC v. Watkins Motor Lines, Inc., 463 F.3d 436 (6th Cir. 2006); Francis v. City of Meriden, 129 F.3d 281 (2d Cir. 1997); Coleman v. Ga. Power Co., 81 F. Supp. 2d 1365 (N.D. Ga. 2000).

Therefore, while mere overweight is not enough,[120] morbid obesity may qualify as an actual disability.

Even when morbid obesity is not actually disabling, it may be perceived as such. Under the second prong of the ADA, conditions that are regarded as impairing qualify as perceived disabilities. *Cook*, for example, also ruled that morbid obesity can be a perceived disability. (The court held that morbid obesity could satisfy either prong of the disability definition.[121])

Cook was a particularly clear case of perceived disability. Bonnie Cook applied for and was denied a position as an institutional attendant at a state facility for the mentally retarded. At the time, Cook had been diagnosed as morbidly obese.[122] A routine prehire physical, however, found "no limitations that impinged upon her ability to do the job."[123] Still, Cook was rejected for the job explicitly on the basis of her morbid obesity.[124] The state claimed that Cook's morbid obesity made her physically "incapable of working."[125] The state, however, had no evidence to support this claim. In fact, all the evidence, including prior work records, suggested that Cook was perfectly capable of performing her duties.[126] Nonetheless, the state "relied on generalizations regarding an obese person's capabilities."[127] As a court in a similar case commented, this is exactly the type of "myth[], fear[] and stereotype[]" that the ADA prohibits.[128]

Not all courts, however, are as sympathetic to claims of disability, even by morbidly obese plaintiffs.[129] In sum, under either prong of the ADA's "disability" definition, current case law provides only limited coverage, and only to morbidly obese plaintiffs.

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120. *See, e.g.*, *Francis*, 129 F.3d 281; Andrews v. Ohio, 104 F.3d 803 (6th Cir. 1997); Torcasio v. Murray, 57 F.3d. 1340 (4th Cir. 1995).

121. 10 F.3d at 23.

122. *Id.* at 20.

123. *Id.* at 20–21.

124. *Id.* at 25.

125. *Id.*

126. *Id.*

127. *Id.* at 27.

128. EEOC v. Tex. Bus Lines, 923 F. Supp. 965, 975 (S.D. Tex. 1996).

129. *See, e.g.*, Hazeldine v. Beverage Media, Ltd., 954 F. Supp. 697, 702–06 (S.D.N.Y. 1997).

2. *Weight Discrimination Is Not Disability Discrimination*

Cook gets the law right. Morbid obesity can be an actual or perceived disability, and therefore some fat people do suffer from weight-based disability discrimination. The question, however, is whether the harms documented in Part II can be attributed primarily to disability discrimination. This Note argues that they cannot. The majority of fat people are not discriminated against on the basis of an actual or perceived weight-based disability. Rather, they are discriminated against because employers perceive their weight as a signal of underlying personal flaws (for example, lack of discipline and self-control). Thus, neither weight-based disability prong addresses the type of discrimination that fat people are most likely to encounter.

First, most fat people are not disabled as defined under the ADA or Rehabilitation Act. Being fat is not usually a condition that "substantially limits one or more of the major life activities of such individual."[130] Rarely would the physical demands of the job make weight an issue.[131] Thus, in the vast majority of cases, it would be inaccurate to categorize being fat as an actual disability.[132]

Some commentators, however, argue that being even slightly fat is actually disabling, and that weight's exclusion from protection is itself an example of discrimination.[133] While it is true that obesity can make some physical activities more difficult, mere disadvantage is not enough to establish "disability" for purposes of antidiscrimination protection. Nonmorbid obesity could not fairly be included within the definition of disability unless all other moderately inhibiting physical variations were also included. Therefore, the exclusion of mere obesity from the definition of "disability" is not discriminatory.

The basic issue, however, is not just that fat fails the statutory definition of disability. Rather, it is that there are two independent theories of discrimination at work. In the case of weight-based disability discrimination,

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130. 42 U.S.C. § 12,102(2) (2000).

131. *See* Elizabeth E. Theran, *"Free To Be Arbitrary and . . . Capricious": Weight-Based Discrimination and the Logic of American Antidiscrimination Law*, 11 CORNELL J.L. & PUB. POL'Y 113, 195 (2001); *see also* Rebecca Puhl & Kelly D. Brownell, *Bias, Discrimination, and Obesity*, 9 OBESITY RES. 788, 800 (2001) (concluding that weight is not usually a disabling condition).

132. Moreover, inaccurately labeling fat a disability may have unintended stigmatizing effects. Puhl & Brownell, *supra* note 131, at 800; *see also* Kari Horner, Comment, *A Growing Problem: Why the Federal Government Needs To Shoulder the Burden in Protecting Workers from Weight Discrimination*, 54 CATH. U. L. REV. 589, 618 (2005) (arguing against including obesity as a disability).

133. SOLOVAY, *supra* note 78, at 145; *see also* KIRKLAND, *supra* note 9, at 156 (advocating for a more "flexible" ADA standard).

weight does impact *physical* capacity; society discriminates by applying undifferentiated treatment to differentiated circumstances. In the case of weight discrimination, however, weight does not impact *professional* capacity; society discriminates by applying differentiated treatment to undifferentiated circumstances.

The controversy over fat as a disability stems from confusion over these theories. On both sides of the debate, commentators and activists misleadingly treat the two as mutually exclusive. In her new book, *Fat Rights: Dilemmas of Difference and Personhood*, Anna Kirkland articulates this perceived tension: "Stressing that one functions the same as others means that there is no reason for accommodations if one turns out to be different."[134] The perceived conflict, however, arises from ambiguity in the scope of "function." Fat people can function the same as others in one context (professional capacity) while functioning differently in another context (physical capacity). Thus, there is no real inconsistency between the two forms of discrimination; both are no doubt occurring in the workplace.

The question remains, however, which type of discrimination produces the type of harm that fat people most commonly suffer? Between the two, weight discrimination is more plausibly linked to employment discrimination. Fat people report that the most common form of stigmatizing situation they face is "[o]thers making negative assumptions."[135] Physical obstacles due to their size, while common, were reported much less frequently.[136] Thus, while disabled fat people of course ought to be protected against disability discrimination, doing so will not address the weight discrimination that all fat people face.

