COMMENT

A Fatter Butt Equals a Skinnier Wallet: Why Workplace Wellness Programs Discriminate Against the Obese and Violate Federal Employment Law

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I. Introduction 639
II. Background 641
  A. *Obesity: The Alleged American Epidemic* 642
  B. *Choice, Genetics, and Environment* 643
  C. *Workplace Wellness Programs* 646
  D. *The Americans with Disabilities Act* 647
  E. *The Genetic Information Nondiscrimination Act* 652
III. Analysis 654
  A. *The Courts and Obesity Discrimination* 654
  B. *Obesity: Not Merely a Choice* 656
  C. *Workplace Wellness Programs Are Not Permissible Under the ADA and GINA* 661
IV. Conclusion 666

I. Introduction

American society is largely one of image and choice. A person's societal status is increasingly marked by his clothes, car, house, and waist size. However, this idea of image is not new to American society. America's image, symbolized by the American Dream and epitomized by every citizen's right to life, liberty, and the pursuit of happiness,[1] influences people from around the world to come to America every year. The opportunity to make one's own choices is worth everything to a person who has limited or no freedom. One of the most basic choices in America is a person's right to choose what to consume—particularly

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* Candidate for J.D., University of Wyoming, 2011. I would like to express my love and gratitude to my wife Stephanie for her unwavering patience, resolve, understanding, and assistance during the writing of this comment and throughout my time in law school; without such, neither this comment, nor my J.D. would have been possible. To my two sons, Austin and Henry, thank you for giving up your precious daddy time allowing me the opportunity to obtain my J.D. and write this comment. I would like to express appreciation to my parents, Robert and Marsha Sizemore, for teaching me the importance of education and instilling in me the can-do attitude and stick-to-itiveness from a very young age and to my parents-in-law, Steven and Debbie Sessions, for their support during law school. Finally, thanks to Nick Haderlie and Devon Stiles for their assistance in editing, revising, and providing invaluable feedback and advice throughout the entire process of writing this comment.

[1] *See* The Declaration of Independence para. 2 (U.S. 1776).

when it comes to eating. Consequently, congressional passage of the Patient Protection and Affordable Care Act (PPACA), which awards grants to employers that implement workplace wellness programs, complicates a person's right to make choices and dilutes the American Dream.[2]

In recent years, the obese have increasingly become regarded as lacking in self-control and discipline, as evidenced by the size of their waistline or their weight on a scale.[3] Different advocacy groups have chided the obese for their supposed gluttonous behavior.[4] From having to pay more for plus-sized clothing, being charged for two seats on many airlines, to spending an average of $700 more per year on medical premiums, the obese are increasingly disparaged for their alleged inability to control themselves and their eating habits.[5] To make matters worse, many professionals exacerbate the problem by proposing remedies based on the idea that obesity is solely a result of lifestyle choice.[6]

Sadly, the same society that lobbied for equal pay, refused to sit in the back of the bus, and lost precious American blood to protect freedom is now discriminating against the obese. PPACA's sanction of workplace wellness programs provides a concrete example of obesity discrimination in the workplace because it fails to consider the complex nature of obesity: namely, that it is often due to a complex correlation between individual choice, genetics, and environment.[7] Workplace wellness programs are applauded for helping employees improve fitness, thereby increasing the chance of a happier, healthier workforce and decreasing the employer's bottom line costs of health insurance benefits.[8] However, congressional

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[2] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3021, 124 Stat. 119, 263 (to be codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

[3] Kelly Brownell & Rebecca Puhl, *Stigma and Discrimination in Weight Management and Obesity*, 7 PERMANENTE J. 21, 21 (2003), *available at* http://xnet.kp.org/permanentejournal/sum03/stigma.pdf (discussing attitudes towards the obese including that they "lack self-control and are lazy, obesity is caused by character flaws, and failure to lose weight is due only to noncompliance").

[4] Sayward Byrd, Comment, *Civil Rights and the "Twinkie" Tax: The 900-Pound Gorilla in the War on Obesity*, 65 LA. L. REV. 303, 303–04 (2004).

[5] *Id.*

[6] *Id.* at 304 (including doctors, lawyers, researchers, and legislators).

[7] *See* Nareissa Smith, Article, *Eatin' Good? Not in this Neighborhood: A Legal Analysis of Disparities in Food Availability and Quality at Chain Supermarkets in Poverty-Stricken Areas*, 14 MICH. J. RACE & L. 197, 206 (2009) (determining while individual choice does play a role in obesity, the causes of obesity are "multifactoral" and include genetics and the environment).

[8] *See, e.g.*, Steven A. Burd, *How Safeway Is Cutting Health-Care Costs*, WALL ST. J., June 12, 2009, *available at* http://online.wsj.com/article/SB124476804026308603.html; Deborah Mitchell, *Safeway Health Insurance Plan Rewards Good Habits*, EMAXHEALTH, June 12, 2009, at A15, *available at* http://www.emaxhealth.com/1275/72/32793/safeway-health-insurance-plan-rewards-good-habits.html; *Cutting Health Costs: Discounts For The Healthy?*, NPR (Oct. 7, 2009), http://www.npr.org/templates/story/story.php?storyId=113549864.

sanctioning of these supposedly voluntary programs begs the question of whether requiring disclosure of legally protected genetic information in exchange for health insurance discounts violates federal employment law.[9]

This comment examines the complicated nature of obesity in America to ascertain whether workplace wellness programs requiring the disclosure of legally protected genetic information discriminate against the obese and violate federal employment law.[10] To accomplish this, the background section discusses the facts behind America's alleged obesity epidemic in an attempt to address some of the societal issues underpinning America's growing concern with obesity and the workplace wellness program solution.[11] Following a discussion of the relevant sections of the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA), this comment analyzes whether the ADA and GINA permit employers to provide discounts to the non-obese which results in charging the obese more for the same insurance benefits.[12] This comment concludes PPACA's sanction of workplace wellness programs discriminates against the obese and violates the ADA and GINA by unequally allocating health insurance benefits among employees and requiring the disclosure of statutorily protected genetic information.[13]

While workplace wellness programs provide a multitude of benefits for employers and their employees, ultimately such programs discriminate against the obese through the unequal distribution of health insurance premiums and violate federal employment law by compelling the disclosure of legally protected information.[14] As a result, PPACA's endorsement of workplace wellness through awarding grants to implement workplace wellness programs discriminates against the obese and violates federal employment law.[15]

II. BACKGROUND

Section A of the background examines obesity, its brief history in American society, and the resulting proclamation of an American obesity epidemic.[16] Section B addresses the multiplicity of factors resulting in obesity, including

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[9] *See infra* notes 118–85 and accompanying text.

[10] *See infra* notes 20–185 and accompanying text.

[11] *See infra* notes 20–66 and accompanying text.

[12] *See infra* notes 67–149 and accompanying text.

[13] *See infra* notes 150–85 and accompanying text.

[14] *See infra* notes 53–66, 113–85 and accompanying text.

[15] *See infra* notes 113–85 and accompanying text.

[16] *See infra* notes 20–32 and accompanying text. *See generally* Byrd, *supra* note 4, at 306–11 (discussing the brief history of America's obesity epidemic).

an individual's choice, genetics, and environment.[17] Section C examines one of Congress's responses to America's alleged obesity epidemic: workplace wellness programs.[18] Finally, section D discusses the sections of the ADA and GINA pertinent to obesity discrimination.[19]

A. Obesity: The Alleged American Epidemic

Understanding the problem behind obesity and its proposed workplace wellness solution requires a clear definition of obesity. Obesity is the excessive accumulation and storage of fat in the body.[20] The National Institute of Health utilizes the Body Mass Index (BMI) to determine obesity.[21] BMI is a numerical computation of a person's weight in relation to their height.[22] A BMI between twenty-five and thirty may mean a person is overweight, a BMI between thirty and forty may mean a person is obese, and a BMI of over forty may mean a person is morbidly obese.[23] For the purposes of this comment, obesity includes both the obese and morbidly obese.

