A HOUSE DIVIDED: THE INCOMPATIBLE POSITIONS OF THE CENTERS FOR DISEASE CONTROL AND THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION ON OBESITY AS A DISABILITY

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I. INTRODUCTION

The Centers for Disease Control and Prevention (CDC) is an arm of the Department of Health and Human Services, with a $10.8 billion budget for 2011 and approximately 10,400 employees. According to its website, the mission of the CDC is: “Collaborating to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.” One of the CDC’s highest priorities is combating the nation’s obesity problem, something the CDC refers to as an epidemic. Approximately one-third of Americans are obese, and even though the obesity rates for all age-ranges in America have risen unabated for many decades, the CDC still believes that the battle against obesity can be won. The centerpieces of the CDC’s arsenal against obesity are the

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promotions of increased physical activity and increased consumption of fruits, vegetables and other foods that are low in fats and sugars.\(^7\)

The Equal Employment Opportunity Commission (EEOC) was created by Title VII of the 1964 Civil Rights Act and its mission is to eliminate unlawful employment discrimination.\(^8\) One of the anti-discrimination laws the EEOC is empowered to administer is the Americans with Disabilities Act of 1990 (ADA),\(^9\) which was significantly amended by the Americans with Disabilities Act Amendments Act of 2008 (ADAAA).\(^10\)

While the question whether obesity is covered by the ADA has not been consistently answered by the federal courts, after the passage of the ADAAA the EEOC has taken an active role in asserting that obesity is a covered disability (including filing two noteworthy lawsuits against employers, alleging obesity discrimination). The difficulty with the EEOC’s stance is that it disregards the reality that obesity presents in the workplace, one of ever-burgeoning healthcare and other employment costs that are unsustainable. It is also a stance that is antipathetic to the CDC’s evermore urgent attempts to alter the direction of the obesity trend line.

This article will examine the obesity epidemic, including its causes and costs in the workplace, and explore the dichotomy between the CDC and the EEOC, as it relates to obesity in America. Furthermore, the article will recommend that despite the enlarged scope of disability coverage intended by the ADAAA, if the CDC has any chance to win the obesity battle, the EEOC needs to be a noninterventionist, unless an employee’s obesity is the direct result of a naturally occurring medical condition. The courts and the EEOC took that approach with respect to smoking as a disability, and the disinclination had positive effects toward reducing smoking.

\textbf{II. EEOC V. RESOURCES FOR HUMAN DEVELOPMENT: A TEST CASE IN DISABILITY DISCRIMINATION BASED ON OBESITY}

At the time of her death in 2009 at the age of 48, Lisa Harrison likely had a Body Mass Index (BMI) of ninety-six, which is over three times higher than would qualify as obese. At five feet two inches tall, Ms. Harrison’s


weight through adulthood ranged from 400-527 pounds, something her sister attributed to using food as a source of comfort. Two years before her death, Ms. Harrison was fired from her job at Family House Louisiana, a long-term residential facility for drug addicted women and their children. According Ms. Harrison’s sister, Family House Louisiana fired Harrison—who had been employed at Family House for nine years and who worked with the children residing at Family House—because it was concerned that in her condition she would be unable to perform cardio pulmonary resuscitation in the event of an emergency. Believing she was unlawfully discriminated against because of her weight, Ms. Harrison filed a complaint with the Equal Employment Opportunity Commission (hereafter EEOC). A series of negotiations between her and Family House’s parent organization in Philadelphia, PA, Resources for Human Development, Inc., ended after her death.

But in 2010, the Equal Employment Opportunity Commission (EEOC) filed a federal suit in the Eastern District of Louisiana on behalf of the estate of Ms. Harrison. The lawsuit is one of only a few cases the EEOC has filed

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13 Id. She died in a hospital after having admitted herself for what her family thought at the time may have been due to gall stones or a blood clot.
15 CDC Organization, supra note 1.
16 See Res. for Human Dev., Inc., No. 10-3322. In its press release announcing the lawsuit, the director of the New Orleans EEOC office announced, “This is a classic case of disability bias, based on myths and stereotypes. The evidence shows that Ms. Harrison was a good and dedicated employee who did not deserve to be fired. All covered employers, whether for-profit or non-profit, must abide by the ADA’s provisions.” The EEOC attorney in charge of litigation in Louisiana provided the following for the press release: “The filing of this suit sends a strong message to employers that they cannot fire disabled employees based on perceptions and prejudice. Ms. Harrison’s obesity did not interfere with the care she provided to young children. Those children deserved better from her employer just as she did. The EEOC will continue to scrutinize situations like this very closely, and to file suit where necessary to enforce the ADA. That extends to unfortunate circumstances, like those here, where the fired employee has subsequently died.” EEOC Sues Resources for Human Development, Inc., for Disability Discrimination, U.S. EQUAL EMP. OPPORTUNITY COMMISSION (Sept. 30, 2010), http://www.eeoc.gov/eeoc/newsroom/release/9-30-10u.cfm. The EEOC brought another publicized suit against an employer, alleging disability discrimination based on obesity, when it filed an ADA claim against military vehicle manufacturer BEA Systems in September 2011, on behalf of Ronald Kraz II. Kraz had worked for BEA Systems in Houston, Texas, for 16 years, and weighed between 450 and 680 pounds during that time, but was fired in 2009. L.M. Sixel, Man Fired at 680 Pounds Says Weight Didn’t Hurt His Work, HOUS. CHRONICLE (Sept. 29, 2011), http://www.chron.com/default/article/Man-fired-at-680-pounds-says-weight-didn-t-hurt-2193407.php.
in which it alleged that obesity, itself, (rather than an impairment associated with obesity) is a disability under the ADA.\textsuperscript{17} Although the alleged wrongful conduct occurred before enactment of the ADAAA\textsuperscript{18} and is, therefore, a case not brought under the ADAAA’s provisions, the suit seems to be a response to the ADAAA’s stated desire that the broad scope of protection intended by the ADA be “reinstated.”\textsuperscript{19}

In its answer, Resources for Human Development responded by claiming that the EEOC missed the statute of limitations, as well as failed to state a claim upon which relief may be granted.\textsuperscript{20} Concerning the accusation in the EEOC’s complaint, the answer claims that Resources for Human Development had a “legitimate, non-discriminatory reason” for releasing Ms. Harrison. In regard to the former employee, the answer states she was neither a qualified individual with a disability under the ADA, nor that it regarded her as such.\textsuperscript{21}

On December 6, 2011, the U.S. District Court denied two motions for summary judgment filed by Resources for Human Development.\textsuperscript{22} In its Order, the Court disagreed with the defendant’s argument that the EEOC’s own regulations exclude obesity as a disability and instead concluded that severe obesity qualified as a disability under the ADA.\textsuperscript{23} Furthermore, the Court concluded that there was no requirement that an obese person establish an underlying physiological basis for such a condition.\textsuperscript{24}

\section*{III. The Americans with Disabilities Act Amendments Act of 2008: A Lesson in Checks and Balances}

Passed in 2008,\textsuperscript{25} the Americans with Disabilities Act Amendments Act\textsuperscript{26} was an explicit knuckle-rap on the United States Supreme Court.

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\textsuperscript{18} Jan. 1, 2009.
\textsuperscript{20} Answer, EEOC v. Res. for Human Dev., Inc., No. 10-3322 (E.D. La. Nov. 30, 2010).
\textsuperscript{21} Id. Resources for Human Development also asked for attorney’s fees, on the basis that the lawsuit was filed without merit and with the sole intent of harassment.
\textsuperscript{22} EEOC v. Res. for Human Dev., Inc., No. 10-3322 (E.D. La. Dec. 6, 2011).
\textsuperscript{23} Id.
\textsuperscript{24} Id. Summarily, the Court believed that there was a genuine issue of material fact to be litigated, namely why Ms. Harrison was fired: either she was fired because Resources for Human Development regarded her as being disabled due to her obesity, or because her obesity limited her job performance.
\textsuperscript{25} President George W. Bush signed the unanimously-passed ADAAA into law on September 25, 2008, and it went into effect January 1, 2009.
\textsuperscript{26} Later codified at 42 U.S.C.A. §§ 12101-12213.
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Having observed from the sidelines while the Court’s interpretation of the original Americans with Disabilities Act of 1990 narrowed the scope of the law’s coverage and application, Congress made its displeasure known in the ADAAA’s opening sentence: “An Act to restore the intent and protections of the Americans with Disabilities Act of 1990.” 27 But the reproach did not end there. Section 2(b) of the ADAAA lists two Supreme Court ADA cases that Congress expressly rejected in the revised statute: *Sutton v. United Air Lines, Inc.*, and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams.* 28 In Section 2(b)(3) of the ADAAA, Congress expressed its desire that the ADAAA “reinstate the reasoning of the Supreme Court in *School Board of Nassau County v. Arline*, 29 which set forth a broad view of the third prong of the definition of handicap under the Rehabilitation Act of 1973.” 30

The original Americans with Disabilities Act began with a prologue that “some 43,000,000 million Americans have one or more physical or mental disabilities and this number is increasing as the population as a whole is growing older.” 31 That language was removed in the Americans with Disabilities Act Amendments Act, along with other precatory language from the ADA, including that:

> [I]ndividuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society. 32

The definition of a disability in the ADAAA still retains its prior version’s three-pronged approach: “A) a physical or mental impairment that substantially limits one or more major life activities of such individual; B) a record of such impairment; or C) being regarded as having such

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28 Id. See 527 U.S. 471 (1999); 534 U.S. 184 (2002).
32 Id.
impairment.”33 But the third part of that prong now references a new portion of the statute that establishes what it means to be regarded as having such impairment. It states:

An individual meets the requirement of ‘being regarded as having such an impairment’ if the individual establishes that he or she has been subjected to an action prohibited under this Act because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.34

The ADAAA addresses what would substantially limit a disabled person’s major life activities in another new section,35 which states, “major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.” As it concerns the role that bodily functions play in one’s major life activities, the ADAAA provides that, “a major life activity also includes the operation of major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.”36

In furtherance of its stated desire that the ADAAA be liberally construed, Congress provided rules of construction on the definition of “disability” in a later section:

The definition of “disability” in paragraph (1) shall be construed in accordance with the following:

(A) The definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter, to the maximum extent permitted by the terms of this chapter.