Second, being fat is not usually *perceived* as an "impairment that substantially limits one or more of the major life activities of such individual."[137] While weight discrimination is due to misperceptions about fat people, those "negative assumptions" are not typically about fat people's physical capacities. Of course there are some cases, like Robin Cook's, in which employers underestimate the physical capacities of fat people. If these were the dominant cases, however, we would expect the stereotypes against fat people to be tied to physical limitations. That is not the case. The most common stereotypes are that fat people are "mean, stupid, ugly, unhappy, less

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134. KIRKLAND, *supra* note 9, at 154; *see also* Anna Kirkland, *Think of the Hippopotamus: Rights Consciousness in the Fat Acceptance Movement*, 42 LAW & SOC'Y REV. (forthcoming June 2008) (manuscript at 9, on file with The Yale Law Journal) (discussing the same perceived tension within the rhetoric of fat activists themselves).

135. Puhl & Brownell, *supra* note 2, at 1806 tbl.2.

136. *Id.*

137. 42 U.S.C. § 12,102(2)(a) (2000).

competent, sloppy, lazy, socially isolated, and lacking in self-discipline, motivation, and personal control."[138] These attributions are not about physical limitations. Rather, these stereotypes are predominantly about personal or moral flaws.

Arguments for the inclusion of fatness under the perceived disability prong of the ADA fail to appreciate the difference between these two types of misperceptions. Sondra Solovay, for example, argues: "'Normal' weight and moderately fat people are rightly protected from discrimination on the basis of weight when it stems from an employer's [erroneous] belief, perception, or articulated thoughts that they are substantially limited in their ability to work."[139] Solovay's statement is misleading. If employers are discriminating because they think fat candidates are limited in their ability to perform physical tasks, then Solovay is right: the candidates have a valid claim of weight-based perceived disability discrimination. If employers are discriminating because they think that fat candidates are "limited" in the sense of being less hard-working, then Solovay is wrong: the candidates are discriminated against on the basis of weight, but not because of a perceived disability.

The distinction between what this Note has called "weight-based perceived disability discrimination" and "weight discrimination" is important because the two require different remedies. To address weight-based perceived disability discrimination, the public needs to know that fat people are physically capable of performing major life activities. This kind of public re-education, however, is irrelevant to weight discrimination. Even if people were better educated about the condition of being fat, they would still misperceive its causes. As long as people blame the individual for his weight, they will believe that fat people are lazy.

Thus, courts are right to limit disability protection to those cases in which the basis of discrimination is the belief that the victim has a weight-based disability. Weight discrimination is not the same phenomenon as either actual or perceived disability discrimination.

B. Race and Sex Discrimination: Title VII

Recognizing the weaknesses of the disability argument, other commentators instead advocate for weight discrimination protection based on

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138. Puhl & Brownell, *supra* note 2.

139. SOLOVAY, *supra* note 78, at 164; *see also* Garcia, *supra* note 114, at 233 (arguing in favor of obesity as a disability); Ziolkowski, *supra* note 114, at 685 (same).

Title VII and similar antidiscrimination provisions.[140] Currently, Title VII prohibits employers from discharging or refusing to hire an employee "because of [an] individual's race, color, religion, sex, or national origin."[141] Courts have not accepted weight as an independent basis for Title VII protection. Some courts, however, have considered weight discrimination as a "plus" claim when compounded with discrimination based on one of the protected categories. One state, Michigan, has included weight within its Title VII-like statute, the Elliot Larson Civil Rights Act.[142] To date, this provision has not been heavily litigated and has produced mixed results.

Commentators who support Title VII-like protection make two types of arguments. First, they argue that weight discrimination is just a form of sex-plus discrimination. Therefore, it should already be covered under Title VII. Second, they argue that weight discrimination is like race discrimination. Therefore, weight should be added as another protected class. Both arguments are flawed. Weight discrimination is not merely a subset of sex discrimination. Furthermore, the psychology of weight discrimination differs from that of race discrimination in ways that make Title VII's standards inappropriate.

1. Case Law

Under Title VII, weight discrimination can enter as a plus claim if employers require protected groups (for example, racial minorities or women) to satisfy different weight standards. Examples of successful sex-plus-weight claims include flight attendants' claims against sex-differentiated weight standards[143] and police officers' claims against disparate enforcement of facially neutral weight standards.[144]

Although these claims involve weight standards, courts do not treat weight as an improper basis for discrimination. Courts do not, for example, find weight standards themselves to be problematic under Title VII. As the Ninth

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140. *See, e.g.*, Theran, *supra* note 131; Kristen, *supra* note 96; Paula B. Stolker, Note, *Weigh My Job Performance, Not My Body: Extending Title VII to Weight-Based Discrimination*, 10 N.Y.L. SCH. J. HUM. RTS. 223 (1992). For practical reasons, perhaps, commentators have largely ignored the Equal Protection Clause of the Constitution as a potential source of protection for weight discrimination. Constitutional claims are summarily dismissed. *See, e.g.*, United States v. Santiago-Martinez, 58 F.3d 422 (9th Cir. 1995) (per curiam).

141. 42 U.S.C. § 2000e-2(a) (2000).

142. MICH. COMP. LAWS § 37.2202(1) (2007).

143. *See, e.g.*, Frank v. United Airlines, 216 F.3d 845 (9th Cir. 2000); Gerdom v. Cont'l Airlines, 692 F.2d 602 (9th Cir. 1982) (en banc).

144. *See, e.g.*, Donoghue v. County of Orange, 848 F.2d 926 (9th Cir. 1988).

Circuit explained in *Frank v. United Airlines*, a "standard that imposes different but essentially equal burdens on men and women is not disparate treatment."[145] A Title VII discrimination claim arises only when a weight requirement places greater burdens on one sex.

In contrast, Michigan's Elliot-Larson Civil Rights Act has explicitly prohibited discrimination based on weight and height since 1975.[146] While the law is over thirty years old, the weight provision remains largely unlitigated.[147] The most successful case to date has been *Lamoria v. Health Care & Retirement Corp.*, decided in 1999.[148] In *Lamoria*, the court held that a supervisor's stated intention to fire people she perceived as overweight followed by discharge of plaintiff, who was overweight, was sufficient to show that weight was a "determinative factor" in her firing.[149] Even the *Lamoria* court, however, recognized that the weight prong of the Act was undertheorized, stating, "Interestingly, we have found no published opinion of the Michigan Supreme Court or this Court explicitly addressing the elements necessary for a party to establish a claim of weight discrimination."[150] Today, there remains a dearth of weight discrimination cases in Michigan.[151]

2. *Weight Discrimination Is Not Just Sex Discrimination*

Some commentators argue that weight discrimination is just a form of sex-plus discrimination. As Kate Sablosky argues, "[w]here overweight women disproportionately face negative employment decisions—are denied jobs, promotions, or access to clients for example—we must acknowledge that this discrimination is an outgrowth of outmoded and unhealthy attitudes about

145. 216 F.3d at 854.