America's trend toward expanding waistlines began in the mid-1970s.[24] By 1994, obesity rates among men and women had nearly doubled from ten-and-a-half and fifteen percent in 1962 to twenty and twenty-five percent, respectively.[25] By the end of 2008, over sixty-three percent of adult Americans were overweight or obese, and Colorado was the only state in which less than twenty percent of

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[17] *See infra* notes 33–52 and accompanying text.

[18] *See infra* notes 53–66 and accompanying text.

[19] *See infra* notes 65–112 and accompanying text.

[20] *Obesity*, MERRIAM-WEBSTER.COM, http://www.merriam-webster.com/dictionary/obesity (last visited Apr. 22, 2011).

[21] U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO PREVENT AND DECREASE OVERWEIGHT AND OBESITY (2001) [hereinafter THE SURGEON GENERAL'S CALL TO ACTION], *available at* http://www.surgeongeneral.gov/topics/obesity/calltoaction/CalltoAction.pdf.

[22] *U.S. Obesity Trends*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/data/trends.html (last updated Mar. 3, 2011). However, because the BMI formula does not directly measure body fat, many people are critical of its use to measure obesity. *See About Your BMI*, REVOLUTION HEALTH, http://www.revolutionhealth.com/healthy-living/weight-management/learn-the-basics/ideal-weight/interpret-your-bmi (last updated Mar. 2, 2007). In fact, the main criticism is that the elderly, children, athletes, and people that are short and muscular are incorrectly labeled as overweight or obese because the BMI scale fails to distinguish between muscle and fat. *Id.* For example, Lebron James is six feet eight inches tall and weighs 250 pounds; using the BMI scale, Lebron James's BMI is 27.5, which classifies him as overweight. *See NBA Player Profiles*, ESPN, http://sports.espn.go.com/nba/players/profile?playerId=1966 (last visited Apr. 25, 2011). This example evidences the flaws of the BMI scale in its application to athletes who most people consider are in the best possible shape.

[23] *U.S. Obesity Trends*, *supra* note 22.

[24] Smith, *supra* note 7, at 205.

[25] *Id.*

its adult population was obese.[26] Furthermore, between 1980 and 2006 obesity rates among American children aged six to eleven more than doubled, and obesity rates among adolescents aged twelve to nineteen more than tripled.[27] An increase in childhood obesity rates is significant because obese children are more likely to grow into obese adults.[28]

In an effort to reduce obesity rates, different advocacy groups have attempted to curb the behaviors believed to cause obesity.[29] Specifically, in 1997 the World Health Organization (WHO) officially proclaimed obesity a noncommunicable disease epidemic requiring immediate attention in America and throughout the world.[30] In fact, businesses, hospitals, and Congress acknowledge the WHO's proclamation such that obesity is now referred to as an epidemic.[31] The focus on image and weight in America begins at an early age, resulting in situations such as reducing the caloric intake of school children by mandating "Meatless Mondays" and firing a size four model for being "too fat."[32]

B. Choice, Genetics, and Environment

The aforementioned statistics amplify the debate over whether obesity is purely a choice, a product of our genetic code, a consequence of our environment, or a combination of the three. While obesity may result from an imbalance between energy intake and expenditure operating at the level of individual lifestyle choice, the causes of this imbalance are many.[33] In fact, individual choice,

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[26] *Prevalence and Trends Data*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://apps.nccd.cdc.gov/brfss/list.asp?cat=OB&yr=2008&qkey=4409&state=All (last visited Apr. 25, 2011); *U.S. Obesity Trends*, *supra* note 22.

[27] *Childhood Obesity*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/HealthyYouth/obesity/index.htm (last modified June 3, 2010).

[28] Smith, *supra* note 7, at 205.

[29] Byrd, *supra* note 4, at 304–05.

[30] Benjamin Caballero, *The Global Epidemic of Obesity: An Overview*, 29 EPIDEMIOLOGIC REVIEWS 1-5, 3 (2007); Mickey Chopra et al., *A Global Response to a Global Problem: The Epidemic of Overnutrition, Special Theme—Global Public Health and International Law*, 80 BULL. WORLD HEALTH ORG. 952, 952–58 (2002).

[31] Caballero, *supra* note 30, at 3; Byrd, *supra* note 4, at 304–05; *see* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 10408, 124 Stat. 119, 977–78 (requiring comprehensive workplace wellness programs be made available to all employees and include healthy awareness initiatives, maximization of employee engagement, initiatives to change unhealthy behaviors and lifestyle choices, and policies to encourage a reduction in obesity).

[32] Laura Vozzella, *Eat Hearty, Local: 'Meatless Monday,' Aimed at Delivering Healthier Food for Less, Comes to City Schools*, BALTIMORE SUN, Sept. 24, 2009, *available at* http://articles.baltimoresun.com/2009-09-24/news/0909230124_1_schools-in-maryland-city-schools-school-lunches; Randy Brooke, *Size 4 Model Fired for Being Too Fat*, US WEEKLY, Oct. 14, 2009, *available at* http://www.usmagazine.com/healthylifestyle/news/size-four-model-fired-for-being-too-fat-1970218.

[33] NAT'L CTR. FOR CHRONIC DISEASE PREVENTION & HEALTH PROMOTION, THE POWER OF PREVENTION: CHRONIC DISEASE . . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY (2009), *available at* http://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf; Caballero, *supra*

genetics, and environment all play a significant role in obesity.[34] Additionally, genetic syndromes, diseases, and prescription drugs may also contribute to severe weight gain.[35]

The Thrifty Genotype Hypothesis (TGH) is one explanation for obesity's rapid rise in America.[36] The TGH maintains that an environment where food is plentiful and available year round challenges the same genes our ancestors relied on to survive intermittent famines, resulting in fat accumulation in an individual.[37] The TGH further contends genes can cause fat accumulation in the body through overeating, poor regulation of appetite, lack of physical activity, diminished ability to use dietary fats as fuel, and an increased and easily stimulated capacity to store body fat.[38] While population-wide genetic changes happen too slowly to account for obesity's rapid rise in America, communities in which there is an abundance of calorie-rich foods and few opportunities for physical activity have a major impact on whether a person is obese.[39]

The hormones leptin and ghrelin regulate hunger and appetite levels in the human body.[40] Because leptin and ghrelin levels increase the propensity for obesity by suppressing the desire to engage in physical activity, proportionately balancing and regulating these hormones in the body contributes to a lower BMI.[41] Yet, a number of genetic and environmental factors including stress, nutrition, and culture contribute to the imbalance of these hormones, resulting in spontaneous and uncontrollable weight gain and thereby complicating one's ability to achieve hormonal balance and a low BMI.[42]

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note 30, at 2; Smith, *supra* note 7, at 206; *Causes and Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/causes/index.html (last updated Dec. 7, 2009).

[34] Leah J. Tulin, Communities Note, *Poverty and Chronic Conditions During Natural Disasters: A Glimpse at Health, Healing, and Hurricane Katrina*, 14 GEO. J. ON POVERTY L. & POL'Y 115, 122 (2007). Additionally, factors such as housing, air and water pollution, stress, nutrition, income, education, culture, and preventive health measures play a role in causing obesity. *Id.* at 125 n.43.

[35] *Causes and Consequences*, *supra* note 33 (including such genetic syndromes as Bardet-Biedl syndrome, Prader-Willi syndrome; diseases such as Cushing's disease, polycystic ovary syndrome; and drugs such as steroids and antidepressants).