(B) The term “substantially limits” shall be interpreted consistently with the findings and purposes of the ADA Amendments Act of 2008.

33 42 U.S.C.A. § 12102(1) (West 2009). In the ADA of 1990, this was paragraph 2.
34 Id. at § 12102(3)(A).
35 Id. at § 12102(2)(A).
36 Id. at § 12102(2)(B).
(C) An impairment that substantially limits one major life activity need not limit other major life activities in order to be considered a disability.

(D) An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.

(E)(i) The determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as--

(I) Medication, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies;
(II) Use of assistive technology;
(III) Reasonable accommodations or auxiliary aids or services; or
(IV) Learned behavioral or adaptive neurological modifications. 37

IV. THE BACK STORY TO THE AMERICANS WITH DISABILITIES ACT AMENDMENTS ACT OF 2008; WHAT HAPPENED IN THE INTERVENING EIGHTEEN YEARS

Congress expressed its displeasure not only with the U.S. Supreme Court in the ADAAA, but also the EEOC. In addition to rejecting the Supreme Court’s decisions in *Sutton v. United Air Lines, Inc.* and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams,* 38 Congress twice chided the EEOC. First, in its Public Law Findings section, it spoke to the EEOC’s definition of “substantially limits,” stating that the Commission’s “ADA regulations defining the term ‘substantially limits’ as ‘significantly restricted’ are inconsistent with congressional intent, by expressing too high a standard.” 39 Yet, the EEOC’s then-current regulations were a response to

37 *Id.* at § 12102(4).
39 Americans with Disabilities Act Amendments Act of 2008 § 2(a)(8). Later in its Purposes portion of the Public Law version, Congress signified its “expectation that the Equal Employment Opportunity Commission will revise that portion of its current regulations that
Supreme Court precedent that criticized the EEOC’s earlier interpretation of the ADA, particularly *Sutton v. United Airlines, Inc.*, and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*.

**A. Sutton v. United Airlines, Inc.**

In *Sutton v United Airlines, Inc.*, twin sisters with severe myopia who were commercial pilots with a regional airline applied to be commercial pilots for United Airlines. At their interviews, they were both told that despite meeting all other application requirements, a mistake had been made in inviting them because their uncorrected vision was worse than the 20/100 allowed for United Airline pilots. With corrective lenses, however, each woman had a vision of 20/20. The sisters sued United Airlines for wrongful employment discrimination under the Americans with Disabilities Act, but their complaint was dismissed for failure to state a claim upon which relief can be granted, and this decision was upheld by the Tenth Circuit Court of Appeals. In so doing, the Tenth Circuit concluded that the sisters could not be “substantially limited” in a major life activity, when taking their corrective lenses into account, nor could they show (for defeating a motion to dismiss) that United Airlines “regarded” them as substantially limited.

Acknowledging the split among the federal circuits on the relationship between corrective measures and the substantially limited language of the ADA, the Supreme Court followed the Tenth Circuit’s line of reasoning. A critical part in *Sutton* was the Court’s rejection of the EEOC interpretive guidelines for its regulations that implement the ADA, specifying that mitigating measures should not be considered in determining if one has an impairment or if such an impairment substantially limits a major life activity found in *Sutton*. The Court focused on the language in *Sutton* defining the term ‘substantially limits’ as ‘significantly restricted’ to be consistent with this Act, including the amendments made by this Act.” See Americans with Disabilities Act Amendments Act of 2008 § 2(b)(6).

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41 Both sisters had uncorrected left-eye vision of 20/200 or worse, and uncorrected right-eye vision of 20/400 or worse.
43 *Sutton v. United Airlines, Inc.*, 130 F.3d 893 (10th Cir. 1997).
44 *Id.* at 906.
45 See Bartlett v. N. Y. State Bd. of Law Exam’rs, 156 F.3d 321, 329 (2d Cir. 1998); Baert v. Euclid Beverage, Ltd., 149 F.3d 626 (7th Cir., 1998); Matczak v. Frankford Candy & Chocolate Co., 136 F.3d 933 (3d Cir. 1997); Arnold v. United Parcel Serv., Inc., 136 F.3d 854 (1st Cir. 1998); Washington v. HCA Health Servs. of Texas, Inc., 152 F.3d 464 (5th Cir. 1998).
activity. Finding that the plain meaning of the term “substantially limits,” is a present-tense notion, the majority—in an opinion written by Justice O’Connor—thought the EEOC’s view that mitigating measures may not be considered in the disability-determination was unreasonable and counter to the ADA’s text.49

Justice Stevens dissented, citing the Senate’s and the House of Representative’s Reports, in finding that the legislative history of the ADA showed that Congress intended its disability anti-discrimination coverage to apply to those with impairments, regardless if they are in an corrected or mitigated state.50 But to the majority, the language of the statute was clear and not in need of the influence of legislative history.51 Furthermore, to the majority, the congressional findings at the beginning of the ADA that “some 43,000,000 Americans have one or more physical or mental disabilities…” was essential to its stance that Congress expressed its intent clearly enough in the ADA.52 Following Sutton v. United Airlines, Inc., the EEOC removed the mitigating measures language concerning impairments and substantial limitations from its Appendix accompanying its ADA regulations.53 In 2011, the EEOC revised its ADA-Appendix again, this time to acknowledge the changes made by the ADAAA and the congressional dissatisfaction of cases like Sutton and Toyota Motor Manufacturing.54 A new regulation was issued that, “[t]he determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures.”55 Nine years after Sutton, Congress redacted the “43,000,000 Americans” sentence from its findings in the ADAAA.

B. Toyota Motor Manufacturing, Kentucky, Inc. v. Williams

Unlike the plaintiffs in Sutton who sued a prospective employer for wrongful employment discrimination, the plaintiff in Toyota Motor

49 Id.
50 Id. at 500-01.
51 Id. at 482.
52 Id. at 484. According to Justice O’Connor, that amount was drawn from a report prepared by the National Council on Disabilities, which also listed in the same report a disability population as high as 160 million based on an approach referred to as “nonfunctional” (See id. at 486-487). Such a measure of disability was also referred to in Sutton as the health conditions approach. Therefore, the usage of such a number when there were larger disability numbers available showed Congress’s intent that the ADA was limited to disabled Americans without mitigated or corrective measures.
Manufacturing, Kentucky, Inc. v. Williams\textsuperscript{56} sued her former employer for violating the ADA. Ella Williams began working in 1990 at a Toyota assembly plant in Kentucky and developed carpal tunnel syndrome. She was then assigned to modified duties, although she later filed a workers compensation claim, which was settled in 1992. Unsatisfied with Toyota’s response to her condition, she filed an ADA claim that was settled in 1993, whereupon she returned to work.\textsuperscript{57} In 1996, Ms. Williams’ duties at Toyota were changed and her new job required her to hold her arms above her shoulders for hours at a time. Although she and Toyota disagreed over what caused her to miss work after this change in her duties, Toyota fired her in 1997 for excessive absenteeism. She then sued, alleging Toyota violated the ADA by failing to reasonably accommodate her.\textsuperscript{58} Her disability suit was based on her claimed inability to perform certain manual tasks, which she said substantially limited a major life activity.

The District Court granted summary judgment to Toyota, but the Sixth Circuit Court of Appeals reversed.\textsuperscript{59} Using what it believed to be the reasoning in \textit{Sutton}, the Sixth Circuit held that in order to prove a substantial limitation in the major life activity of performing manual tasks, a “plaintiff must show that her manual disability involves a ‘class’ of manual activities,” and also that such activities affect the ability to perform tasks at work.\textsuperscript{60} It did, however, agree with the District Court that Ms. Williams had no wrongful termination claim because since she was completely restricted from working, she could not be a “qualified individual with a disability” within the meaning of the ADA.\textsuperscript{61}

A unanimous Supreme Court reversed the Sixth Circuit Court of Appeals.\textsuperscript{62} In an opinion also written by Justice O’Connor, the Court concluded the Sixth Circuit did not apply the proper standard in determining that respondent was disabled under the ADA, because it analyzed only a limited class of manual tasks and failed to analyze whether Ms. Williams’ impairments prevented or restricted her from performing tasks that are of central importance to most people’s daily lives.\textsuperscript{63} As the depositions showed, at the time Ms. Williams was claiming to be disabled for the purposes of the manual job-tasks at issue, she was able to perform many tasks associated with daily life.

\textsuperscript{56} 534 U.S. 184 (2002).
\textsuperscript{57} \textit{Id.} at 188.
\textsuperscript{58} \textit{Id.}, at 190.
\textsuperscript{59} Williams v. Toyota Motor Mfg., Kentucky, Inc., 224 F.3d 840 (6th Cir. 2000).
\textsuperscript{60} \textit{Id.} at 843.
\textsuperscript{61} \textit{Id.} at 844.
\textsuperscript{63} \textit{Id.} at 198.
And in a sentence that would catch the ire of a later congressional bill, the Court wrote that terms like “major” in major life activities, and “substantial” in substantially limits, “need to be interpreted strictly to create a demanding standard for qualifying as disabled is confirmed by the first section of the ADA, which lays out the legislative findings and purposes that motivate the Act.”

The Court also ruled that for an impairment to substantially limit a person’s ability to perform manual tasks, the impairment must be permanent or long-term. In so stating, the Court cited the EEOC’s regulation that—at the time—defined what “substantially limits” means. That regulation stated, “The following factors should be considered in determining whether an individual is substantially limited in a major life activity:

(i) The nature and severity of the impairment;
(ii) The duration or expected duration of the impairment; and
(iii) The permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.