146. MICH. COMP. LAWS § 37.2202(1) (2007) (prohibiting hiring and firing decisions based upon "religion, race, color, national origin, age, sex, height, weight, or marital status").

147. Elizabeth E. Theran, *Legal Theory on Weight Discrimination, in* WEIGHT BIAS, *supra* note 1, at 195, 205. Most cases brought under the weight clause are dismissed for lack of evidence. *See, e.g.*, Hein v. All Am. Plywood Co., 232 F.3d 482 (6th Cir. 2000); Byrnes v. Frito-Lay, Inc., 811 F. Supp. 286 (E.D. Mich. 1993); Ross v. Beaumont Hosp., 687 F. Supp. 1115 (E.D. Mich. 1988).

148. 584 N.W.2d 589 (Mich. Ct. App. 1998), *adopted*, 593 N.W.2d 699 (Mich. Ct. App. 1999).

149. *Id.* at 594-95.

150. *Id.* at 594.

151. In two unreported weight discrimination cases since *Lamoria*, Michigan courts have rejected claims of weight discrimination for lack of evidence of discrimination. Webb v. Swartz Creek Cmty. Schs., No. 214038, 2001 WL 777131 (Mich. Ct. App. Jan. 16, 2001); Farino v. Renaissance Club, No. 206031, 1999 WL 33440929 (Mich. Ct. App. June 29, 1999).

what constitutes an acceptable woman."[152] Sablosky is certainly right that when employers enforce different standards of weight for men and women, they are guilty of sex discrimination. As mentioned above, courts already view weight as a legitimate plus claim under Title VII.

As a legal approach to weight discrimination, however, Sablosky's strategy is limited in two ways. First, Sablosky treats weight discrimination as a form of appearance discrimination. Sablosky assumes that fat women face employment discrimination because thinness is a standard of female beauty.[153] But weight discrimination is more than skin deep: people discriminate against fat people because they think fat people are incompetent.[154] By framing weight discrimination as an issue of female beauty, Sablosky does not do justice to the discrimination that fat people suffer.

Second, Sablosky treats weight discrimination as just a female problem. Many studies, particularly early studies, showed that women are discriminated against more than men.[155] More recent work, however, shows little or no difference.[156] Today, more research is focusing on the impact of weight discrimination on men.[157] As a practical matter, therefore, Sablosky's approach is limited by the fact that weight discrimination is already or is becoming a gender-neutral problem.

3. Weight Discrimination Is Not Like Race Discrimination

Alternatively, some commentators argue for the addition of "weight" to Title VII based on the analogy between weight discrimination and race discrimination. There are two versions of this argument. Both are misleading and unhelpful.

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152. Kate Sablosky, *Probative "Weight": Rethinking Evidentiary Standards in Title VII Sex Discrimination Cases*, 30 N.Y.U. REV. L. & SOC. CHANGE 325, 327 (2006). In a similar vein, Stacey Baron addresses weight discrimination within the context of appearance discrimination against unattractive women. Stacey S. Baron, *(Un)lawfully Beautiful: The Legal (De)construction of Female Beauty*, 46 B.C. L. REV. 359 (2005).

153. Sablosky, *supra* note 152, at 335.

154. *See supra* Section II.B.

155. *See, e.g.*, K.A. Kraig & P.K. Peel, *Weight-Based Stigmatization in Children*, 25 INT'L J. OBESITY 1661 (2001).

156. Puhl & Brownell, *supra* note 2, at 1813. ("Although some literature has suggested gender differences for certain forms of weight stigma . . . , the present findings parallel more recent work that did not observe differences between men and women in reported levels of stigma and discrimination . . . .").

157. *See, e.g.*, Michelle R. Hebl & Julie M. Turchin, *The Stigma of Obesity: What About Men?*, 27 BASIC & APPLIED SOC. PSYCHOL. 267 (2005).

First, commentators argue that weight itself is like race. Both weight and race are visible physical characteristics. Because weight is no more related to (nonphysical) job performance than race,[158] fairness dictates that weight be included in Title VII.[159]

Race and weight, however, are different in important ways. In pushing the race analogy, commentators often argue that weight is an immutable and completely irrelevant characteristic, for example, "I assume that to be fat is not necessarily unhealthy and that weight is either immutable or so difficult or dangerous to permanently change as to be practically immutable."[160] Although it is true that being fat "is not necessarily unhealthy," it is not true that weight is irrelevant to health. Similarly, although one's weight is significantly outside one's personal control, it is not true to say that weight is "immutable." Thus, the race analogy supports weight discrimination protection only at the expense of opposing weight management.

Second, commentators argue that weight stereotypes are like racial stereotypes. As one explains, "[S]tereotypes and prejudices surrounding race in this country have . . . been laced with a strong dose of moral condemnation and animus . . . . In this sense, antifat prejudice is more like race than like disability . . . ."[161]

While weight and race stereotypes are both morally loaded, they operate under opposing rationales. Weight discrimination begins with the assumption that fat and thin people are essentially the same; fat people are just thin people who make poor choices. In contrast, race discrimination begins with the assumption that being of a different race makes you inherently different. That is, the underlying logic of racial stereotypes is: Being *X* race makes you prone to having *Y* moral flaw. Whereas, the underlying logic of fat stereotypes is: Having *Y* moral flaw makes you prone to being *X* weight. Although both stereotypes are about moral flaws, the arrow of causation goes in opposite directions. The race discrimination analogy obscures the actual reasoning that motivates weight discrimination.