[36] *Genomics and Health*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/genomics/resources/diseases/obesity/index.htm (last updated Mar. 9, 2010) (hypothesizing TGH is a mismatch between today's environment and energy-thrifty genes that multiplied in the past under different environmental settings).

[37] *Id.*

[38] *Id.*

[39] *Id.*; *Causes and Consequences*, *supra* note 33.

[40] Joseph P. McMenamin & Andrea D. Tiglio, Trend in Consumer Litigation, *Not the Next Tobacco: Defenses to Obesity Claims*, 61 FOOD & DRUG L.J. 445, 473–77 (2006) (determining leptin hormones suppress appetite, ghrelin hormones stimulate hunger and promote food ingestion, and an imbalance in many other hormones may lead to obesity).

[41] *Id.*

[42] *Id.*

While the influence of genetics as well as environmental factors leading to an abundant food supply or little physical activity increase a person's propensity for obesity, specific environmental factors are difficult to isolate.[43] The availability of food resources to different socioeconomic groups in America is one environmental contribution to a person's obesity.[44] Because poorer Americans are less likely to find and have the ability to afford healthy foods, food resources are a critical factor in rising obesity levels in America.[45] The unavailability of healthy food in poorer communities throughout America is at the center of the idea that a connection between obesity and poverty exists.[46]

However, merely linking obesity to poverty and healthcare inequality may not be enough because the solution to obesity, like its causes, is multifaceted.[47] Understanding the relationship between a person's choices, genes, and environment continues to lead to great advances in comprehending the underlying causes of obesity and resolving its associated problems.[48] By examining this relationship, medical practitioners are able to identify, evaluate, and develop interventions to improve individual health and prevent obesity.[49]

Most Americans are aware of some of the medical consequences related to obesity, but few realize the associated increased propensity for certain diseases or additional medical costs.[50] As a person's weight increases to obese BMI levels, the likelihood of coronary heart disease, adult-onset diabetes, stroke, and other life-threatening diseases and conditions increases dramatically.[51] Obesity also

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[43] *Causes and Consequences*, *supra* note 33.

[44] Smith, *supra* note 7, at 206. Food resources include the type and number of food stores available in a given location, as well as the variety, type, and quality of foods offered within those stores. *Id.*

[45] *Id.* at 206–07.

[46] Byrd, *supra* note 4, at 313.

[47] *Id.*; *see also* NANCY L. JONES & AMANDA K. SARATA, CONG. RESEARCH SERV., RL 30006, GENETIC INFORMATION: LEGAL ISSUES RELATING TO DISCRIMINATION AND PRIVACY 2, at 2 (2008) (explaining all diseases have a genetic component), *available at* http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3000602232005.pdf.

[48] *Genomics and Health*, *supra* note 36.

[49] *Id.*

[50] *Economic Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/causes/economics.html (last updated Mar. 3, 2011); *Overweight and Obesity*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/index.html (last updated Mar. 1, 2011).

[51] NAT'L HEART, LUNG, & BLOOD INST., NAT'L INST. OF HEALTH, NIH PUB. 98-4083, THE EVIDENCE REORT: CLINICAL GUIDELINES ON THE IDENTIFICATION, EVALUATION, AND TREATMENT OF OVERWEIGHT & OBESITY IN ADULTS (1998); *Health Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/causes/health.html (last updated Mar. 3, 2011) (including hypertension, dyslipidemia, liver disease, gallbladder disease, sleep apnea, respiratory problems, and osteoarthritis).

exponentially increases preventive, diagnostic, and treatment expenses for the individual, the state, and the nation.[52]

C. *Workplace Wellness Programs*

Because of the various concerns and consequences linked to obesity, workplace wellness programs have emerged as a modern solution to America's alleged obesity epidemic.[53] Employers implement workplace wellness programs to lower insurance premiums by rewarding healthy behavior in an effort to deter unhealthy behavior.[54] Such programs stand for the idea that individuals making poor health decisions should not have their decisions subsidized through an insurance program by those making good health decisions.[55] Accordingly, workplace wellness programs begin with a detailed questionnaire called a Health Risk Assessment (HRA) followed by a medical exam to determine the employee's modifiable risk factors based on health practices, health history, family health history, and health status.[56] Then, the employer evaluates the employee's modifiable risk factors and recommends enrollment in certain programs designed to reduce or improve that employee's tobacco use, weight, blood pressure, or cholesterol levels.[57] Adhering to specific program requirements provides an employee with discounts to his health insurance premiums.[58] Consequently, employers differentiate health insurance premiums based on an employee's HRA results and the imposed healthy behaviors that follow.[59]

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[52] *Economic Consequences*, *supra* note 50 (including lost incomes resulting from decreased productivity, restricted activity, absenteeism, and premature death).

[53] *See* Burd, *supra* note 8 (naming Safeway Stores as one of the largest supporters and lobbyists in favor of workplace wellness programs); Mitchell, *supra* note 8 (finding Congress strongly considered Safeway's Healthy Measures Program as a solution for America's health insurance problem before passing PPACA); Kimberly A. Strassel, *Mr. Burd Goes to Washington: Business Will Pay for Government Health Care*, WALL ST. J., June 12, 2009, at A13, *available at* http://online.wsj.com/article/NA_WSJ_PUB:SB124536722522229323.html; *Cutting Health Costs: Discounts For The Healthy?*, *supra* note 8 (discussing how Safeway Stores' Healthy Measures Program was considered by Congress as the solution for today's healthcare issues and is a primary example of workplace wellness programs implemented by employers to reduce insurance costs).

[54] *See* Burd, *supra* note 8 (basing the workplace wellness program idea on the concept of car insurance; namely, that driving behavior correlates to accident risk and translates into premium differences among drivers).

[55] Strassel, *supra* note 53.

[56] Ann Hendrix & Josh Buck, *Employer-Sponsored Wellness Programs: Should Your Employer Be the Boss of More Than Your Work?*, 38 SW. U. L. REV. 465, 477–79 (2009); Sandy Szwarc, *Life Inside Company "Wellness Programs"—See Those Frowny Faces*, JUNKFOOD SCI. (May 6, 2007), http://junkfoodscience.blogspot.com/2007/05/life-inside-company-wellness-programs.html.

[57] Szwarc, *supra* note 56.

[58] *Id.*

[59] *Id.*

By implementing workplace wellness programs, employers hope to build a culture of health and fitness among their employees while reducing employee obesity rates, thereby keeping employer health insurance costs static and improving the bottom line.[60] However, the disadvantages of workplace wellness programs are rarely discussed, and specific groups are inevitably unable to participate for a variety of reasons.[61] For example, some employees may be unable to meet the demands of being tested for modifiable risk factors, while other employees may have undergone medical procedures barring them from participation in the program.[62] Additionally, some conditions are exacerbated or even caused by an individual's genetics.[63] Moreover, some employees may feel compelled to take medications determined necessary to modify certain risk factors in order to stay healthy, keep their cost of insurance down, or even remain employed.[64] Finally, the potential for discrimination and harassment at the workplace for failure to participate in the program also exists.[65]

Despite the foreseeable discrimination in workplace wellness programs, employers are inclined to continue implementing them because of their cost saving advantages. In addition to reducing costs, employers purport to see a multitude of benefits after implementing a workplace wellness program including higher employee morale, improved employee health, fewer workers' compensation claims, less employee absenteeism, and more employee productivity.[66]

D. The Americans with Disabilities Act

Before the enactment of the ADA, disability claims were brought under various civil rights acts and section 504 of the Rehabilitation Act of 1973

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[60] *Id.*; Burd, *supra* note 8; Mitchell, *supra* note 8; Strassel, *supra* note 53; *Cutting Health Costs: Discounts For The Healthy?*, *supra* note 8.