In response to the congressional directive of the ADAAA, the EEOC revised its ADA regulations in 2011, removing the above language. In its place are regulations stating that “[t]he term ‘substantially limits’ shall be construed broadly in favor of expansive coverage, to the maximum extent permitted by the terms of the ADA. ‘Substantially limits’ is not meant to be a demanding standard.” The new regulations also provide that episodic impairments are covered by the ADA if considered substantially limiting when active, and that, “[a]n impairment that substantially limits one major life activity need not substantially limit other major life activities in order to be considered a substantially limiting impairment.”


On July 26, 2007, House Resolution 3195 was introduced and, as it stated forthrightly, was a “Bill to restore the intent and protections of the

64 Id. at 201-02.
66 See Toyota Motor Mfg., 534 U.S. at 197.
67 Id.
69 Id.
70 29 C.F.R. § 1630.2(j) (2011).
Americans with Disabilities Act of 1990.” Like the opening of the ADAAA of 2008, H.R. 3195 contained the similar invective against post-ADA Supreme Court decisions. Beyond *Sutton* and *Toyota*, H.R. 3195 cited other Supreme Court cases that “have narrowed the class of people who can invoke the protection from discrimination the ADA provides,” including *Murphy v. United Parcel Service, Inc.*, and *Albertson’s, Inc. v. Kirkingburg*.\(^7\)

In *Murphy*, a UPS mechanic, whose job required that he drive commercial vehicles, had blood pressure that exceeded the Department of Transportation’s (DOT) allowance for commercial drivers, but was erroneously certified by UPS when he was hired. When UPS discovered the error, it fired the mechanic, who then brought an ADA claim. In upholding the lower courts’ dismissal, the Supreme Court held that the mechanic was not regarded as disabled, but was unqualified to drive because of valid DOT safety regulations.\(^7\) The Court also reiterated its rationale from *Sutton* that the determination whether one is disabled must be considered in light of available mitigating circumstances,\(^7\) which in this case was high-blood pressure medication that, when taken, still did not bring down the plaintiff’s high-blood pressure sufficiently to allow him to drive a commercial vehicle.

*Albertson’s, Inc.*, was decided the same day as *Murphy* and also involved a commercial driver erroneously certified to drive a commercial vehicle, in this instance due to vision impairment. As in *Murphy*, the plaintiff was erroneously certified to drive and then fired after the error was discovered two years later. Albertson’s also refused the driver after he obtained a DOT waiver. In its unanimous decision, the Court reversed the Ninth Circuit Court of Appeals, reminding the Ninth Circuit that that mitigating measures need to be considered when analyzing if an impairment

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76 527 U.S. 516 (1999). This decision was written by Justice O’Connor.


78 527 U.S. at 522.

79 Id. at 521.
rises to the level of being substantially limiting, and that an ADA-qualified disability must be determined on a case-by-case basis, not reflexively.

The substance of the ADA Restoration Act of 2007 was similar to that in the ADAAA of 2008. It had a rule of construction declaring that a physical or mental impairment should be determined, “without considering the impact of any mitigating measures the individual may or may not be using or whether or not any manifestations of an impairment are episodic, in remission, or latent.” It also required that the provisions of the ADA Restoration Act be “broadly construed to advance their remedial purpose.”

V. OBESITY: THE SLOWEST-MOVING EPIDEMIC

Unlike the rapidity with which traditional epidemics (such as the bubonic plague of the 14th century or the Spanish Influenza of the early 20th century) traverse a country rendering it impossible to prevent or avoid, the obesity plague has had a slow-moving and still inexorable result. Those who are obese, and particularly those who are morbidly obese, face an all too familiar fate: loss of quality of life on the way to a high rate of premature mortality.

A. What it Means to be Obese

Obesity is nothing more than a large imbalance of the intake of calories versus calories burnt, resulting in excess body fat. Although once thought of as a cosmetic issue, obesity was classified as a chronic disease in 1985. As far back as the 17th and 18th centuries, some doctors considered

80 Id. at 565.
81 527 U.S. at 566.
83 ADA Restoration Act of 2007, supra note 75, at § 7. According to Representatives Hoyer and Sensenbrenner, as a result of negotiations between various representatives of the business and disability communities on a compromise to H.R. 3195, it was reintroduced in a substituted form in 2008 (See Joint Statement of Representatives Hoyer and Sensenbrenner, supra note 82). On the same day, a similar piece of legislation, S 3406, was jointly introduced in the Senate by Senators Tom Harkin and Arlen Specter (See Sensenbrenner Introduces Legislation to Restore Americans with Disabilities Act Protections, CONGRESSMAN JIM SENSENBRENNER (July 26, 2007), http://sensenbrenner.house.gov/News/DocumentSingle.aspx?DocumentID=70108. It was that legislation that was eventually passed unanimously as the Americans with Disabilities Act Amendments Act of 2008.
“corpulency” a disease.\textsuperscript{86} Body Mass Index (BMI) determines whether one has a healthy weight or is overweight. That number is the result of a calculation of one’s weight in kilograms divided by the square of one’s height in meters.\textsuperscript{87} In 1998 the National Institutes of Health revised its BMI standards, resulting in a stricter determination when one qualifies as overweight.\textsuperscript{88} As a result of that controversial reclassification, twenty-five million more Americans qualified as overweight.\textsuperscript{89}

Being overweight is thought of as having a Body Mass Index (BMI) of at least twenty-five.\textsuperscript{90} Obesity is generally defined by having a BMI of between 30-34.99, while severe obesity—sometimes referred to as Class II obesity—is having a BMI between 35-39.99.\textsuperscript{91} Class III obesity is generally thought to be a BMI of at least forty, and is also known as morbid obesity, a term alternately used when one weighs at least 100lbs above their ideal body weight.\textsuperscript{92} Class IV obesity is called super obesity, and applies when one’s BMI is at least fifty.\textsuperscript{93}

Not all health experts agree with labeling obesity as a disease,\textsuperscript{94} while some in the self-proclaimed “acceptance” groups argue that obesity is not necessarily unhealthy, in and of itself, but is pushed as a disease by anti-fat

\textsuperscript{86} Five centuries ago, English physician Thomas Sydenham said, “corpulency may be ranked amongst the diseases arising from original imperfections in the functions of some of the organs, yet it must be admitted also, to be most intimately connected with our habits of life.” WILLIAM WADD, CURSORY REMARKS ON CORPULENCE: OR OBESITY AS CONSIDERED A DISEASE 75 (London, Smith & Davy, 3d ed. 1816). See David Haslam, Obesity: A Medical History, 8 Obes. Rev. (Supp. 1) 31, 33 (2007).

\textsuperscript{87} Amy Berrington de Gonzalez, Body-Mass Index and Mortality Among 1.46 Million White Adults, 363 NEW ENGL. J. MED., 2211, 2212 (2010).


\textsuperscript{89} Id.


\textsuperscript{91} Christopher J. Ruhm, Current and Future Prevalence of Obesity and Severe Obesity in the United States, 10 Forum for Health Econ. & Pol’y. (Forums) Article 6 (2007).


\textsuperscript{94} Allison, supra note 84.
biased physicians.\textsuperscript{95} In 2008, a panel commissioned by The Obesity Society wrestled with the question of whether obesity is a disease and concluded that the question was so ill-founded (due to a lack of widely accepted clarity on what a disease actually is) as to not beget an answer.\textsuperscript{96} The panel did reach consensus that obesity should be considered as a disease, in order to reap positive gains in dealing with the obesity epidemic.\textsuperscript{97}

The Centers for Disease Control and Prevention (CDC) would like to see all states have an obesity rate of 15%,\textsuperscript{98} a percentage that none have achieved since 1980 when all the states had obesity rates below 15%.\textsuperscript{99} According to the CDC, as of 2009 Colorado had the lowest adult obesity rate (18.6%), and Mississippi the highest (34.4%).\textsuperscript{100} At that time, thirty-three states had at least 25% of their populace who were obese.\textsuperscript{101} By 2010, Colorado was the only state with an adult obesity rate under 20%, but it had increased to 19.8%, while forty-one states had at least 25% of their populace who were obese.\textsuperscript{102} But in July 2011, the CDC released its latest obesity-data, drawn from a survey of over 400,000 adults, and it showed that Colorado’s obesity rate was no longer under 20%, but was 21%.\textsuperscript{103} The 2011 information also showed that thirty-six states experienced a 25% increase in their obesity rates over the prior year.\textsuperscript{104} Some clinicians believe BMI is too loose a definer of obesity, in that it aggregates two data pieces without taking


\textsuperscript{96} Allison, \textit{supra} note 84.

\textsuperscript{97} \textit{Id.}


\textsuperscript{101} \textit{Id.}


into consideration other factors, such as percentage of body fat.\textsuperscript{105} For example, one might have a BMI that is over twenty-five (or even thirty, qualifying as obese) and yet be healthy with a very low body fat percentage.\textsuperscript{106}

B. The Life Cycle and Trend of Obesity

Obesity has at least one characteristic that qualifies it for the epidemic label: it is no respecter of age groups. According to a 2011 report issued by the Institute of Medicine, almost one in ten American babies is overweight,\textsuperscript{107} and a little over 20% of them are either overweight or obese.\textsuperscript{108} An alarming percentage of American school-aged children are overweight or obese, a trend that has ominously increased. In 1980, the prevalence of childhood obesity was 6.8%; but by 2008, it was 19.6%.\textsuperscript{109} During that same time period, adolescent obesity went from 5.0% to 18.1%.\textsuperscript{110} Whether or not


\textsuperscript{106} Id. That is the case for those athletes who have considerable muscle tissue, which is denser than fatty tissue. BMI may be less effective in assessing a person’s healthy weight, in light of its inability—as a basic calculation—to measure lifestyle factors that might contradict the conclusion that one is overweight or obese. But as a macro-measure of unhealthy weight, it has proven to be effective.


\textsuperscript{108} For those aged 2-19, the CDC defines overweight as a BMI at or above the 85\textsuperscript{th} percentile and lower than the 95\textsuperscript{th} percentile for children of the same age and sex, and it defines obesity as a BMI at or above the 95\textsuperscript{th} percentile for those of the same age and sex. \textit{Basics About Childhood Obesity}, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/obesity/childhood/basics.html (last updated Apr. 26, 2011).