One might object, however, that these are distinctions without a difference. Weight discrimination relies on inaccurate inferences. In this respect, "weight

158. Stolker, *supra* note 140, at 249-50.

159. Kristen, *supra* note 96, at 73; Theran, *supra* note 131, at 198.

160. Kristen, *supra* note 96, at 71.

161. Theran, *supra* note 131, at 196; *see* Horner, *supra* note 132, at 612 (making a similar argument).

discrimination is fundamentally no different from any other form of discrimination—race, gender, national origin, or disability."[162]

Weight discrimination is certainly deserving of protection. In this respect, weight discrimination is "no different" from other forms of discrimination. But effective protection requires legal standards that respond to the right theory of discrimination. If weight is like race, then anything less than immutability ought to defeat a claim of discrimination. If weight discrimination is like race discrimination, then innate difference, not causation, should be the key consideration. Simply including weight as another protected category misleadingly suggests that the same legal standards apply. As the Michigan example shows, this kind of undifferentiated legal mandate is unhelpful to judges.[163] Giving "weight" equal treatment within an antidiscrimination statute does not guarantee equal results.

C. Appearance Discrimination Law

Finally, a few jurisdictions have enacted appearance discrimination laws that also attempt to cover weight discrimination. These laws have been almost completely unlitigated. The most celebrated cases have been mediated or negotiated. Furthermore, these cases seem to be addressing neither appearance nor weight discrimination, but rather disability discrimination. Appearance discrimination laws are generally supported by fat-rights advocates. But weight discrimination is not merely a subset of appearance discrimination. While the two forms of discrimination are related, appearance discrimination laws are therefore not the best way to target the distinct problem of weight discrimination.

1. Case Law

Currently, two local ordinances and one District of Columbia statute protect against weight discrimination on the theory of appearance discrimination. First, in 1992, the city of Santa Cruz passed an all-encompassing antidiscrimination ordinance prohibiting, among other things, discrimination on the basis of "height, weight, or physical characteristic."[164] Second, in 2000, San Francisco passed a specific weight discrimination

162. Theran, *supra* note 131, at 198.

163. *See supra* notes 147-151 and accompanying text.

164. SANTA CRUZ, CAL., MUN. CODE § 9.83.010 (1995).

ordinance.[165] Compliance guidelines reveal two underlying theories: appearance discrimination and disability discrimination.[166] Finally, in 2001, the District of Columbia passed a human rights law prohibiting discrimination on the basis of "personal appearance."[167]

None of these laws has generated much litigation. The most notable cases have been mediated and negotiated under the San Francisco and Santa Cruz laws respectively. In San Francisco, Jennifer Portnick filed a discrimination claim after the fitness company Jazzercise denied her a job as an aerobics instructor.[168] At the time, Portnick weighed 240 pounds, but was in good cardiovascular shape. Jazzercise, however, refused to hire her because she did not have a "fit appearance."[169] Portnick and Jazzercise mediated, and Jazzercise eventually revised its weight standards to allow for physically fit instructors who did not look thin. Similarly, in Santa Cruz, an advocacy group, Body Image Task Force, used the local ordinance to successfully negotiate with companies to install extrawide seats in newly constructed theaters.[170] Finally, no weight discrimination suits have succeeded under the District of Columbia appearance law.[171]

2. *Weight Discrimination Is Related to but Distinct from Appearance Discrimination*

Like Michigan's Elliot-Larson Civil Rights Act, these local ordinances do not establish a clear theory of weight discrimination. The two successful mediation and negotiation cases seem to be about perceived disability (Jazzercise) and actual disability (Body Image Task Forces). Perhaps the ordinances have helped give fat people greater disability protection. The stated

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165. S.F. CAL. ADMINISTRATIVE CODE ch. 12A-C (2001).

166. City and County of S.F. Human Rights Comm'n, Compliance Guidelines To Prohibit Weight and Height Discrimination 5-6 (July 26, 2001), *available at* http://www.naafa.org/fatf/sf_height_weight_guidelines.pdf (targeting "professional appearance" and physical accessibility).

167. D.C. CODE § 2-1402.11(a) (2001).

168. Elizabeth Fernandez, *Exercising Her Right To Work: Fitness Instructor Wins Weight-Bias Fight*, S.F. CHRON., May 7, 2002, at A1.

169. *Id.*

170. Leah Garchik, *Room with a View*, S.F. CHRON., Feb. 8, 1995, at F8.

171. Only one weight discrimination suit has been brought. The suit, however, claimed insurance discrimination, not employment discrimination. Flecha de Lima v. Int'l Med. Group, Inc., No. 01CA6866, 2004 WL 2745654 (D.C. Super. Ct. Nov. 29, 2004). Part V addresses the issue of insurance discrimination.

goal of these ordinances and the District of Columbia statute, however, is to address appearance discrimination.

Weight discrimination and appearance discrimination are often treated as loosely synonymous.[172] Conceptually, however, weight discrimination is not a mere subset of appearance discrimination. Furthermore, policy considerations caution against treating the two as a single problem.

As discussed above,[173] weight discrimination requires both: (1) that being fat is considered a negative life outcome, and (2) that fat people are considered responsible for their weight. Appearance discrimination contributes to fatness being a negative life outcome. That alone, however, is not enough for weight discrimination; the victim must also be held personally responsible for her negative life outcome. To put it another way, you could eliminate weight discrimination—by eliminating the element of responsibility—without eliminating weight-based appearance discrimination.

Equally important, you can eliminate appearance discrimination without eliminating weight discrimination. Even without appearance discrimination, the negative health consequences alone would give people reason to blame fat people for being fat. Therefore, while eliminating weight-based appearance discrimination would reduce weight discrimination, it would not eliminate it.

In sum, eliminating appearance discrimination is neither necessary nor sufficient to eliminate weight discrimination. Moreover, for several policy reasons, we should not treat the two forms of discrimination as one.

First, appearance discrimination is a much more amorphous problem than weight discrimination; attractiveness itself is difficult to define. Appearance discrimination is also very broad; attractive people are preferred on almost all dimensions. Moreover, attractiveness discrimination is evolutionarily ingrained, whereas weight discrimination is not.[174] For all of these reasons, the law may have a better chance of eliminating weight discrimination than attractiveness discrimination. Therefore, it may be strategically wise to target weight discrimination outside the context of appearance discrimination.

Second, the moral cases for prohibiting appearance and weight discrimination have conflicting strengths and weaknesses. The best argument for appearance discrimination protection is that appearance is immutable. In

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172. *See, e.g.*, Elizabeth M. Adamitis, Note, *Appearance Matters: A Proposal To Prohibit Appearance Discrimination in Employment*, 75 WASH. L. REV. 195 (2000).

173. *See supra* Section II.B.