[61] *See* Michelle Mello & Meredith Rosenthal, *Wellness Programs & Lifestyle Discrimination—The Legal Limits*, 359 NEW ENG. J. MED. 2, 196–98 (2008) (discussing the overarching litmus test of program legality and the need for employers to exercise caution in implementing workplace wellness programs).

[62] Szwarc, *supra* note 56.

[63] For example, obesity, in some cases, is caused by genetics factors including genetic diseases such as Bardet–Biedl syndrome, Prader-Willi syndrome; non-genetic diseases such as Cushing's disease, polycystic ovary syndrome; and drugs such as steroids and antidepressants. *Causes and Consequences*, *supra* note 33.

[64] Szwarc, *supra* note 56; *see* Mello & Rosenthal, *supra* note 61, at 196–98 (discussing the legal boundaries around which workplace wellness programs must maneuver).

[65] Szwarc, *supra* note 56; *see* Mello & Rosenthal, *supra* note 61, at 196–98 (cautioning employers not to "pay for performance" but only for participation).

[66] AM. INST. FOR PREVENTIVE MED., THE HEALTH & ECONOMIC IMPLICATIONS OF WORKSITE WELLNESS PROGRAMS 6 (2008), *available at* http://www.healthylife.com/template.asp?pageid=75.

(RHA).[67] Fourteen years after the RHA was passed, the United States Supreme Court broadly interpreted its definition of disability in *School Board of Nassau County, Florida v. Arline*.[68] Specifically, the *Arline* Court utilized a more inclusive definition of the term disability, unlike the original definition in the RHA limiting disabilities to traditional handicaps.[69] Shortly after the *Arline* holding, Congress discussed a broader statutory framework to provide protection for disabled Americans, ultimately resulting in the enactment of the ADA in 1990.[70]

Because Congress focused heavily on resolving the issues with the RHA, the ADA utilizes a more functional definition of disability than section 504 of the RHA with the primary goal of ending disability discrimination by focusing more on individual abilities and less on individual handicaps.[71] In its effort to end disability discrimination, the ADA defines the term disability as (1) a physical or mental impairment that substantially limits one or more major life activities; (2) a record of such an impairment; or (3) being regarded as having such an impairment.[72] Under the ADA, a physical or mental impairment is defined as a condition, disfigurement, or loss affecting specified body systems; a mental or psychological disorder; or a contagious or non-contagious disease or condition.[73]

While the ADA lists some examples of physical or mental impairments, the list was not meant to be exhaustive.[74] Rather, the list merely illustrates what

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[67] *See* LAURA ROTHSTEIN & JULIA ROTHSTEIN, DISABILITIES AND THE LAW § 1:2 (4th ed. 2009), *available at* Westlaw DISABLAW (including the Fourteenth Amendment, the Social Security Act, the LaFollette-Barden Act of 1943, the Architectural Barriers Act, and the Urban Mass Transportation Act).

[68] 480 U.S. 273, 289 (1987) (determining whether the RHA provides discrimination protection for individuals with contagious diseases, such as tuberculosis, and whether a person with a record of impairment that is also contagious is removed from RHA protection), *superseded by statute*, 29 U.S.C. § 794 (2006), *as recognized in* Shiring v. Runyon, 90 F.3d 827, 831–32 (3d Cir. 1996).

[69] *Id.* at 279.

[70] 42 U.S.C. § 12101(b)(1); U.S. Equal Emp't Opportunity Comm'n, *Americans with Disabilities Act: Questions and Answers*, ADA.GOV, http://www.ada.gov/q&aeng02.htm (last updated Nov. 14, 2008).

[71] *See* 42 U.S.C. §§ 12101(a), (b)(1) (stating the purpose of the Act is to "provide a clear and comprehensive mandate for the elimination of discrimination against individuals with disabilities"); H.R. REP. NO. 101-485, pt. 3, at 23–29 (1990), *reprinted in* 1990 U.S.C.C.A.N. 445, 446–50 ("The ADA uses the same basic definition of 'disability' first used in the Rehabilitation Act of 1973 and in the Fair Housing Amendments Act of 1988."); U.S. Equal Emp't Opportunity Comm'n, *supra* note 70.

[72] 42 U.S.C. § 12102(1)–(2) (defining disability and major life activities); H.R. REP. NO. 101-485, pt. 3, at 27–29 (defining the term disability).

[73] 29 C.F.R. § 1630.2(h)(1) (2010) (defining the term physical or mental impairment under the ADA).

[74] 42 U.S.C. § 12102; H.R. REP. NO. 101-485, pt. 3, at 26–29. In fact, Congress explicitly stated that providing a list of specific disabilities would limit the "comprehensiveness" of the statute "because new disorders may develop in the future, as they have since the definition was first

constitutes a physical or mental impairment limiting a major life activity.[75] Protection for such impairment requires evidence showing essential life activities are extremely restricted.[76] Specifically, the extremely restricted life activity must be limited to the conditions, manner, or duration under which it can be performed in comparison to most people.[77] The ADA includes working as a major life activity.[78] However, the inability of a person to perform a single particular job function of his or her work is not considered a substantial limitation to working under the ADA.[79] Although the ADA's three general prongs of coverage identify the protected impairments, the ADA's five distinct titles categorize the circumstances in which the ADA provides protection against discrimination.[80] Specifically, Title I of the ADA prohibits employer discrimination of qualified employees, which are defined as individuals with a disability who are able to perform the essential functions of their employment position, with or without reasonable accommodations by the employer.[81]

Notably, courts prohibit discrimination through the administration of insurance benefits because they are a form of employee compensation, thereby bringing equal benefit distribution under the purview of the ADA and further eliminating workplace discrimination.[82] However, before the Americans with Disabilities Act Amendments Act of 2008 (ADAAA), inconsistent court holdings of what constituted an ADA protected disability resulted in the unequal administration of health insurance benefits between obese and non-obese

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established in 1973" and that "[t]he definition is specifically designed to be able to incorporate new conditions and diseases that may affect individuals in the future." H.R. REP. NO. 101-485, pt. 3, at 27, 28 n.16.

[75] H.R. REP. NO. 101-485, pt. 3, at 27–29 (stating a major life activity is a function "such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working").

[76] 29 C.F.R. § 1630.2(n).

[77] *Id.* § 1630.2(j)(1), (n); H.R. REP. NO. 101-485, pt. 2, at 52.

[78] 29 C.F.R. § 1630.2(j)(3)(i).

[79] *Id.*

[80] 42 U.S.C. § 12112 (2006).

[81] *Id.* §§ 12111(8), 12112(a)–(b).

[82] H.R. REP. NO. 101-485, pt. 3, at 38; Jennifer S. Geetter, Note, *The Condition Dilemma: A New Approach to Insurance Coverage of Disabilities*, 37 HARV. J. ON LEGIS. 521, 525–26 (2000); *see, e.g.*, Equal Emp't Opportunity Comm'n v. Staten Island Sav. Bank, 207 F.3d 144, 151 (2d Cir. 2000) ("It is fully consistent with an understanding that the ADA protects the individual from discrimination based on his or her disability to read the Act to require no more than that access to an employer's fringe benefit program not be denied or limited on the basis of his or her particular disability."); Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1112 (9th Cir. 2000) (discussing whether the ADA governs the equal distribution of "fringe benefits" amongst employees and non-employees thereby recognizing the ADA precludes discrimination through employer benefit administration).

employees.[83] While many courts discussed whether obesity was a disability deserving ADA protection before passage of the ADAAA, most examined state laws mirroring ADA language; their decisions, therefore, were nonbinding throughout the country.[84] Additionally, the reasoning underlying each court's analysis varied widely, highlighting the differing attitudes toward obesity as an ADA protected disability and a reluctance to be the first court to expand disability protection to the obese under the ADA.[85] The few federal courts that have discussed whether obesity is a disability focused on analyzing the perceived disability claim under the third general prong of the ADA: namely, the perceived as having a disability