\textsuperscript{109} \textit{Childhood Obesity Facts}, supra note 84.

\textsuperscript{110} Cynthia L. Ogden et al. \textit{Prevalence of High Body Mass Index in US Children and Adolescents, 2007-2008}, 303 JAMA 242, 245-246 (2010). (Adolescents are those from 12-19 years old.) A 2001 cross-sectional, self-reported survey of 137,593 children from the ages of 10-16, across 34 primarily European countries, showed the prevalence of obesity among American children to be second at 6.8%, with only Malta having a higher obesity rate. See Ian Jansen, \textit{Comparison of Overweight and Obesity Prevalence in School-Aged Youth in 34 Countries and Their Relationships with Physical Activity and Dietary Patterns}, 6 Obes. Rev. 123 (2005). According to the work of Dr. David Freedman from the Centers for Disease Control and Prevention (who examined data from the largest study of heart disease factors in the United States), 2 out of 3 obese children will grow up to be obese (See Laura Blue, \textit{Do Obese Kids Become Obese Adults?}, \textit{TIME MAGAZINE} (Apr. 28, 2008), http://www.time.com/time/health/article/0,8599,1735638,00.html), and if they become parents, they are more likely to have obese children (See Robert Whitaker, \textit{Predicting Obesity in Young Adulthood from Childhood and Parental Obesity}, 337 NEW ENGL. J. MED. 869 (1997)).
obesity is predetermined, either way, overweight parents pass on obesity to their children – as a learned habit or as a biological bequest.

The percentage of American college students who are overweight or obese has also increased noticeably. According to one study that collected data in 1993 and 1999, the rate of overweight college students increased from 21.7% to 26.8%, while the rate of obesity rose from 4.1% to 6.5%. Class II Obesity (defined as those with a BMI of 35-39.99) increased from 0.9% to 1.9%. As the study showed, every class—from freshman to fifth-year seniors—had markedly increased in weight over the seven-year time-span.

Adult overweight and obesity rates have also dramatically increased in recent decades. Between 2007 and 2009, the number of obese adult Americans increased by 2.74 million people. According to the CDC, between 1960-1962, 44.8% of American adults (age 20-74) were overweight (having a BMI of at least twenty-five), while in 1999-2002, the percentage had increased to 65.2%. Obesity rates have increased more noticeably over that time period. Obesity (a BMI of at least thirty) in American adults was 13.3% during 1960-1962, but by 1999-2002, obesity had almost tripled to 31.1%.

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112 The rate of obesity among American teenagers has risen dramatically, so much so that the U.S. Army has been recruiting from an ever-heavier pool of prospective soldiers from 1993-2006, the prevalence of overweight 18-year-old civilian applicants to the Army increased from 22.8% to 27.1%. For this study, the researchers looked at the data of 759,269 subjects, collected at the Military Entrance Processing Stations (MEPS), as part of the administrative intake for applicants to the Army. More alarming is that obesity among those Army applicants increased from 2.8% to 6.8% during that period, a 240% increase. (See Lucy L. Hsu, *Trends in Overweight and Obesity Among 18-year-old Applicants to the United States Military, 1993-2006*, 41 J. ADOLESCENT HEALTH 610 (2007)).
114 See id. The data for this survey were collected from 119 four-year colleges or universities with data in both the 1993 and 1999 Harvard School of Public Health College Alcohol Study. Male students were more likely than female students to be overweight and obese, with African-American and Hispanic males having the highest rates.
115 See id. The freshmen obesity rate went from 3.1 to 5.2, while their morbid obesity (Class II) rate went from 0.7 to 1.7. Obesity rates continued to worsen as students matriculated and by the time the last class of fifth-year seniors was heading to the working world, their obesity rate was 5.7 in 1993, but nearly doubled to 10.9 in 1999. For those same college seniors, their Class II obesity rate moved from 1.2 to 3.7, the second-highest rate increase. According to the study, sophomores had the highest rate increase for Class II obesity: 0.8 to 2.5.
116 Vital Signs Adult Obesity, supra note 98.
118 See id. A study that investigated obesity prevalence during 2007-2008 concluded that the age-adjusted prevalence of adult obesity in America was 33.8%, with men having a prevalence of 32.2% and women a prevalence of 35.5%. See Katherine M. Flegal et al., *Prevalence and
researchers who looked at obesity data from 1970-2004 estimated that by 2030, 86.3% of American adults will be overweight or obese. Without a change of direction, by 2048 all of America will be overweight or obese, a situation that will provide the English language the conundrum of having a term of imbalance—overweight—without a frame of reference. Obesity’s effects reach into every aspect of society, even the U.S. automobile industry. A 2011 consulting report suggested that Americans are becoming so obese that they are becoming too large to fit comfortably into

_Trends in Obesity Among US Adults, 1999-2008, 303 JAMA 235, 238 (2010)._ One researcher examined past and current rates of obesity and severe obesity in predicting that, by 2020, 77.6% of U.S. men and 71.1% of U.S. women will be overweight, while 40.2% of men and 43.3% of women will be obese (See Ruhm, supra note 91). Continuing the trend that more women than men will be obese by 2020, the research predicts Class II, III, and IV obesity percentages for women to be 25.3%, 12.8%, 5.6%, in contrast to the same obesity class-predictions of 16.4%, 6.3%, and 3.1% for men.


According to The Centers for Disease Control and Prevention, obesity currently is highest among black women (41.9%) and Hispanics (30.7%). See Vital Sings Adult Obesity, Latest Findings, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/vitalsigns/AdultObesity/LatestFindings.html (last updated Aug. 3, 2010). A research study presented at the Endocrine Society’s annual meeting in 2009 suggested that BMI and body fat measurements overestimate fatness among blacks, and may require race-specific obesity standards. See Widely Used Body Fat Measurements Overestimate Obesity in African-Americans, Study Finds, Science Daily (June 11, 2009), http://www.sciencedaily.com/releases/2009/06/090611142407.htm. The lower educated and the poor have the highest obesity rates: more than 33% of those who earn less than $15,000 per year are obese, compared to 24.6% of those who earn more than $50,000 per year (see Report, _F as in Fat_, supra note 102). Research shows that Class II and higher obesity rates among adults are increasing more rapidly than their overweight and Class I obesity counterparts. One study showed that, between 1986-2000, those reporting a BMI of 40 (Class III obesity) quadrupled, while those whose BMI was 50 (Class IV obesity) increased by a factor of 5. See Roland Sturm, _Increases in Clinically Severe Obesity in the US, 1986-2000_, 163 Arch. Intern. Med. 2146, 2147 (2003). During the same period, Class I obesity increased, but it only doubled (from 1 in 10 to 1 in 5). Other data show that between 1960-2004, obesity nearly tripled, from a prevalence rate of 13.4% to 31.5%, while Class II obesity nearly quadrupled, from a prevalence rate of 3.3% to 12.9% (See Ruhm, _supra_ note 91). During that time frame, Class III obesity increased by nearly a factor of 5, from a prevalence rate of 0.88% to 5.17%, and Class IV obesity increased by over a factor of 6, from a prevalence rate of 0.28 to 2.07%. Another researcher investigated the rate increase in obesity between 2000-2005, which showed that while the rate of increase in Class I obesity was 24%, the prevalence of Class III (morbid) obesity increased 50%, and the prevalence of Class IV (super) obesity increased 75%. In fact, using 1986 as a baseline, the rates of increase for all classes of obesity have increased in an inversely proportionate way: the more severe the obesity, the greater its prevalence increase. See Roland Sturm, _Increases in Morbid Obesity in the USA: 2000-2005_, 121 PUB. HEALTH 492 (2007).
gasoline-saving, subcompact cars. In order to reduce foreign-oil dependence, more fuel-efficient cars need to be driven. Yet in 2011, small cars constituted a smaller part of the U.S. automotive market than in 2008. Hippocrates realized the deleterious connection between obesity and mortality, writing over 2,400 years ago that “persons who are naturally very fat are apt to die earlier than those who are slender.” A mortality study using data from 527,265 U.S. men and women, between age 51-70, in 1995-1996 (of which 61,317 died during the ten-year follow-up) showed that the risk of death for those who were overweight increased by 20-40%, but for those who were obese the risk increased by 200-300%. This increased risk was for otherwise healthy, non-smokers. A 2010 study on the mortality of 1.46 million white adults concluded that the estimated hazard ratio for death increased as the subjects’ BMI entered the overweight range.

In 1980, the Journal of the American Medical Association published the research of a medical doctor who studied 200 morbidly obese men who were admitted to a weight control program from 1960-1977, fifty of whom died during that time or the follow-up time. As compared to the general population, the rate of mortality was twelve times greater for the morbidly obese men aged 25-34, and was 6 times greater for the morbidly obese men aged 35-44. A study on the causes of death in the United States in 2000 showed that being overweight was the second leading cause (400,000 deaths)

122 Id. However, car manufacturers have responded to the expanding consumer. Toyota, for instance, has redesigned the Prius V with concave door panels, thus allowing those with much wider hips to fit in the front and back. James Tate, U.S. Obesity Rates Contribute to Poor Sales of Small Cars, MSN (June 16, 2011), http://editorial.autos.msn.com/blogs/autosblogpost.aspx?post=90f4da4c-a334-4288-86f9-2da339269426.
123 Hippocrates, Aphorisms, II.44.
124 Kenneth F. Adams et al., Overweight, Obesity, and Mortality in a Large Prospective Cohort of Persons 50 to 71 Years Old, 355 NEW ENGL. J. MED. 763 (2006).
125 Id.
126 Berrington de Gonzalez, supra note 87. (A hazard ratio is the effect a given variable (in this instance, BMI) has on the risk or hazard of an event). The subjects had a median age of 58 with a median BMI of 26.2, and 47% reported they were never smokers. The estimated hazard ratio for those who had never smoked, but had a BMI of 25-27.5 was 1.12; for those with a BMI of 30-34.9 the hazard ratio was 1.41; for those with a BMI of 35-39.9 was 2.04; and for those with a BMI of 40-49.9 was 3.11. These hazard ratios reflect a follow-up time period of 15 years.
128 Id.
behind smoking (435,000 deaths). The results of that survey caused Dr. Julie Gerberding, the director of the CDC (and a co-author of the study) to say, “This is tragic. Our worst fears were confirmed.”