174. For the evolutionary explanation of the attractiveness bias, see KENNETH S. BORDENS & IRWAN A. HOROWITZ, SOCIAL PSYCHOLOGY 340 (2d ed. 2001). For arguments as to why weight discrimination is not based on evolutionary selection, see Puhl & Brownell, *supra* note 83, at 219-20.

fact, advocates usually base their argument explicitly on immutability.[175] If immutability is the governing rationale, weight discrimination looks less worthy of protection. At best, this just means that weight discrimination would not gain much protection. At worst, the application of appearance discrimination laws to protect weight could create an anti-fat backlash. As one advocate of appearance discrimination law exclaims, "Imagine the public outcry" if antidiscrimination law started protecting a mutable aspect of appearance.[176]

Conversely, the best argument for trying to eliminate weight discrimination is that it is uniquely personal. Unlike most forms of discrimination, weight discrimination ascribes moral blame and personal failure to its victims. As Solovay puts it: "Unlike biases against thin people perceived as unattractive, stereotypes of fat people tend to include character shortcomings . . . meaning [that] fat people [are] viewed not as only 'lacking' but also as 'responsible' for the prejudices held against them."[177] If this is the governing rationale, appearance discrimination looks less worthy of protection. Because of this tension between appearance and weight discrimination, it is strategically unwise for these two forms of discrimination to be treated under the same standard.

Thus, both theoretical and strategic reasons support targeting weight discrimination independently from appearance discrimination. As with the Title VII approach, there is nothing wrong with attacking different types of discrimination within one statute.[178] The danger is, however, that such a statute will fail to address the unique issues of weight discrimination and ultimately prove useless or counterproductive.

D. Effective Weight Discrimination Legislation

Fat-rights activists have rightly pointed out that weight discrimination is a harm without a remedy. There is no remedy because there is no legal theory. As the few existing weight discrimination laws show, it is not enough to just prohibit discrimination "on the basis of weight." These symbolic victories are

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175. *See, e.g.*, Karen Zakrzewski, Comment, *The Prevalence of "Look"ism in Hiring Decisions: How Federal Law Should Be Amended To Prevent Appearance Discrimination in the Workplace*, 7 U. PA. J. LAB. & EMP. L. 431 (2005).

176. *Id.* at 455.

177. SOLOVAY, *supra* note 78, at 102.

178. *See* KIRKLAND, *supra* note 9, at 134, 144-5 (arguing that a strength of the San Francisco law is that it does not choose between differing theories of discrimination). As the next Section argues, however, without a clear theory, no law can provide effective protection.

empty promises because nobody is really clear on what the laws prohibit. Furthermore, judges cannot simply import legal theories from other forms of discrimination.

To make antidiscrimination law work for fat people, legislators must specify what type of discrimination they aim to redress and tailor their standards accordingly. Specifically, the law must answer the question: what does it mean to discriminate "because of weight?" This was the major difficulty the *Lamoria* court faced. Ultimately, the court found that the discrimination had occurred "because of weight," but could not articulate a theory of discrimination or construct a standard of proof.[179] A useful anti-weight-discrimination law must fill this conceptual void.

This Part has surveyed several different dimensions of discrimination against fat people: disability, sex-plus, appearance, and weight discrimination. All involve weight. Each, however, operates under a different rationale and requires different legal standards. This Note has argued that weight discrimination is the primary source of discrimination against fat people. Therefore, weight discrimination ought to be the top priority for any employment antidiscrimination law aimed at protecting fat people.

V. A NEW FOCUS

Thus far, legal commentators have been trying to analogize weight discrimination to traditional forms of discrimination like race. The workplace is a familiar setting for such conflicts, so employment discrimination law is the natural focus of that inquiry. But what if instead of asking, "How can we make weight discrimination look more like race discrimination?" commentators started asking, "How can we make the greatest impact in reducing weight discrimination?" This Part argues that if we really care about improving the lives of fat people, we should focus on health care. Furthermore, remedying health care discrimination will require new and creative approaches to antidiscrimination protection. Section A will clarify the problem of health care discrimination. Section B will suggest solving the problem indirectly by increasing health care insurance coverage of obesity treatments. This Section will then analyze the problems with existing strategies for increasing insurance coverage and suggest an alternative solution.

179. 584 N.W.2d 589 (Mich. Ct. App. 1998), *adopted*, 593 N.W.2d 699, 701 (Mich. Ct. App. 1999).

A. Health Care Discrimination

Although employment discrimination has garnered more legal attention, fat people report experiencing discrimination from physicians more than from employers and supervisors.[180] Discrimination from physicians is one of the most prevalent types of stigmatizing situations that fat people suffer from.[181]

Likewise, fat people themselves say that health care discrimination is their top concern. As Anna Kirkland describes in a forthcoming article, *Revising Rights Across Contexts: Fat, Health, and Antidiscrimination Law*, what fat people really want is dignity in health care.[182] In a series of interviews about social justice, Kirkland found that health care discrimination was the most common type of experience that interviewees brought up when asked about "unfair treatment."[183] As one frustrated interviewee put it, "How can people claim to be so concerned about fat people's health . . . when some of the main problems faced by fat people are in access to [health] care in the first place?"[184] Kirkland's interviewees reaffirm survey data that health care discrimination is as prevalent, if not more prevalent, than employment discrimination.[185]

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180. Puhl & Brownell, *supra* note 2, at 1808. Physicians are the second most common source of discrimination. Among fat survey respondents, sixty-nine percent reported discrimination from a physician, and fifty-two percent reported experiencing such discrimination multiple times. In contrast, only forty-three percent of respondents reported experiencing discrimination from an employer or supervisor, and only twenty-six reported experiencing such discrimination multiple times. The question of which type of discrimination is more prevalent depends, of course, on how broadly one defines discrimination. The Puhl and Brownell study asked participants to rate the frequency of stigmatizing experiences and found stigmatization from doctors to be extremely prevalent. On the other hand, a different survey asked individuals to rate the frequency they had been "denied or provided inferior medical care" and found much less discrimination. Deborah Carr & Michael A. Friedman, *Is Obesity Stigmatizing? Body Weight, Perceived Discrimination, and Psychological Well-Being in the United States*, 46 J. HEALTH & SOC. BEHAV. 244, 248-52 (2005). This discrepancy reveals the interesting dynamic of health care discrimination. Even though fat people feel disrespected and stigmatized by their doctors, they cannot always point to specific denial of care. As the next Section discusses, the lack of a direct harm (other than dignitary harm) makes health care discrimination difficult to remedy by tort liability.