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[83] *Compare* Sutton v. United Air Lines, Inc., 527 U.S. 471, 494 (1999) (holding if a disability can be corrected or mitigated, it does not amount to a substantial limitation), *superseded by statute*, ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553, Greene v. Union Pac. R.R. Co., 548 F. Supp. 3, 5 (W.D. Wash. 1981) (finding obesity is "not an immutable condition such as blindness or lameness" and is therefore not statutorily protected), Cassista v. Cmty. Foods, Inc., 856 P.2d 1143, 1154 (Cal. 1993) (concluding a plaintiff must prove "weight is the result of a physiological condition or disorder affecting one or more of the body systems" to prevail in a perceived disability claim against an employer), *and* Krein v. Marian Manor Nursing Home, 415 N.W.2d 793, 795–96 (N.D. 1987) (holding if an employee does not consider obesity to be disabling then it is not a disability), *with* Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17, 28 (1st Cir. 1993) (holding statutorily protected disabilities include more than immutable or involuntary conditions), Gimello v. Agency Rent-A-Car Sys., Inc., 594 A.2d 264, 278 (N.J. Super. Ct. App. Div. 1991) (deciding an "employer's actual perception may not be particularly important when a real medical or pathological condition exists"), *and* State Div. of Human Rights on Complaint of McDermott v. Xerox Corp., 480 N.E.2d 695, 699 (N.Y. 1985) (holding obesity is a statutorily protected disability prohibiting employers from denying employment, even if it is treatable).

[84] *See, e.g.*, *Cassista*, 856 P.2d at 1152 (considering claims brought under California's Fair Employment and Housing Act); *Gimello*, 594 A.2d at 341 (scrutinizing the New Jersey Law Against Discrimination); *Xerox Corp.*, 480 N.E.2d at 696 (reviewing complaints pursuant to New York's Human Rights Law); *Krein*, 415 N.W.2d at 794 (examining North Dakota's Worker's Compensation Act); Civil Serv. Comm'n of Pittsburgh v. Human Relations Comm'n, 591 A.2d 281, 282 (Pa. 1991) (assessing Pennsylvania's Human Relations Act); Phila. Elec. Co. v. Human Relations Comm'n, 448 A.2d 701, 703 (Pa. Commw. Ct. 1982) (evaluating claims brought under Pennsylvania's Human Relations Act), *superseded by statute*, 43 PA. CONS. STAT. § 954 (West 1982), *as recognized in* Jenks v. Avco Corp., 340 Pa. Super. 542, 549 (1985).

[85] *E.g.*, *Greene*, 548 F. Supp. at 4 (promulgating company-wide medical standards for employment seekers or employees transferring across job categories determined reasonable); *Cassista*, 856 P.2d at 1153 (interpreting that both federal and state statutes "reject the argument that weight unrelated to a physiological, systemic disorder constitutes a handicap or disability"); *Gimello*, 594 A.2d at 276 (contemplating "that an obese person may be considered 'handicapped under [New Jersey] statute'"); *Xerox Corp.*, 480 N.E.2d at 697 (noting "that if a person suffers an impairment, employment may not be denied because of any actual or perceived undesirable effect the person's employment may have on disability or life insurance programs"); *Krein*, 415 N.W.2d at 796 (stating "the mere assertion that one is overweight or obese is not alone adequate to make a claimant one of the class of persons afforded relief"); *Civil Serv. Comm'n of Pittsburgh*, 591 A.2d at 283 (indicating obesity does not fit into one or more of the categories of being regarded as having a physical or mental impairment, physiological disorder, cosmetic disfigurement, or anatomical loss affecting one of the body systems); *Phila. Elec. Co.*, 448 A.2d 701, 707 (concluding obesity may be a handicap or disability deserving statutory protection, but the condition of "obesity, alone, is not such a handicap or disability").

prong.[86] Two prominent federal cases, *Cook v. Rhode Island Department of Mental Health, Retardation, & Hospitals* and *Sutton v. United Air Lines, Inc.*, decided six years apart, reached entirely different conclusions regarding what constitutes an ADA protected disability under the third prong.[87] While both *Cook* and *Sutton* discussed ADA perceived disability discrimination claims under the third prong, their difference of opinion caused unnecessary confusion as to whether obesity or any other perceived disability was an ADA protected disability.[88]

In *Cook*, the United States Court of Appeals for the First Circuit rejected the argument that a disability must be an involuntary, immutable condition.[89] Instead, the *Cook* court determined the RHA, and by extension the ADA, contained no language suggesting its protection is linked to whether an individual contributed to his own impairment.[90] Supporting its conclusion by finding evidence of the RHA's indisputable application to numerous conditions either caused or exacerbated by voluntary conduct, the *Cook* court extended disability protection to obesity.[91] In *Sutton*, which did not discuss obesity directly, the United States Supreme Court determined that if a perceived disability could be corrected by

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[86] *E.g.*, *Cook*, 10 F.3d at 20 ("This pathbreaking 'perceived disability' case presents a textbook illustration of the need for, and the operation of, the prohibition against handicap discrimination contained in section 504 of the Rehabilitation Act of 1973."); Smaw v. Dep't of State Police, 862 F. Supp. 1469, 1470 (E.D. Va. 1994) (deciding whether, by reason of plaintiff's obesity, plaintiff is "regarded . . . as either handicapped or disabled"); Francis v. City of Meriden, 129 F.3d 281, 282 (2d Cir. 1997) (determining whether the defendant perceived that the plaintiff had a disability and discriminated against him on that basis), *superseded by statute*, 42 U.S.C. § 12101 (2006).

[87] In *Cook*, the plaintiff was a five-foot-two-inch-tall 320-pound Rhode Island Department of Mental Health, Retardation, and Hospitals institutional attendant for eight years. 10 F.3d at 20. After a break from employment, the plaintiff sought and was accepted for reemployment pending her passage of a medical examination. *Id.* When the plaintiff failed to lose weight to pass the medical exam, she was denied the position partly because it was perceived that her obesity would impede her ability to evacuate patients in the event of an emergency. *Id.* at 20–21.

In *Sutton*, the plaintiffs were twin sisters with severe myopia. 527 U.S. at 488. Without corrective lenses, neither sister could see well enough to conduct numerous activities such as driving; however, with corrective measures, both could function identically to individuals without similar impairments. *Id.* The plaintiffs applied to United Air Lines for employment as commercial airline pilots but were rejected because neither met the minimum requirement of uncorrected visual acuity. *Id.* Accordingly, the plaintiffs filed suit under the ADA arguing they had been discriminated against for their perceived vision disability. *Id.* at 488–89. The Court held the plaintiffs were not actually disabled under subsection (A) of the ADA's disability definition because they could fully correct their visual impairments so a major life activity was no longer substantially limited. *Id.* at 489.

[88] *See* Americans with Disabilities Act Amendments Act, § 2, 122 Stat. at 3553–54 ("[W]hile Congress expected that the definition of disability under the ADA would be interpreted consistently . . . that expectation has not been fulfilled . . . [because] lower courts have incorrectly found in individual cases that people with a range of substantially limiting impairments are not people with disabilities.").

[89] 10 F.3d at 23–24.