Not only is obesity a leading cause of death, but it is also the second leading cause of preventable death. There is strong evidence that obesity is on pace to overtake smoking as the leading cause of preventable death, particularly since the proportion of smokers in America decreased by 18.3%, between 1993-2008, while the proportion of those who are obese has increased during the same time by 85%.

**C. The Causes of Obesity**

While the rates of obesity and its associated costs can be quantified and generally agreed to, the same cannot be said about the causes of obesity as a cultural phenomenon. Some see obesity as the primary result of genetics, while others see it as consequence of the sedentary, calorie-crazed, supersize-me culture.

A study begun by researchers at Boston University School of Medicine resulted in the discovery in 2006 of what had been for over a decade mischaracterized in other studies as the fat gene. Using DNA samples from the Framingham Heart Study, the researchers identified a common obesity-gene among 10% of individuals, and replicated their findings with four other population samples. In 2007, researchers funded by the

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132 *Id.*

133 Officially, heart disease is the leading catalyst of death in America, causing 26% of the deaths in 2006. *See Heart Disease Facts, CENTERS FOR DISEASE CONTROL AND PREVENTION*, http://www.cdc.gov/heartdisease/facts.htm (last updated Jan. 27, 2012); Mokdad, *Actual Causes of Death, supra* note 129. Of the leading risk factors for heart disease, obesity is second, while physical inactivity is first, high blood pressure is third, high cholesterol is fifth, and diabetes is sixth-- all of which are consequences of obesity.


135 The Framingham Heart Study began in 1948 as a search for the causes of cardiovascular disease, and had a sample of 5,209 residents of Framingham, Massachusetts. The Framingham study also examined the health of over 5,000 of the offspring of the 1948 participants. *FRAMINGHAM HEART STUDY*, http://www.framinghamheartstudy.org/index.html (last updated Feb. 28, 2012).

136 *Herbert, supra* note 133.
Wellcome Trust, identified a gene in one out of six people that was correlated with a 70% higher chance of obesity for those study participants who possessed two copies of the gene, compared to those who had no copy of the gene.

While acknowledging the role that genetics play in obesity, the CDC emphasizes behavior as obesity’s primary cause. The CDC’s obesity web page focuses on “Calories In” and “Calories Out,” and stresses physical activity, reduction in television time, and healthier food choices as ways to prevent obesity. A 2009 study published in the American Journal of Clinical Nutrition, showed that the risk of obesity for those who inherited the fat gene from both biological parents was 2.5 times higher than for those who did not have that gene – but only if they consumed a high-fat diet and exercised little. For those with the FTO gene variant who got less than 41% of their calorie-intake from fat, obesity was not more prevalent.

The Wellcome Trust is the United Kingdom’s largest medical charity, which funds research in biomedical research and the medical humanities. WELLCOME TRUST, http://www.wellcome.ac.uk/index.htm (last visited Feb. 29, 2012).

Timothy M. Frayling et al., A Common Variant in the FTO Gene Is Associated with Body Mass Index and Predisposes to Childhood and Adult Obesity, 316 SCI. 889 (2007). Researchers in the United Kingdom released a study in 2011, concluding that there is a master switch gene that controls other genes found in one’s fat cells. Named KLF14, this gene is thought powerful enough to regulate genes that affect insulin, cholesterol, and BMI, which may make it a target in the biological fight against obesity. See Kerrin S. Small et al., Identification of an Imprinted Master Trans Regulator at the KLF14 Locus Related to Multiple Metabolic Phenotypes, 43 NATURE GENETICS 561 (2011). There is a corollary to the fat gene: the skinny gene which was first discovered in fruit flies in 1960. Winifred W. Doane, Developmental Physiology of the Mutant Female Sterile(2)Adipose of Drosophila Melanogaster. II. Effects of Altered Environment and Residual Genome on Its Expression, 145 J. EXP. ZOOL. 23 (1960). This gene—named the Adipose gene—is thought to be responsible for keeping those who are inordinately thin in that state, regardless what they eat. Jae Myoung Suh et al., Adipose Is a Conserved Dosage-Sensitive Antioesity Gene, 6 CELL METABOLISM 195 (2007). Recent data suggests that 13% of the population possess this “lucky” gene. Dolores Corella et al., APOA5 Gene Variation Modulates the Effects of Dietary Fat Intake on Body Mass Index and Obesity Risk in the Framingham Heart Study, 85 J. MOL. MED. 119 (2007). Causes and Consequences: Is There a Quick Answer to the Question, “What Contributes to overweight and obesity?” CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/obesity/causes/index.html (last updated May 16, 2011); Obesity and Genomics, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/genomics/resources/diseases/obesity/obesedit.htm (last updated Apr. 20, 2010).

Causes and Consequences, supra, note 138.

Emily Sonestedt et al., Fat and Carbohydrate Intake Modify the Association Between Genetic Variation in the FTO Genotype and Obesity, 90 AM. J. CLINICAL NUTRITION 1418 (2009).

Fat mass and obesity-associated proteins are known as FTO genes, and are located on chromosome 16. MeSH Supplementary Concept Data, NAT’L LIBR. OF MED. (2011),
Some think the fat gene—as it is known—can be kept at bay, if not conquered, by the old-fashioned lifestyle that includes lots of physical activity. After observing 711 members of the Amish community in Lancaster County, Pennsylvania, including those with the FTO gene variant, researchers from the University of Maryland noticed that despite all the high-caloric foods the Amish eat daily, those with the fat gene who did the most exercise weighed on average fifteen pounds less than their neighbors or family members who did not have the fat gene but did the least exercise.143

**D. The Costs of Obesity**

Obesity’s costs are intertwined with obesity’s consequences: a litany of illnesses and health complications, and a troubling array of direct and indirect costs. For example, according to the Office of the United States Surgeon General: over 80% of those with diabetes are overweight or obese; high-blood pressure is twice as common for those who are obese (compared to those with a healthy weight); and, the risk of developing arthritis increases between 9-13% for every two pound increase in weight.144

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142 Id.

143 Evadnie Rampersoud et al., *Physical Activity and the Association of Common FTO Gene Variants with Body Mass Index and Obesity*, 168 ARCHIVES INTERNAL MED. 1791 (2008). The Amish would not use the word “exercise” because for them physical activity begins at daybreak and ends at nightfall. Having spurned for religious reasons the combustion engine and electricity, the Amish lifestyle is equivalent to a daily “exercise” regimen of three to four hours, a fact the researchers observed through the use of battery-operated, activity monitors worn by the study participants.

144 *Overweight and Obesity: Health Consequences*, OFF. OF THE SERGEANT GENERAL, http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.html (last visited Feb. 29, 2012). As dramatic an increase in the obesity rate has been over the past decades, it is actually outdistanced by the increase in the rate of diabetes over the same time. In 1960, 0.91% of Americans had diabetes; in 2000, the percentage was 4.4% (an increase of 383.5% over 40 years); by 2009, 6.86% of America had diabetes (an increase of 56% in nine years). There are the following types of diabetes: Type 1 diabetes is commonly known as childhood diabetes, and Type 2 diabetes is referred to as adult-onset diabetes. Type 2 diabetes has become so prevalent that data on the increases in “diabetes” refer to increases in Type 2 diabetes. *Long-term Trends in Diabetes October 2010*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 2011), http://www.cdc.gov/diabetes/statistics/slides/long_term_trends.pdf. The Centers for Disease Control estimated that diabetes costs in 2007 were $174 billion. Of that figure, the CDC allocated $116 billion to direct costs—which on an individual basis calculated to be 2.3 times higher for those persons with diabetes compared to those without it—and $58 billion to indirect costs, such as disability, loss of work and premature death. *2011 National Diabetes Fact Sheet*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf (last visited Feb. 29, 2012). And according to the Mayo Clinic, Type 2 diabetes is preventable through proper diet and...
The medical costs of obesity are calculated by considering direct costs (preventative, diagnostic, and treatment) and indirect costs (morbidity and mortality). According to the CDC, these costs are “staggering.” A study on the associated costs of obesity estimated that the total for 2008 could have been as high as $148 billion, while ten years earlier the costs were $78.5 billion. A 2010 study asserted that the per capita costs for full-time male employees with Class III obesity were $6,087, and for women with Class III obesity the costs were $6,694.