181. Puhl & Brownell, *supra* note 2, at 1806 (ranking "[i]nappropriate comments from doctors" as the fourth most common type of stigmatizing situation).

182. Anna Kirkland, *Revisiting Rights Across Contexts: Fat, Health, and Antidiscrimination Law*, STUD. L. & POL'Y & SOC'Y (forthcoming 2008) (manuscript at 15, on file with The Yale Law Journal).

183. *Id.*

184. *Id.*

185. *Id.* (manuscript at 16).

B. Cutting Edge: Insurance Coverage

Survey and interview evidence show that fat people are commonly mistreated within health care systems. Although there may be many forms of mistreatment, this Note focuses on discrimination by physicians against fat patients. Like employment discrimination, health care discrimination stems from the problem of causal misattribution. Despite their medical background, physicians share the same biases about fat people as the rest of the society.[186] Consequently, they mistreat their fat patients, denying them equal quality of care.[187] Although the problem of physician discrimination is simple enough, direct solutions are surprisingly unavailable.

One simple response would be to legally mandate equal quality of care. In the employment context, such antidiscrimination mandates are enforced through litigation. Differences between the employer-employee and physician-patient relationship, however, make this solution unworkable.

In the employment context, litigation works because there is a close relationship between the discrimination and a negative outcome (for example, loss of a job). This causal proximity makes it easier for victims to sue. In the health care context, however, the causal relationship between the physician's discrimination and an eventual adverse health outcome is extremely attenuated. One harm of physician discrimination, for example, is that it discourages future preventative care. Yet it would be difficult for a fat plaintiff to prove that physician discrimination prevented him from later seeking care, which then caused a negative health outcome. Thus, litigation against doctors is unlikely to stop physician mistreatment.

On the other hand, the unique relationship between physicians and patients also creates new opportunities for legal intervention. Unlike employers, physicians are actually supposed to be treating the patient's overweight or obesity. Yet, physicians systematically fail do so.[188] So fat patients face two problems; not only do physicians mistreat them personally, they also fail to treat their underlying disease.

The two problems are interrelated: treating obesity as a disease necessarily involves treating obese patients with respect and dignity. As the NIH guidelines direct, treating physicians must "communicate a nonjudgmental attitude that distinguishes between the weight problem and the patient with

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186. *See supra* notes 55-56 and accompanying text.

187. *See supra* notes 56-57 and accompanying text.

188. *See supra* notes 58-60 and accompanying text.

the problem."[189] So instead of punishing physicians for abusing fat patients, an alternative approach may be to support physicians for treating the disease of obesity.

One way of increasing treatment for obesity would be to fund greater physician education. With more education, physicians would be more willing and better equipped to treat obesity. Again, however, the nature of the physician-patient relationship makes this solution insufficient. Even if patients want treatment and physicians want to treat, both parties are under constraints from a third party intermediary: the health care insurance provider. As discussed above, private insurers often refuse to cover obesity-related treatments.[190] The lack of health insurance coverage imposes an economic restraint on obesity treatment. Consequently, providing greater insurance coverage for obesity treatment is the first step in increasing treatment of obesity and decreasing physician discrimination against fat patients.[191]

Thus far, two legal strategies for gaining insurance coverage have been attempted. First, litigants have challenged coverage exclusions under various federal and state antidiscrimination laws. Second, several states have passed specific mandates that require private insurance providers to cover obesity surgery.

Unfortunately, neither approach has been terribly successful. Both approaches ultimately run up against the same problem: what does it mean to provide equal access to health insurance? This is a broad question that haunts theories of insurance.[192] This Section argues that fat people can avoid this fundamental problem by demanding coverage only when it is medically necessary for the treatment of an otherwise covered condition. This rule could be implemented as part of a judicially constructed rule under existing antidiscrimination law or as a new legislative mandate.

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189. PRACTICAL GUIDE, *supra* note 20, at 30.

190. *See supra* notes 62-65 and accompanying text.

191. Today, health insurance coverage is already a central issue for obesity activist groups, such as the American Obesity Association. *See, e.g.*, Downey, *supra* note 62, at 142. Similarly, in an effort to help consumers obtain health insurance coverage, the state of New York has established an online consumer guide. N.Y. STATE DEP'T OF LAW HEALTH CARE BUREAU, FOCUS ON: OVERCOMING OBESITY (2004), *available at* http://www.oag.state.ny.us/press/2004/nov/nov28a_04_attach1.pdf. Legal commentators have also analyzed insurance coverage but only as a public health and policy problem. *See, e.g.*, Hinton, *supra* note 63; Deena Patel, *Are We Too Darned Fat? Trying To Prevent and Treat Obesity with Health Care Reform*, 8 QUINNIPIAC HEALTH L.J. 141 (2004).

192. *See, e.g.*, KIRKLAND, *supra* note 9, at 102, 123-24.

1. Health Care Antidiscrimination Lawsuits

One approach to gaining insurance coverage is to make the claim that denial of coverage constitutes discrimination. To date, there have been very few cases of patients suing for insurance coverage of obesity treatments under antidiscrimination law. All the cases involve denial of coverage for medically necessary gastric bypass surgery; none have been successful. The judicial opinions, however, give guidance as to what a successful theory might be.

In an early case, *Mullen v. Boyd Gaming Corp*, the plaintiff claimed discrimination under the ADA.[193] Specifically, the plaintiff argued that the insurance policy discriminated against the morbidly obese by not covering a procedure that is medically necessary only for that class. In an unpublished decision, the Fifth Circuit rejected this argument. While the ADA does cover insurance, it does not prohibit coverage distinctions that apply to both disabled and nondisabled patients.[194] A denial of coverage that applies to everyone is legal even if it has a disparate impact on disabled groups. The exclusion of gastric bypass surgery, the court argued, "is just such a distinction, as it applies to all who seek surgical or invasive treatment for weight, regardless of whether they are disabled."[195] In other words, nobody gets the treatment.

The Superior Court of the District of Columbia followed the same rationale in rejecting a weight discrimination claim under the District of Columbia Human Rights Act.[196] In an unpublished opinion in *Flecha de Lima v. International Medical Group, Inc.*, the district court reasoned that everyone is denied treatment for "[w]eight modification, or surgical treatment of obesity,"[197] so there is no discrimination—whether based on appearance or disability. The court noted, however, that a closer case would be presented if the insurance policy covered treatment for stomach cancer by means "of gastric bypass surgery for non-morbidly obese persons, but denied such treatment to morbidly obese persons . . . ."[198]

The problem with these cases is that they were framed as denial of obesity treatment, that is, treatment for the purpose of weight reduction.