[90] *Id.*

[91] *Id.* at 24 (including conditions such as alcoholism, AIDS, diabetes, cancer resulting from cigarette smoking, heart disease resulting from excesses of various types, and the like).

utilizing some available measure, then the perceived disability would no longer be eligible for protection under the ADA.[92] The *Sutton* Court concluded its holding is applicable even in situations where the disease or condition disabling the individual is specifically listed under the ADA.[93]

During the course of the litigation leading to these inconsistent decisions, the Equal Employment Opportunity Commission (EEOC) also weighed in on the issue. After *Cook*, but before *Sutton*, the EEOC reversed its long-standing opinion that obesity is not a disability, supporting the *Cook* court's decision and despite the later *Sutton* decision to the contrary.[94] In the time between the two cases, however, the EEOC also heightened its standard of what constituted a disability, which spawned the difference in analysis between the cases and ultimately gave rise to the ADAAA.[95]

E. The Genetic Information Nondiscrimination Act

The ADA does not contain any protections for discrimination based on genetic information.[96] To alleviate the concern that genetic information may be used to deny, limit, or cancel health insurance, or discriminate against individuals in the workplace, Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996.[97] HIPAA provides some protection against health insurance

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[92] *Sutton*, 527 U.S. at 482–88.

[93] *Id.* at 501–02.

[94] *See* Brief of the Equal Employment Opportunity Commission as Amicus Curiae Supporting Appellee, *Cook*, 10 F.3d 17 (No. 93-1093), 1993 WL 13625007 [hereinafter EEOC Amicus Curiae Brief] (supporting Cook's argument that her obesity constituted a disability deserving statutory protection against discrimination). *Compare id.* (stating "obesity may, in appropriate circumstances, constitute a disability"), *with* Americans with Disabilities Act Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3553–54 (to be codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.) (finding the EEOC's current standard of what constitutes a disability expresses "too high a standard").

[95] *See* 42 U.S.C.A. § 12101 (West 2009); Americans with Disabilities Act Amendments Act, § 2, 122 Stat. at 3553–54 (discussing the various reasons why Congress felt the ADA needed to be amended, including a rejection of the narrowed standard determined by the *Sutton* Court and the then current heightened standard promulgated by the EEOC); EEOC Amicus Curiae Brief, *supra* note 94 (supporting Cook's argument that obesity may be a disability deserving legal protection).

[96] JONES & SARATA, *supra* note 47, at 11. Although the combination of the ADA's legislative history and the EEOC's guidance has led commentators to argue that the ADA would cover genetic discrimination, the merit of these arguments has been uncertain since there have been no reported cases holding that the ADA prohibits genetic discrimination. *Id.* This uncertainty has increased in light of Supreme Court decisions on the definition of disability under the ADA. *Id.*

[97] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 2702 , 110 Stat. 1936, 1936, 1962–63; *Genetic Information in Health Insurance or Employment*, NAT'L HUM. GENOME RES. INST., http://www.genome.gov/11510227 (last reviewed Nov. 3, 2010).

and employment discrimination.[98] In 2000, Congress realized protection against genetic discrimination was deficient and worked toward finding a solution.[99] After nearly eight years of negotiation and several unsuccessful attempts to ban genetic discrimination in healthcare and the workplace, Congress amended HIPAA by enacting GINA.[100]

GINA is designed to address concerns that (1) employers would rely on genetic testing to terminate employees based on the discovery of genes associated with diseases; (2) health insurers would deny coverage to individuals seen as bad genetic risks; and (3) genetic information would be used against consumers in a variety of other ways.[101] Congress determined if genetic discrimination was not made unlawful, individuals would be less willing to participate in research or take full advantage of the clinical benefits of genetic tests and technologies.[102] Through GINA, Congress acknowledged that HIPAA affords some protection against discrimination based on genetic information.[103] Specifically, the nondiscrimination regulations promulgated by HIPAA prohibit a group health plan or health insurer from using genetic information to deny coverage, apply pre-existing condition exclusions, or charge an individual in a group a higher

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[98] *Genetic Information in Health Insurance or Employment*, *supra* note 97; *see* 42 U.S.C. § 300gg-1(a) (2006) (stating under HIPAA, a group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following factors in relation to the individual or a dependent of the individual: (a) health status, (b) medical condition (including both physical and mental illnesses), (c) claims experience, (d) receipt of healthcare, (e) medical history, (f) genetic information, (g) evidence of insurability (including conditions arising out of acts of domestic violence), and (h) disability).

[99] 42 U.S.C. § 300gg-1(a); *Genetic Information in Health Insurance or Employment*, *supra* note 97.

[100] *See* Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 2, 122 Stat. 881, 881–83 (to be codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.) (discussing the history of protection against genetic information discrimination).

[101] Kathy Bakich, *Taking a New Look at Genetic Discrimination, Privacy,* 11 No. 4 EMPLOYER'S GUIDE TO HIPAA NEWSL. 15 (Thompson Publ'g Grp., Inc., Tampa, Fla.), Sept. 2008, at 15. GINA's origins stemmed from the ability to map and understand the genetic code. *See* S. REP. NO. 110-48 (2007). In fact, the Senate Health, Education, Labor and Pensions Committee (SHELPC) concluded understanding the genetic code is a discovery so significant that it has the potential to transform both science and society. *Id.* To demonstrate its conclusion, SHELPC found that an early milestone has been the link between mutations in two genes, BRCA1 and BRCA2, and an elevated risk of breast and ovarian cancer, respectively. *Id.* Performing genetic testing can help women and their healthcare providers evaluate their risk of those diseases and take steps to prevent them. *Id.* When Congress reviewed these findings, it noted the newfound sequencing of the human genetic code is a breakthrough that holds "dangers as well as opportunities." *Id.* Relevant legislative history cites multiple studies showing that Americans and their healthcare providers fear genetic testing will be used against individuals. *Id.*

[102] S. REP. NO. 110-48; JONES & SARATA, *supra* note 47, at 1–7.

[103] S. REP. NO. 110-48.

premium based on genetic information.[104] Nevertheless, HIPAA did not prohibit group health plans or insurers from using genetic information when setting the premium for a plan as a whole, nor did it protect individuals in the insurance market against discrimination based on genetic information.[105] As a result of HIPAA's deficiencies, GINA broadly prohibits discrimination based on genetic information.[106]

GINA defines genetic information as information about the genetic tests of an employee and their family members, as well as the manifestation of a disease or disorder in family members of an employee.[107] Specifically, GINA prohibits employers from discriminating against any employee based on family history of disease or disorder.[108] Title II of GINA prohibits employers from using genetic information to discriminate against employees with respect to compensation and other privileges of employment.[109] Additionally, Title II prohibits segregating or classifying employees in a way that would deprive or tend to deprive the employee of any opportunity or adversely affect the employee's status because of his or her genetic information.[110] GINA's Title II also prohibits employers from requesting, requiring, or purchasing an employee's genetic information.[111] Yet, Title II permits an employer to collect genetic information in compliance with the certification requirements of family and medical leave laws or through inadvertent lawful inquiries under, for example, the ADA, so long as the employer does not use the information to discriminate.[112]

III. ANALYSIS

A. *The Courts and Obesity Discrimination*

Ultimately, the *Cook* court reached the correct decision in holding obesity is a perceived disability and therefore deserves protection under the ADA.[113] Before

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[104] 42 U.S.C. § 300gg-1; S. REP. NO. 110-48; JONES & SARATA, *supra* note 47, at 7–8.

[105] Genetic Information Nondiscrimination Act, § 2, 122 Stat. at 882; JONES & SARATA, *supra* note 47, at 7–8.

[106] 42 U.S.C. § 2000ff-1; Genetic Information Nondiscrimination Act, § 2, 122 Stat. at 881.

[107] 42 U.S.C. § 2000ff(4).

[108] *Id.*

[109] *Id.* § 2000ff-1(a)(1).

[110] *Id.* § 2000ff-1(a)(2).

[111] *Id.* § 2000ff-1(b).

[112] *Id.* § 2000ff-5(b).