In the workplace, the costs of obesity are attributed to absenteeism and presenteeism, in addition to its direct medical costs. While obese employees make up 37% of the American workforce, they account for 61%

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146 Eric A. Finkelstein et al., Annual Medical Spending Attributed to Obesity: Payer- and Service-Specific Estimates, 28 HEALTH AFFAIRS w822 (2009). According to the authors, about half of the estimated costs for obesity are borne by Medicare and Medicaid. That study also used data from 2000-2001 to conclude that overweight- and obesity-attributed medical costs varied from $170 per year for overweight male employees to at least $1,500 per year for female employees with Class II obesity.
147 Eric A. Finkelstein et al., The Costs of Obesity in the Workplace, 52 J. OCCUPATIONAL ENVTL. MED. 971 (2010). This study also estimated that those with a BMI above 35 represent 37% of the population, but are responsible for 61% of obesity’s excess medical costs. According to a national weight-loss organization that runs obesity camps for children and adolescents, the costs of being and staying obese over one’s life total $549,907. See Cost of Obesity, WELLSPRING CAMPS, http://www.wellspringcamps.com/childhood_obesity_cost (last visited Feb. 29, 2012). While this organization has a self-interest in viewing the costs of obesity as inordinately high, its figure is derived from examining the treatment costs of the illnesses most directly associated with obesity, as well as diminished or lost wages associated with obesity, and the costs of diet programs. The sources upon which that number is drawn are varied, including the Centers for Disease Control and Prevention, the American Heart Association, and the American Diabetes Association, as well as peer-reviewed journal article. An economic study concluded, after examining the literature on marginal costs of obesity (reduced earnings due to premature death, increased healthcare costs), that for a 50-year-old male the marginal costs of obesity were slightly under $400,000. See Jay Bhattacharya & Neeraj Sood, Who Pays for Obesity?, 25 J. ECON. PERSP. 139, 146 (2011). The authors estimated that, of that amount, $15,000 was attributed to increased medical-care costs (without taking into account health care insurance costs).
148 Finkelstein, supra note 147. Presenteeism was coined by Manchester University (UK) psychology professor Cary Cooper, and refers to being at work but being less than fully functioning or productive, due to a medical condition, which includes depression; Definition of Presenteeism, MEDICINE.NET.COM, http://www.medterms.com/script/main/art.asp?articlekey=40516 (last editorial review Nov. 12 2004); Professor Cary Cooper Explains Presenteeism, YOUTUBE, http://www.youtube.com/watch?v=firSwj_3jBM (uploaded Dec. 3, 2010).
of the excess costs in the workplace attributed to obesity.\textsuperscript{149} Absenteeism has been shown to be highest among obese women, who miss one week of work more per year than non-obese women.\textsuperscript{150} A study on absenteeism, using data collected by the Agency for Healthcare Research and Quality, found that across all occupations, the overweight are 32\% more likely, the obese are 61\% more likely, and the morbidly obese are 118\% more likely to miss work than employees with a healthy weight.\textsuperscript{151} This study estimates the that absenteeism costs related to morbid obesity were $238 per morbidly-obese employee, and that the aggregate costs of obesity were $4.3 billion, in 2004 dollars, of which $3.2 billion was attributed to female employees.\textsuperscript{152}

The loss of productivity at work due to medical factors, known as presenteeism, has been studied for its connection to obesity. A 2005 study on presenteeism asserted that obesity was a significant factor in presenteeism and that the obese were more likely to have lost-productive time than overweight or non-overweight workers.\textsuperscript{153} This study asserted that lost-productivity due to obesity cost $42.29 billion ($1,627 per obese employee), of which two-thirds was attributed to presenteeism.\textsuperscript{154}

VI. OBESITY AS A DISABILITY: THE DISTINCTION BETWEEN PHYSIOLOGICAL AND NON-Physiological Roots

The U.S. Supreme Court has never taken a disability case involving obesity, but, after the passage of the ADA in 1990, several federal courts have.\textsuperscript{155} In 1993, the First Circuit Court of Appeals concluded in \textit{Cook v.}\textsuperscript{149} Finkelstein, \textit{supra} note 147.

\textsuperscript{149} Finkelstein, \textit{supra} note 147.

\textsuperscript{150} Finkelstein, \textit{supra} note 146.

\textsuperscript{151} John Cawley et al., \textit{Occupation-Specific Absenteeism Costs Associated with Obesity and Morbid Obesity}, 49 J. OCCUPATIONAL ENVTL. MED. 1317 (2007). While absenteeism costs for obese women are more than those for obese men, across occupations, both male and female managers (as opposed to salespersons or professionals, for instance) have the highest per-employee costs related to morbid obesity.

\textsuperscript{152} See \textit{id.} While that study attributed the costs of obesity-caused presenteeism to be greater than $11 billion annually, a later study asserted that presenteeism cost $30 billion annually, part of a total annual cost of obesity among full-time employees attributed to be $73.1 billion. See Finkelstein, \textit{supra} note 147. This and the earlier study on presenteeism were based on data gathered from questions the researchers asked employees about their workplace habits, with respect to productivity.


\textsuperscript{154} See \textit{id.} While that study attributed the costs of obesity-caused presenteeism to be greater than $11 billion annually, a later study asserted that presenteeism cost $30 billion annually, part of a total annual cost of obesity among full-time employees attributed to be $73.1 billion. See Finkelstein, \textit{supra} note 147. This and the earlier study on presenteeism were based on data gathered from questions the researchers asked employees about their workplace habits, with respect to productivity.

Rhode Island Department of Mental Health, Retardation, and Hospitals,\textsuperscript{156} that the plaintiff’s obesity\textsuperscript{157} was a disability covered by federal antidiscrimination law.\textsuperscript{158} Although this suit was brought under section 504 of the Rehabilitation Act of 1973, the analysis on which it was based is identical to the Americans with Disabilities Act and its decision was cited by later courts interpreting morbid obesity cases under the ADA.\textsuperscript{159} The plaintiff in \textit{Cook} claimed that her denial of a medical attendant job in a facility for the developmentally disabled was based on her morbid obesity. In upholding the plaintiff’s award of $100,000 at trial, the First Circuit found disability coverage for the plaintiff under the “regarded as having a disability” prong of the statute.\textsuperscript{160} Despite the defendant-employer’s claim that obesity is a mutable condition that negates its coverage as protected impairment, the court found just the opposite.\textsuperscript{161} And speaking to the argument that obesity is a voluntarily-induced condition that hinders it as the predicate for a disability-discrimination claim, the court stated, “Given the plethoric evidence introduced concerning the physiological roots of morbid obesity, the jury certainly could have concluded that the metabolic dysfunction and failed appetite-suppressing neural signals were beyond plaintiff's control and rendered her effectively powerless to manage her weight.”\textsuperscript{162} \textit{Cook} is a rare case, in that a federal court upheld the finding of obesity-based discrimination.

In 1997 in \textit{Francis v. City of Meridian}, the Second Circuit Court of Appeals ruled on a discrimination claim where a firefighter claimed he had been discriminated against because he was disciplined for exceeding his department’s weight limit.\textsuperscript{163} The firefighter’s discrimination claim was tied

\textsuperscript{156} 10 F.3d 17 (1st Cir. 1993).
\textsuperscript{157} According to the case, the plaintiff was a 5’2” woman who weighed over 320 pounds. Her BMI would have been 59, which is Class IV, Super Obesity, not “morbid” obesity, the term the Court used. \textit{See} text accompanying footnote 94.
\textsuperscript{158} Although the case was brought under the Rehabilitation Act, the Court stated in its footnote 10 that it relied upon the regulations implementing the ADA in determining if an impairment “substantially limits” a major life activity.
\textsuperscript{160} That part of the Rehabilitation Act is the language of the ADA, 42 U.S.C. A. § 12102(1).
\textsuperscript{161} \textit{Cook} v. Rhode Island Dep’t. of Mental Health, Retardation, and Hospitals, 10 F.3d 17, 24 (1st Cir. 1993).
\textsuperscript{162} \textit{Id.} Inserting itself into the cultural morass over obesity, the court stated at the end of its opinion, “In a society that all too often confuses “slim” with “beautiful” or “good,” morbid obesity can present formidable barriers to employment.”
\textsuperscript{163} 129 F.3d 281 (2d Cir. 1997). Based on the firefighter’s weight, his maximum allowable weight was 188 pounds, but his weight fluctuated between 217 and 243 pounds, which would have been up to 29% over his allowable weight.
to the “regarded as” prong of ADA, but the court found the claim defective in that it didn’t allege that the fire department “regarded him as suffering from a physiological weight-related disorder.”\footnote{Id. at 285.} In so doing, it cited a similar Sixth Circuit obesity-discrimination case brought by state police officers who lost a discrimination claim after being disciplined for failing to meet departmental weight standards.\footnote{Andrews v. Ohio, 104 F.3d 803 (6th Cir. 1997).} As to whether obesity was a disability covered by the ADA, the court stated that “obesity, except in special cases where the obesity relates to a physiological disorder, is not a ‘physical impairment’ within the meaning of the statutes.”\footnote{See Francis, 129 F.3d. at 286.}

The Sixth Circuit Court of Appeals reiterated its view on obesity as a perceived disability in 2006, when it held that non-physiological morbid obesity was not an impairment under the Americans with Disabilities Act.\footnote{EEOC v. Watkins Motor Lines, Inc., 463 F.3d 436 (6th Cir. 2006).} In \textit{E.E.O.C. v. Watkins Motor Lines, Inc.}, the employee worked as a driver/dock worker and had a weight ranging from 340-450 pounds.\footnote{Id. at 438.} After a ladder accident injured his knee, the employee was placed on a leave of absence that resulted in his termination after 180 days, following the employer’s doctor’s conclusion that the employee could not safely perform his job. Believing the employee was discriminated against, and regarded as disabled by his employer, because of his obesity, the EEOC sued on the employee’s behalf. However, the District Court granted a summary judgment, ruling that non-physiologically caused obesity was not an ADA-covered impairment. On appeal, the Sixth Circuit affirmed.\footnote{Id. at 443.} In its decision, the court cited the \textit{Cook} decision,\footnote{Id. at 442.} even though the court in \textit{Cook} discussed that employee’s inability to control her eating, while the court in \textit{Watkins} did not consider what caused the employee’s obesity, other than to say that it was not established to be physiologically-caused. A concurrence in \textit{Watkins} acknowledged that the EEOC did nothing to establish the physiological cause of the employee’s obesity (unlike what the \textit{Cook} plaintiff did), but thought (in a footnote) that morbid obesity might be a disorder that by its very nature has a physiological cause.\footnote{Id. at 445 (Smithgibbons, J., concurring, footnote 1).}

In \textit{Walton v. Mental Health Association of Southeastern Pennsylvania}, a 1999 case from the Third Circuit Court of Appeals, the court stated that it had not recognized a cause of action against an employer who discriminates against an employee based on a perception that the employee is disabled due
to obesity.\textsuperscript{172} In the case, a mental health agency terminated an employee in charge of advocacy consumer training, due to excessive absences that were the result of the employee’s depression.\textsuperscript{173} Having been denied the chance to amend her complaint to alleges discrimination based on the perceived disability of obesity, the employee appealed to the Third Circuit, which upheld the lower court. In so doing, the Court of Appeals noted that being perceived as being disabled because of obesity was not tantamount to being perceived “as disabled by some impairment that substantially limits one of her major life activities.”\textsuperscript{174}