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193. No. 98-30333, 1999 WL 423054 (5th Cir. June 2, 1999).

194. *Id.*

195. *Id.* at *1.

196. Flecha de Lima v. Int'l Med. Group, Inc., No. 01-6866, 2004 WL 2745654 (D.C. Super. Ct. Nov. 29, 2004). As noted earlier, this is the only case under the DCHRA that involves obesity. *See supra* note 171.

197. 2004 WL 2745654, at *3.

198. *Id.* at *7.

Antidiscrimination statutes like the ADA and the D.C. Human Rights Act do not require insurance companies to cover treatment just because it applies to a protected class. That argument has been tried unsuccessfully in similar contexts such as infertility treatment (ADA, Title VII),[199] AIDS treatment (ADA),[200] and contraception (Title VII).[201] Rather, antidiscrimination statutes require that whatever insurance companies cover, they must offer to all policyholders. Therefore, plaintiffs would do much better to frame their claim as a denial of coverage for an already-covered condition, such as hypertension.

The case that comes closest to articulating such a theory is *Cain v. Fortis Insurance Co.*[202] In this most recent (and only reported) insurance discrimination decision, plaintiff argued that she was denied gastric bypass surgery that was medically necessary to treat her hypertension and degenerative joint disease. The Supreme Court of South Dakota, however, still treated her claim as one of obesity treatment, not hypertension or joint disease treatment: "Cain has presented no evidence to suggest that she was denied surgical treatment *for obesity* while some favored class of persons was granted treatment *for obesity*."[203] Furthermore, the court ruled only on the state law claim under a vaguely worded insurance statute.[204] Thus, the only reported case on the issue skirts the best argument for protection.

The basic problem in insurance discrimination suits is that courts are reluctant to compare a class-specific disease to diseases more broadly. As the Seventh Circuit reasoned, to do so would require courts to "discriminate among diseases."[205] This kind of inquiry would invite "unprincipled distinction[s]."[206] The incommensurability between different diseases is why claims for coverage under antidiscrimination law have generally failed.

2. *Affirmative Mandate Approach*

An alternative approach to gaining protection is to simply mandate coverage through specific legislation. Between 1999 and 2001, four states

199. *See, e.g.*, Saks v. Franklin Covey Co., 316 F.3d 337 (2d Cir. 2003).

200. *See, e.g.*, Doe v. Mut. of Omaha Ins. Co., 179 F.3d 557 (7th Cir. 1999).

201. *See In re* Union Pac. R.R. Employment Practices Litig., 479 F.3d 936 (8th Cir. 2007).

202. 694 N.W.2d 709 (S.D. 2005).

203. *Id.* at 714 (emphasis added).

204. *Id.*

205. *Mut. of Omaha Ins. Co.*, 179 F.3d at 559.

206. *Id.* at 561.

passed laws encouraging or mandating insurance coverage of obesity treatments: Georgia, Indiana, Maryland, and Virginia.[207]

Currently, Georgia's statute is the broadest, extending to all "primary treatment of morbid obesity."[208] Unfortunately, Georgia does not go so far as to mandate coverage. Instead, the statute states that "[e]very health benefit policy . . . *may* offer coverage for the treatment of morbid obesity."[209]

The remaining three statutes do mandate coverage, but mainly for surgical treatment. Virginia's statute covers gastric bypass "or such *other methods* as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity."[210] In contrast, Maryland covers only surgical treatment.[211] Finally, Indiana covers only surgical treatment, and only under the following conditions: (1) morbid obesity has persisted for at least five years, and (2) nonsurgical, physician-supervised, treatment has been unsuccessful for at least six months.[212]

To date, limited evidence suggests that such laws have not actually increased coverage. Virginia is the only state to report insurance statistics before and after the mandate.[213] According to its numbers, insurance claims increased by less than one percent as a result of the law.[214] Correspondingly, insurance premiums did not increase much either.[215] It seems, therefore, that the law did not dramatically change the insurance market in Virginia. Furthermore, survey reports suggest that the mandates were ineffective because insurers simply imposed more restrictive requirements on the mandated coverage.[216] So even though more policies in Virginia may be offering coverage, policyholders are still being refused reimbursement.

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207. MORBID OBESITY ANTI-DISCRIMINATION ACT, GA. CODE ANN. § 33-24-59.7 (2005); IND. CODE § 27-8-14.1-4 (2008); MD. CODE ANN., INS. § 15-839 (LexisNexis 2006); VA. CODE ANN. § 38.2-3418.13 (2007). Interestingly, two states have also mandated coverage for state employees. IND. CODE § 5-10-8-7.7 (2008); VA. CODE ANN. § 2.2-2818 (2005).

208. GA. CODE ANN. § 33-24-59.7(b)(3) (2005).

209. *Id.* § 33-24-59.7(c)(2) (emphasis added).

210. VA. CODE ANN. § 38.2-3418.13 (2007) (emphasis added).

211. MD. CODE ANN., INS. § 15-839 (LexisNexis 2006).

212. IND. CODE § 27-8-14.1-4 (2008).

213. Vincent W. Vanek, *State Laws on Insurance Coverage for Bariatric Surgery: Help or a Hindrance?*, 1 SURGERY FOR OBESITY & RELATED DISEASES 424, 428 (2005).

214. *Id.* at 427 tbl.2.

215. *Id.*

216. *Id.* at 428.

The challenge in implementing a mandate, then, is to regulate the extent which insurers can restrict coverage. One solution to the problem would be to specify the exact conditions under which insurers must cover treatment. This solution, however, would be a radical departure from the general policy of deferring to physicians to make treatment decisions. Essentially, the state would be dictating the exact conditions under which fat patients can receive care.

A more flexible approach would be to incorporate a broad antidiscrimination standard. The Maryland and Virginia laws, for example, require that reimbursement for obesity surgery be no less favorable than for other surgeries[217] or treatment for physical illness in general.[218] The problem with this solution is that obesity surgery has completely different goals, costs, and risks than other treatments. As in the antidiscrimination context, courts would be faced with the problem of comparing different classes of disease.