[113] Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17, 20 (1st Cir. 1993); *see* Americans with Disabilities Act Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3553 (to be codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.) ("[W]hile Congress expected that the definition of disability under the ADA would be interpreted consistently . . . that expectation has not been fulfilled . . . [because] lower courts have incorrectly found in individual cases that people with a range of substantially limiting impairments are not people with disabilities.")

the ADAAA's passage, many courts recognized the ADA prohibited the unequal distribution of employee benefits, but they were inconsistent in interpreting what constituted an ADA protected disability.[114] Thus, courts indirectly concluded health insurance benefits could be unequally distributed between the obese and non-obese, thereby avoiding the congressional intent that a broad expansion of ADA protection be applied to conditions, diseases, and illnesses beyond the nonexclusive list of conditions provided therein.[115] Specifically, the *Sutton* holding failed to adequately account for what the *Cook* court and the ADAAA's congressional drafters realized: namely, obesity is not merely a mutable and controllable condition but a complex problem involving individual choice, genetics, and environment.[116] Congress passed the ADAAA to overturn *Sutton*'s narrow interpretation of what constitutes a disability under the ADA and to remove the imposition of a more rigorous standard for determining a protected disability under the ADA.[117] Unfortunately, the ADA currently does not include protection against the discriminatory use of genetic information.[118]

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[114] *See, e.g.*, Equal Emp't Opportunity Comm'n v. Staten Island Sav. Bank, 207 F.3d 144, 151 (2d Cir. 2000) (discussing whether the administration of long-term disability plans violates the ADA); Weyer v. Twentieth Century Fox Film Corp., 198 F.3d 1104, 1110–11 (9th Cir. 2000) (discussing whether the ADA governs the equal distribution of "fringe benefits" amongst employees). *Compare* Cassista v. Cmty. Foods, Inc., 856 P.2d 1143, 1154 (Cal. 1993) (concluding a plaintiff must prove "weight is the result of a physiological condition or disorder affecting one or more of the body systems" to prevail in a perceived disability claim against an employer), *with Cook*, 10 F.3d at 23–24 (holding statutorily protected disabilities include more than immutable or involuntary conditions).

[115] *Compare* Greene v. Union Pac. R.R. Co., 548 F. Supp. 3, 5 (W.D. Wash. 1981) (finding obesity is "not an immutable condition such as blindness or lameness" and is therefore not statutorily protected), *Cassista*, 856 P.2d at 1154 (concluding a plaintiff must prove "weight is the result of a physiological condition or disorder affecting one or more of the body systems" to prevail in a perceived disability claim against an employer), *and* Krein v. Marian Manor Nursing Home, 415 N.W.2d 793, 795–96 (N.D. 1987) (holding if an employee does not consider obesity to be disabling, then it is not a disability), *with* Gimello v. Agency Rent-A-Car Sys., Inc., 594 A.2d 264, 278 (N.J. Super. Ct. App. Div. 1991) (deciding an "employer's actual perception may not be particularly important when a real medical or pathological condition exists"), *and* State Div. of Human Rights on Complaint of McDermott v. Xerox Corp., 480 N.E.2d 695, 699 (N.Y. 1985) (holding obesity is a statutorily protected disability prohibiting employers from denying employment, even if it is treatable).

[116] *See* Americans with Disabilities Act Amendments Act, § 2, 122 Stat. at 3553–54 (stating the *Sutton* Court "narrowed the broad scope of protection intended to be afforded by the ADA, thus eliminating protection for many individuals whom Congress intended to protect").

[117] *Id.* § 2, 122 Stat. at 3554. In fact, Congress cited the *Sutton* Court and its companion cases as examples of incorrect holdings directly conflicting with the original intent of Congress regarding who should be afforded protection under the ADA. *Id.* Congress determined there was a multitude of holdings incorrectly concluding people with a range of substantially limiting impairments were not people with disabilities. *Id.* Further, Congress explicitly stated the current EEOC ADA regulations defining the term "substantially limits" as "significantly restricted" were inconsistent with congressional intent because they expressed too high a standard. *Id.*

[118] *See* JONES & SARATA, *supra* note 47, at 1–8, 11, 14 (discussing the lack of statutory protection for genetic information and an absence of reported cases and Supreme Court decisions discussing an ADA prohibition of genetic discrimination prior to GINA's enactment in 2008).

B. Obesity: Not Merely a Choice

Blaming obesity on individual choice, poverty, or disproportionate healthcare benefits is inadequate because the solutions to obesity, like its causes, are not based solely on choice, lack of money, or the inability to receive basic healthcare benefits.[119] Many obese people either choose to become or remain obese by failing to exercise, eat healthily, or alter their lifestyle in a number of modest ways, but obesity is also caused and perpetuated by genes, the environment, and other uncontrollable variables.[120] It is true obesity can be brought on or made worse by undesirable lifestyle choices that are easily modifiable; nevertheless, this comment focuses on instances in which obesity is caused by, exacerbated by, or made irreversible because of genetic or environmental factors.

The *Cook* court's discussion that auto immune deficiency syndrome (AIDS) can be a condition caused or exacerbated by voluntary conduct is relevant to the discussion of obesity.[121] Specifically, the *Cook* court found that contracting AIDS was not voluntary despite the voluntary acts of having unprotected sex or sharing infected needles.[122] Thus, a person's choice to knowingly or unknowingly interact with someone infected with AIDS does not invalidate available legal protections if that person subsequently contracts the disease; legal protection is not linked to how the person became infected with AIDS or whether they contributed to contracting the disease.[123]

Similarly, in many instances obesity results from a voluntary act: consuming too much food, failing to exercise, or a combination thereof; however, becoming obese is not exclusively a matter of making poor food choices or failing to

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[119] Byrd, *supra* note 4, at 313; THE SURGEON GENERAL'S CALL TO ACTION, *supra* note 21; *Obesity Bias, and Stigmatization*, AM. OBESITY ASS'N, http://www.obesity.org/resources-for/obesity-bias-and-stigmatization.htm (last visited Apr. 4, 2011).

[120] *See* Carol R. Buxton, Student Comment, *Obesity and the Americans with Disabilities Act*, 4 BARRY L. REV. 109, 120 (2003) ("[O]ne who simply eats too much food and becomes obese can negate that condition through proper diet and exercise."); Madison Park, *Twinkie Diet Helps Nutrition Professor Lose 27 Pounds*, CNN HEALTH (Nov. 8, 2010), http://www.cnn.com/2010/HEALTH/11/08/twinkie.diet.professor/index.html?hpt=T2 ("[I]n weight loss, pure calorie counting is what matters most—not the nutritional value of the food."). *See generally supra* notes 33–52 and accompanying text (discussing various situations in which obesity may be involuntary or immutable).

[121] Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17, 24 (1st Cir. 1993) ("[T]he Act indisputably applies to numerous conditions that may be caused or exacerbated by voluntary conduct, such as alcoholism, AIDS, diabetes, cancer resulting from cigarette smoking, heart disease resulting from excesses of various types, and the like.").

[122] *Id.*; *see also* Buxton, *supra* note 120, at 120 (discussing the *Cook* court's analysis of the regarded as prong of the ADA and concluding that because AIDS is an involuntary and immutable disease "no affirmative act will eradicate the condition").