\textbf{VII. CONTRASTING SMOKERS WITH THE OBESE: WHY ARE THE FORMER NOT CONSIDERED DISABLED?}

There is another activity that, like overeating, shortens one’s life and burdens it with a host of degenerative conditions, as well as subjects society to ever-escalating costs: smoking. And the effects smokers have had on society—in addition to their own health—is evident in the way smokers are treated. Smokers are subject to an increase in health care premiums,\textsuperscript{175} cigarettes are hit with a heavy “sin tax,”\textsuperscript{176} and smoking has become anathema in almost every public place, including parks. For example, New York City passed in 2002 its Smoke Free Air Act (SFAA), which prohibits smoking in public buildings, in all bars and restaurants, and on public transportation.\textsuperscript{177} Such was the outrage of Academy-Award winning actor

\textsuperscript{172} Walton v. Mental Health Ass’n of Sc. Pa., 168 F.3d 661 (3d Cir. 1999).
\textsuperscript{173} Id. at 665. Before taking a leave of absence that was longer than she stated it would be, the employee missed 125 days of work in the three-year period leading up to her termination.\textsuperscript{174} Id.
\textsuperscript{175} Jillian Mincer, \textit{Insight: Firms to Charge Smokers, Obese More for Healthcare}, \textit{Reuters} (Oct. 30, 2011), http://www.reuters.com/article/2011/10/30/us-penalties-idUSTRE79T2S220111030. As indicated in the Reuters article, Wal-Mart is one employer who will be increasing the employee-portions of health care premiums in 2012 for those who are smokers. Greg Rossiter, a Wal-Mart spokesman, was quoted in the article as explaining the increase in the premiums on smokers thusly: Tobacco users consume 25 percent more health-care services than non-smokers. This trend of increasing premiums on tobacco users has been part of what is called a shift from “smoke-free workplaces to smoker-free workplaces. According to the \textit{New York Times}, a smoking employee costs, on average, $3,391 more per year for health care lost productivity. A. G. Sulzberger, \textit{Hospitals Shift Smoking Bans to Smoker Bans}, \textit{N.Y. Times} (Feb. 10, 2011), http://www.nytimes.com/2011/02/11/us/11smoking.html?pagewanted=all.
\textsuperscript{177} Smoke Free Air Act of 2002, N.Y. ADC. LAW § 17-501- 1514. The SFAA has since been amended to extend the smoking ban to hospital entrances, public parks and beaches (\textit{See id. at}}
and inveterate smoker Jeremy Irons towards New York City’s smoking bans and fines, that in a 2011 interview he advocated that smokers be treated like the disabled.\textsuperscript{178}

The similarity between the way public health experts view the obese and smokers extends into the home. In 2011, a lighting-rod commentary published in the \textit{American Journal of the American Medical Association} suggested removing severely obese children from their homes and parents.\textsuperscript{179} While acknowledging the constitutional rights of parents to raise their own children as they deem necessary, the authors’ concern for the associated health repercussions of childhood obesity—and in particular type 2 diabetes—led them to conclude that states could rely upon federal child abuse and neglect law\textsuperscript{180} to “intervene to protect the child’s interest.”\textsuperscript{181} The authors’ position was prescient and came to fruition in September 2011, when an eight-year-old boy in Cleveland, Ohio, was removed from his home

\textsuperscript{178} Jada Yuan, \textit{Just Like You Imagined}, \textsc{N.Y. Magazine} (March 27, 2011), http://nymag.com/arts/tv/features/jeremy-irons-2011-4. In the article, Irons spoke of New York City’s anti-smoking laws as “terrible bullying of a minority that cannot speak back,” stating that smokers should be treated like “the handicapped people and children.” The response by the National Organization on Disability to Mr. Iron’s view on smokers as handicapped was that it was a “very inappropriate comparison.” Furthermore, the National Organization on Disability stated, “We all know smoking imposes huge costs on society, not only on the smoker but also on those around them. How can one say that people who choose to smoke deserve protection as those born with disabilities through no fault of their own is beyond me.” Jon Swaine, \textit{Jeremy Irons Says Smokers Deserve Special Protections, Like Disable People}, \textsc{The Telegraph} (Apr. 4, 2011),


\textsuperscript{179} Lindsey Murtagh & David S. Ludwig, \textit{State-Intervention in Life Threatening Childhood Obesity}, 306 \textit{JAMA} 206 (2011). Ms. Murtagh is a professor in the Department of Health Policy and Management at the Harvard School of Public Health, and Dr. Ludwig is a doctor at Children’s Hospital, in Boston, Massachusetts.

\textsuperscript{180} \textit{CAPTA Reauthorization Act of 2010}, Pub. L. No. 111-320, Title I,Subtitle B, §142(a), 124 Stat. 3482 (2010). \textit{Specifically, CAPTA defines child abuse or neglect as “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm . . . or an act or failure to act which presents an imminent risk of serious harm.”}

\textsuperscript{181} Murtagh, \textit{supra} note 179. The recommendation for putting children in foster care was only for those who were severely obese, but the authors also envisioned lesser interventions ranging from in-home social supports to financial assistance.
and placed in foster care because he weighed over 200 pounds.\textsuperscript{182} Although the child’s removal from his mother was not predicated on a specific policy, the Cuyahoga County Department of Children and Family Services—which took custody of the boy—claimed that the child’s severe obesity was the result of medical neglect.\textsuperscript{183}

And with respect to smoking, as early as 1997 James Garbarino, the director of the Cornell University Family Life Center, averred that parents who smoke were committing child abuse.\textsuperscript{184} Part of the reasoning behind Dr. Garbarino’s argument that parental smoking constituted abuse that required government intervention was not only the health risks associated with second-hand smoke, but also the opinion that children of smokers are more likely to become smokers.\textsuperscript{185} Though removal of obese children from their parents and charging smoking parents with child abuse may seem overreaching and invasive to the family unit, such responses may be on the increase as society seeks evermore urgent efforts to stem the associated costs (financial and otherwise) of dangerous lifestyles.

VIII. THE ADA HAS NOT BEEN FOUND TO APPLY TO SMOKERS

In the employment setting, smoking has in the past few decades gone from being the unsavory act one does outside in a designated space to being no longer allowable during working hours.\textsuperscript{186} While second hand smoke concerns may have been the impetus behind ever-increasing restrictions on smoking at work, increased healthcare costs and an opposition to the smoking lifestyle are taking smoking bans to the next progression: refusing to employ smokers. Beginning in 2012, the Baylor Healthcare System will

\textsuperscript{182} Rachel Dissell, County Places Obese Cleveland Heights Child in Foster Care, CLEVELAND.COM BLOG (Nov. 26, 2011, 9:00 PM), http://blog.cleveland.com/metro/2011/11/obese_cleveland_heights_child.html. One question raised by the action taken by the Cuyahoga County Department of Children and Family Services is that, according to state estimates on childhood severe obesity, 1,380 children in Cuyahoga County are severely obese, as is the boy put into foster care.\textsuperscript{183} See id. In fact, according to Mary Louise Madigan, a spokesperson for the Department, the county had been working with the child’s mother for over a year, without success, before asking the Juvenile Court for custody.\textsuperscript{184} Cornell Child Abuse Expert Says It’s Time to Recognize Smoking as Child Abuse, CORNELL UNIV. SCI. NEWS (Sept. 26, 1997), http://www.news.cornell.edu/releases/Sept97/smoking.abuse.ssl.html.\textsuperscript{185} Id.\textsuperscript{186} See generally Leslie Zellers et al., Legal Risks to Employers Who Allow Smoking in the Workplace, 97 AM. J. PUB. HEALTH 1376 (2007). This article discusses the liability employers face due to second hand smoke dangers when they allow smoking at their places of employment. Its authors state that over 2000 municipalities and 11 states have passed laws either restricting the right to smoke at work or mandating smoke-free work places.
no longer hire smokers, including doctors and hospital volunteers.\footnote{Gary Jacobson, \textit{Dallas-based Baylor Health Care System to Stop Hiring Smokers}, DALLASNEWS.COM (Sept. 21, 2011), http://www.dallasnews.com/business/health-care/20110921-dallas-based-baylor-health-care-system-to-stop-hiring-smokers.ece.} This employer of almost 20,000\footnote{As of 2010. Facts and Stats, BAYLOR HEALTH CARE SYS., http://media.baylorhealth.com/pages/baylorfacts (last visited Dec. 30, 2011).} will not consider the applications of those who profess to be smokers and will rescind the employment offers of those who test positive for nicotine after being hired.\footnote{Id.} Concerning the reason for such a strict policy, Baylor Healthcare Systems CEO Joel Allison stated, “It’s about how we deal with rising healthcare costs.” And Baylor is not alone. The Cleveland Clinic stopped hiring smokers in 2007,\footnote{Cleveland Clinic Won’t Hire Smokers, FOXNEWS.COM (June 28, 2007), http://www.foxnews.com/story/0,2933,287137,00.html. As of 2007, the Cleveland Clinic was the second largest employer in Ohio, with 36,000 employees.} and health insurance giant Humana announced in 2011 that it would no longer hire smokers who work at its facilities in Arizona.\footnote{Ken Alltucker, \textit{Humana Won’t Hire Smokers in Arizona}, ARIZ. REPUBLIC (June 30, 2011), http://www.azcentral.com/arizonarepublic/news/articles/2011/06/30/20110630arizona-smokers-not-hired-by-humana.html. Before instituting this ban on smokers, Humana applied it to its Ohio employees.}