3. An Improved Approach

In sum, neither of the two existing legal responses to insurance restrictions has been terribly successful. Although they approach the issue from very different perspectives, they share a common problem: both fail to define what constitutes fair or comparable coverage of obesity treatment.

Fat people nonetheless have a unique claim for coverage that may avoid this conceptual and practical difficulty. Fat people do not just suffer from obesity; they also suffer from all the same diseases as thin people. For these diseases, however, treatments that work for thin people do not necessarily work for fat people. In many cases, the only viable treatment for a fat person is to address the root cause: excess weight. Under the current regime, fat people pay for the same coverage but are denied treatments that work for them.

As medicine becomes increasingly specialized, doctors are increasingly able to tailor treatments to subgroups of patients. The newest hypertension research, for example, shows that African Americans and Caucasians, men and women, respond differently to drug therapy.[219] Given the same cost of treatment, insurance companies would have a difficult time defending the

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217. MD. CODE ANN., INS. § 15-839(d) (LexisNexis 2006).

218. VA. CODE ANN. § 38.2-3418.13(B) (2007).

219. *See, e.g.*, J.N. Bella et al., *Sex-Related Difference in Regression of Left Ventricular Hypertrophy with Antihypertensive Treatment: The LIFE Study*, 18 J. HUM. HYPERTENSION 411 (2004); Barry J. Materson, *Variability in Response to Antihypertensive Drug Treatment*, 43 HYPERTENSION 1166 (2004).

decision to cover only one treatment. The same is true for fat patients. Although fat patients have the same diseases as thin patients, their underlying physiology is different; they require different treatments.

Therefore, instead of asking courts to compare two disease classes (for example, obesity and cancer), fat patients should ask courts to compare two patients with the same disease (for example, a fat and thin patient who both have hypertension). The question then becomes: can insurance companies charge obese people for coverage of a disease but only offer treatments that save thin people? No court has answered this question, but this framing gives fat plaintiffs better theoretical ground than any previous class.

Similarly, this framing also provides the most workable standard for determining when insurance companies violate mandates to provide coverage. It is not empty to say that obesity treatments should be treated comparably to other types of treatments *for the same disease*. Therefore, an effective legislative mandate would require obesity treatment whenever medically necessary to treat an otherwise covered condition.

There remains the question of how to implement this new standard. One possibility is for judges to apply it under existing antidiscrimination law. As discussed above, no court has ruled on this theory of discrimination. Litigants testing this new theory might sue under either the ADA or the Health Insurance Portability and Accountability Act (HIPAA).

While the ADA is the more familiar regulation, the ADA strategy may be limited because it applies only to the morbidly obese. At best, the ADA could require coverage of gastric bypass surgery. Fat people, however, have a broader moral claim to insurance coverage of medical treatment.

Therefore, an alternative strategy might be to claim discrimination under HIPAA. HIPAA regulates the accessibility, portability, and renewability of health insurance. Specifically, the antidiscrimination provisions of HIPAA prohibit insurers from discriminating on the basis of "health status-related factors."[220] Weight and BMI are health factors. Like the ADA, HIPAA does not guarantee any particular benefit.[221] Rather, HIPAA requires that coverage "be uniformly available to all similarly situated individuals."[222] HIPAA has the

220. 29 U.S.C. § 1182(a)(1) (2000).

221. *Id.* § 1182(a)(2).

222. Nondiscrimination and Wellness Programs in Health Coverage in the Group Market, 71 Fed. Reg. 75,014, 75,014-15 (Dec. 13, 2006) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 146). By "similarly situated" individuals, the statute means that individuals of the same employment class (for example, full-time versus part-time) must have access to the same package of benefits. U.S. Dep't of Labor, FAQs About the HIPAA

advantage that it applies to discrimination based on "health status" and not just disability. Furthermore, HIPAA is specifically targeted toward health insurance rather than employment benefits and public accommodations in general. Therefore, future litigants could consider making claims under both the ADA and HIPAA.

Alternatively, the proposed rule could also be mandated through a federal amendment to the Employee Retirement Income Security Act of 1974 (ERISA).[223] The Mental Health Parity Act of 1996, for example, amended ERISA to require that insurers limit benefits for mental health only to the extent that they limit benefits for physical health.[224] An obesity mandate could take a similar approach by mandating that insurers limit obesity treatment only to the extent that they limit nonobesity treatments of the same disease. Ideally, a federal mandate would apply to obesity treatments broadly and not just gastric bypass surgery.

In sum, requiring obesity coverage whenever necessary to treat an otherwise covered condition would advance antidiscrimination principles and achieve the policy goal of expanding insurance. Expanded insurance coverage would, in turn, create incentives for doctors to actively treat overweight and obesity. Finally, greater medical attention to obesity would generate better treatment of fat patients.

CONCLUSION

Weight discrimination is a costly and pervasive problem. On moral and utilitarian grounds, society should take action to protect victims of weight discrimination. Current efforts to fit weight discrimination into existing antidiscrimination frameworks, however, are misguided. The psychological and social reality of weight discrimination calls for a new perspective.

Within the employment context, commentators and activists must first clarify their objective. Even fat-rights activists have not reached consensus on what rights are centrally at issue. Some focus on disability discrimination, others on sex and appearance discrimination. These types of discrimination, however, fail to capture the unique dimension of personal responsibility and

Nondiscrimination Requirements, http://www.dol.gov/ebsa/faqs/faq_hipaa_ND.html (last visited Apr. 12, 2008).

223. Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C.).

224. Pub. L. No. 104-204, 110 Stat. 2944 (1996) (codified as amended at 29 U.S.C. § 1185a and 42 U.S.C. § 300gg-5 (2000)).

blame. Weight discrimination is about ability, not attractiveness; it is about willpower, not physical power.

Because weight discrimination is distinct from disability, sex, or appearance discrimination, existing antidiscrimination statutes do not (and should not be construed to) cover weight discrimination. Furthermore, because weight discrimination is based on causal misattribution, existing legal standards for other types of discrimination cannot be directly applied to weight discrimination. Therefore, an effective weight discrimination statute must announce a new theory of discrimination and develop appropriate evidentiary standards for it.

More broadly, the current antidiscrimination strategy is misguided because it ignores health care discrimination. Discrimination by physicians is an omnipresent problem in the lives of fat people. Physicians, however, have a very different relationship to fat people than employers, one that is largely constrained by insurance providers. Therefore, instead of directly targeting the discriminators, a strategy to combat health care discrimination should start by expanding health care coverage of obesity treatments.