Perhaps not unsurprisingly, smokers have not been treated as if they were disabled under federal law.\footnote{The rules interpreting the ADAAA allow employers to restrict or prohibit its employees from smoking at work. 29 C.F.R. § 1630.16(d) (2011).} The EEOC has never filed a suit against an employer, alleging that its treatment of a smoking employee was in violation of the ADA. Rare is the case where one has alleged that smoking is a disability. In one such case, \textit{Brashear v. Simms},\footnote{138 F.Supp.2d 693 (D.Md. 2001).} a Maryland prison inmate who was left smokeless after a state regulation barred the use of tobacco in Maryland prisons, sought an injunction to prevent him from being discriminated against in violation of the Americans with Disabilities Act. The District Court declared his suit frivolous as a matter of law, but it addressed his claim that he was protected under the ADA. Without deciding if the ADA applies in penal institutions but assuming for the sake of the point that it did, the court rejected the notion that smoking is a disability. In fact, it did so without the need for reliance on legal precedent:

\begin{quote}
[C]ommon sense compels the conclusion that smoking, whether denominated as ‘nicotine addiction’ or not, is not a ‘disability’ within the meaning of the ADA. Congress could not possibly have intended the absurd result of including smoking within the
\end{quote}
definition of ‘disability,’ which would render somewhere between 25% and 30% of the American public disabled under federal law because they smoke.195

And yet, the very next sentence in Brashear v. Simms portends a possibility that smokers might be covered under the ADAAA, in that it cites the yet-to-be legislatively-overruled Sutton v. United Airlines as conclusive that smokers—whether nicotine-addicted or not—are ineligible for ADA protection because they have a remediable condition.196 As a result of the passage of the ADAAA and its rejection of the precedent that ameliorative effects or mitigating measures limit a substantial impairment, a few employment law practitioners wondered aloud if smoking would now be a condition requiring reasonable accommodations.197

IX. RECOMMENDATIONS

Congress’s desire in expanding disability-coverage is laudable. Likewise, the EEOC’s championing of obesity-based discrimination in employment is also commendable, particularly in light of Congress’s directive to the EEOC that its actions are to be more reflective of legislative will.198 In accord with the congressional edict that the ADAAA provide expanded coverage, the EEOC revised its Interpretive Guidance on Title I of the Americans with Disabilities Act in 2011.199 Part of those revisions included the deletion of the EEOC’s guidance on obesity, which stated: “[E]xcept in rare circumstances, obesity is not considered a disabling impairment.”200 But the ramifications of the ADAAA’s removal of the

195 Id. at 696.
196 Id.
197 See Michael Moore, ADA Amendments May Open the Door for Nicotine Addiction Claims, PA. LAB. AND EMP. BLOG (Oct. 29, 2008), http://www.palaborandemploymentblog.com/2008/10/articles/discrimination-harassment/ada-amendments-may-open-the-door-for-nicotine-addiction-claims; Jon Hyman, More on Smoking as a Disability, OHIO EMPLOYER’S L. BLOG (Oct. 30, 2008), http://www.ohioemployerlawblog.com/2008/10/more-on-smoking-as-disability.html. The conclusion reached by the Pennsylvania practitioner was that because of the high percentage of smokers who are nicotine dependent and in light of the expansive coverage of the ADAAA, nicotine addicted smokers could well find coverage in a similar fashion to those who are covered because of drug or alcohol addictions. The Ohio practitioner thought just the opposite, that smokers, whether nicotine addicted or not, would still find no coverage under the ADAAA.
200 Id.
“mitigating measures” language in the ADA, as well as its rejection of *Sutton v. United Air Lines, Inc.* and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*, are problematic when applied to obesity. Furthermore, the EEOC’s corresponding shift creates an untenable dilemma in which a national health crisis that is absolutely reversible is given the kind of legal imprimatur that will unintentionally contribute to its growth.

Too mixed a message is being sent when the CDC makes fighting obesity a paramount priority, while the EEOC considers obesity a protected status and seeks to affect public policy by making test cases of employment discrimination claims based on non-medically caused obesity. The federal government needs a more unified approach. In light of the ominous consequences of obesity on the U.S. healthcare system, and in light of the similar tactic the CDC takes to both obesity and smoking—which is to stop now—obesity should be treated like smoking for disability law purposes, unless one seeking federal disability protection because of obesity can establish that the obesity is due to naturally occurring or genetic medical reasons.201

As the District Court in *EEOC v. Resources for Human Development* noted in its Order denying the summary judgment motions,202 the EEOC Compliance Manual section 902 on the definition of “Disability,” states “Voluntariness is irrelevant when determining whether a condition constitutes an impairment.”203 Furthermore, the Manual cites from a House Judiciary Report on the original ADA, which stated “[t]he cause of a disability is always irrelevant to the determination of disability.”204 Yet when one federal appellate court cited that phrase, it failed to provide behavioral causes as supportive of that statement, but rather surmised whether a disability was caused by “birth defect, injury, defect, or disease.”205

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201 According to WebMd.com, about 1% of obesity is due to medical causes, such as thyroid problems or Cushing’s syndrome. *Medical Causes of Obesity*, WEBMD.COM, http://www.webmd.com/diet/medical-reasons-obesity (last reviewed Sept. 19, 2009).

According to a British healthcare website, less than 1 in 100 adult obese people have a medical cause for obesity. *Obesity and Overweight in Adults*, PATIENT.CO.UK, http://www.patient.co.uk/health/Obesity-and-Overweight.htm (last visited Feb. 29, 2012). And according to a 2009 article on the rise of obesity in developed countries, medical causes are insignificant as a reason for the alarming increase. Instead, an increase in caloric intake and a decrease in physical activity due to technological innovations are the causes. Sara Bleich et al., *Why Is the Developed World Obese?*, 29 ANN. REV. PUB. HEALTH 273 (2008).

202 See Section II, supra.


If the CDC’s attempt to stem the tide of the obesity epidemic has any hope of success, it needs the law and the EEOC to be noninterventionists, as it has been with smoking as a disability. The rate of smoking in America has decreased,\(^{206}\) and it is fair to attribute the non-accommodation stance as a contributing factor. New York City, which at the direction of Mayor Bloomberg has made smokers persona non grata, experienced such a smoking reduction that the number of adult smokers in New York is at an all-time low since 2002.\(^{207}\) Whereas smoking is recognized as an addiction,\(^{208}\) obesity—or that which leads to the state of being obese—is not considered the result of an addiction.

One wonders if Congress’s desire in the ADAAA that the determination that an impairment substantially limits a major life activity be made “without regard to the ameliorative effects of mitigating measures,”\(^{209}\) included taking America’s number one public health problem and requiring that it be accommodated in the workplace. Furthermore, where obesity is not medically caused, such as because of hyperthyroidism, it is not so much a

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\(^{206}\) According to *Cigarette Smoking Among Adults - United States, 2007*, CENTERS FOR DISEASE CONTROL AND PREVENTION, 57 Morbidity and Mortality Weekly Report 1221 (2008), smoking prevalence fell to 19.8% in 2007. Reacting to the report, Tom Glynn, director of International Cancer Control of the American Cancer Society, said this was the lowest smoking rate since the 1920s. When the CDC began keeping smoking prevalence records, the rate of smoking was over 40%. The credit to that reduction went to non-accommodation tactics, including increased cigarette taxes and no-smoking laws. Bill Hendrick, *Smoking Rate is Declining in the U.S.*, WebMD (Nov. 13, 2008), http://www.webmd.com/smoking-cessation/news/20081113/smoking-rate-is-declining-in-us.

\(^{207}\) Mayor Bloomberg, Speaker Quinn, Deputy Mayor Gibbs, and Health Commissioner Farley Announce Number of City Smokers has Hit an All-time Low at 14 Percent, NYC.GOV (Sept. 15, 2011), http://www.nyc.gov/portal/site/nycgov/menuitem.c0935b9a57bb4ef3da2f1c701c789a0/index.jsp?pageID=mayor_press_release&catID=1194&doc_name=http%3A%2F%2Fwww.nyc.gov%2Fhtml%2Fom%2Fhtml%2F2011b%2Fp327-11.html&cc=unused1978&rc=1194&ndi=1. According to the press release, the number of New York City smokers who have stopped smoking is 450,000. Part of the credit to the decrease in smoking was given to the city’s Smoke Free Air Act.

\(^{208}\) While addictions are thought to be covered under the ADA, the only addictions that have been denominated by the EEOC are drug addiction and alcoholism. II-2.2000 Physical or Mental Impairments, *Title II Technical Assistance Manual*, THE AMERICANS WITH DISABILITIES ACT, http://www.ada.gov/taman2.html (last visited Feb. 29, 2011). In contrast, a gambling addiction is not covered, according to the EEOC’s rules. 29 C.F.R. § 1630.3(d)(2) (2011). According to the CDC, most smokers are addicted to nicotine, which is the most common form of chemical dependence in the United States. *Nicotine Addiction*, CENTERS FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/tobacco/quit_smoking/how_to_quit/you_can_quit/nicotine (last updated Jan. 24, 2011).

condition that is ameliorative as it is curable, and self-curable at that.\textsuperscript{210} Assuming the CDC achieves its Healthy People 2020 target of a 30% obesity rate in America\textsuperscript{211} (an obesity rate that is double what the CDC sought to achieve for its Healthy People 2010 campaign), that would still mean that much more than 120 million Americans would be obese. As was said in \textit{Brashear v. Simms} about whether smoking was a disability under the ADA, could Congress have wanted that many Americans to be considered disabled?\textsuperscript{212} The numbers are daunting and the implications, both in and out of the workplace, are breathtaking.

\textsuperscript{210} The CDC’s obesity web site has a web page listing “What Can Be Done” and categorizes actions for federal and state governments, communities, and individuals to reduce obesity. All recommendations concern eating healthier foods or increasing physical activities. \textit{See Vital Signs Adult Obesity, supra} note 98. Centuries earlier, the Greek physician Galen recounted his response to an obese patient: “I reduced a huge fat fellow to a moderate size in a short time, by making him run every morning until he fell into a profuse sweat; I then had him rubbed hard, and put into a warm bath; after which I ordered him a small breakfast, and sent him to the warm bath a second time. Some hours after, I permitted him to eat freely of food, which afforded but little nourishment; and lastly, set him to some work which he was accustomed to for the remaining part of the day.” \textit{Haslam, supra} note 86.

\textsuperscript{211} \textit{Allison, supra} note 84.

\textsuperscript{212} \textit{Murtagh, supra} note 179.