[123] *Cook*, 10 F.3d at 24.

exercise.[124] Although the acts leading to obesity are in many instances voluntary, in some situations once a person is obese nothing can counteract it because of certain genes, diseases, conditions, medicines, or environments.[125] While an obese person may have knowingly participated in behavior leading to or perpetuating obesity, the actual cause of obesity may be not voluntary in some situations due to a genetic or environmental component.[126] Consequently, obesity should be a protected disability under the ADA because, similar to some AIDS cases, even though individual choice led to the condition, obesity cannot, in some circumstances, be eliminated by any affirmative act.[127] Moreover, legal protection under the ADA is not linked to how a person became impaired or whether they contributed to the impairment but to the limiting nature of the impairment.[128]

Another factor relevant to whether a person becomes obese hinges on hormone levels within the body.[129] Specifically, an imbalance of the hormones leptin and ghrelin suppresses a person's desire to engage in physical activity—often resulting in obesity.[130] Similarly, in situations of alcoholism a person's genetics, choices, and environment may influence his or her risk for developing the addiction such that the cravings for alcohol can be as strong as the need for food or water, leading some alcoholics to continue drinking despite serious family, health, or

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[124] *See* McMenamin & Tiglio, *supra* note 40, at 473–77 (discussing how an imbalance of hormones can lead to obesity); Park, *supra* note 120 ("There seems to be a disconnect between eating healthy and being healthy . . . . It may not be the same. I was eating healthier, but I wasn't healthy. I was eating too much."). *Contra* Buxton, *supra* note 120, at 119–21 ("[O]ne who simply eats too much food and becomes obese can negate that condition through proper diet and exercise. The obese plaintiff has an option not available to the truly disabled: he can stop his actions and thereby negate his condition; he can take positive steps to nullify his state.").

[125] *See* McMenamin & Tiglio, *supra* note 40, at 476 (identifying the multitude of hormones that can cause weight gain); *Causes and Consequences*, *supra* note 33 ("Body weight is the result of genes, metabolism, behavior, environment, culture, and socioeconomic status. Behavior and environment play a large role causing people to be overweight and obese. . . . Science shows that genetics plays a role in obesity. Genes can directly cause obesity . . . ."); *Genomics and Health*, *supra* note 36 ("[G]enes do play a role in the development of obesity. Most likely, genes regulate how our bodies capture, store, and release energy from food.").

[126] *See Causes and Consequences*, *supra* note 33 (concluding genetic syndromes, diseases, illnesses, and drugs can cause severe weight gain and lead to obesity); *Genomics and Health*, *supra* note 36 (discussing how genes that multiplied in the past under different environmental settings may contribute to the rise in obesity).

[127] 28 C.F.R. § 36.104(1)(iii) (2009); *Cook*, 10 F.3d at 24.

[128] *Cook*, 10 F.3d, at 24.

[129] *See* McMenamin & Tiglio, *supra* note 40, at 473–77 (identifying the multitude of hormones regulating fat in the body, including leptin and ghrelin); *see also supra* notes 40–42 and accompanying text (discussing the hormones leptin and ghrelin and how they may contribute to obesity).

[130] *See* McMenamin & Tiglio, *supra* note 40, at 476 (detailing how the hormones leptin and ghrelin work together in the body to regulate hunger, appetite level, food intake, and a person's desire to engage in physical activity).

legal problems.[131] Several genes increase a person's initial desire to drink alcohol and exponentially increase a person's desire to continue drinking, leading to a compulsive craving.[132] During initial use, drugs also interfere with normal brain function creating powerful feelings of pleasure and producing long-term changes in brain metabolism and activity.[133] Moreover, a drug's powerful interference with certain functions of the human brain creates a compulsive craving, preventing the user from quitting, and thereby often requiring treatment to stop the compulsive behavior.[134] While alcoholics and drug addicts voluntarily participate in the behavior leading to the addiction, in many situations no affirmative act can undo the disease or condition because a genetic or environmental condition beyond the control of the individual exists. Thus, individual genetics and environment play a major role in alcoholism and drug addiction.[135] Despite the voluntary nature

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[131] *See Defining Alcohol-Related Phenotypes in Humans: The Collaborative Study on the Genetics of Alcohol*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM (June 2003), http://pubs.niaaa.nih.gov/publications/arh26-3/208-213.htm ("Alcoholism is a disease that runs in families and results at least in part from genetic risk factors."); *Is Alcoholism a Disease?*, NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM (Feb. 2007), http://www.niaaa.nih.gov/FAQs/General-English/default.htm#disease ("The craving that an alcoholic feels for alcohol can be as strong as the need for food or water. An alcoholic will continue to drink despite serious family, health, or legal problems.").

[132] *Defining Alcohol-Related Phenotypes in Humans: The Collaborative Study on the Genetics of Alcohol*, *supra* note 131; *Is Alcoholism a Disease?*, *supra* note 131 ("Research shows that the risk for developing alcoholism does indeed run in families. The genes a person inherits partially explain this pattern, but lifestyle is also a factor.").

[133] *See NIDA InfoFacts: Comorbidity: Addiction and Other Mental Disorders*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/infofacts/comorbidity.html (last updated Mar. 2011) (noting "addiction changes the brain in fundamental ways"); *NIDA InfoFacts: Understanding Drug Abuse and Addiction*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/infofacts/understand.html (last updated Mar. 2011) ("Addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use despite harmful consequences to the individual who is addicted and to those around them."); *see also* Nora D. Volkow, *What Do We Know About Drug Addiction?*, 162 AM. J. PSYCHIATRY 1401, 1401–02 (2005) (noting "drug addiction is a disease of the brain"), *available at* http://ajp.psychiatryonline.org/cgi/content/full/162/8/1401.

[134] *See NIDA InfoFacts: Comorbidity: Addiction and Other Mental Disorders*, *supra* note 133 (concluding drug addiction disturbs "a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug"); *NIDA InfoFacts: Understanding Drug Abuse and Addiction*, *supra* note 133 (determining "the abuse of drugs leads to changes in the structure and function of the brain" and while "the initial decision to take drugs is voluntary, over time the changes in the brain caused by repeated drug abuse can affect a person's self control and ability to make sound decisions" and creates an "intense [impulse] to take drugs").

[135] *See* Volkow, *supra* note 133, at 1401–02 ("Genetic factors are estimated to contribute to 40%–60% of the variability in the risk of addiction, but this includes the contribution of combined genetic-environmental interactions."); *see also Is Alcoholism A Disease?*, *supra* note 131 (concluding alcoholism is in part genetic); *NIDA InfoFacts: Understanding Drug Abuse and Addiction*, *supra* note 133 ("The genes that people are born with—in combination with environmental influences—account for about half of their addiction vulnerability.").

of the person's behavior, both alcoholism and drug addiction are protected as disabling conditions under the ADA provided a person is no longer using alcohol or drugs.[136]

Likewise, while many individuals may voluntarily choose to eat too much or fail to regularly exercise, there may be little they can do to remedy their obesity because genetic or environmental conditions exist beyond their control.[137] Specifically, a genetic or environmental disruption in the proper balance and regulation of leptin and ghrelin may contribute to obesity because leptin and ghrelin control appetite levels and a person's desire to participate in physical activity.[138] Additionally, certain genes favoring fat accumulation through uncontrollable overeating, poor regulation of appetite, lack of physical activity, diminished ability to use dietary fats as fuel, and an increased and easily stimulated capacity to store body fat may also cause obesity.[139] Moreover, communities in which there is an abundance of calorie-rich foods and few opportunities for physical activity magnify a person's genetically compulsive cravings for food, often leading to obesity.[140]

Aside from the choices resulting in the consumption of too much food or the failure to regularly exercise, no single affirmative act can control hormones, eliminate genes, or alter environments to control obesity.[141] Moreover, individual

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[136] 28 C.F.R. § 36.104(1)(iii) (2009); *see also* Cook v. R.I. Dep't of Mental Health, Retardation, & Hosps., 10 F.3d 17. 24 (1st Cir. 1993) (discussing how people suffering from AIDS, alcoholism, and drug addiction are protected against discrimination); Teahan v. Metro-North Commuter R. Co., 951 F.2d 511, 517–18 (2d Cir.1991), *cert. denied*, 506 U.S. 815 (1992) (discussing alcoholism and drug use as statutorily protected handicaps); Gallagher v. Catto, 778 F. Supp. 570, 577 (D.D.C. 1991), *aff'd*, 988 F.2d 1280 (D.C. Cir. 1993) ("Alcoholism is a handicapping condition within the purview of the Rehabilitation Act of 1973.").

[137] McMenamin & Tiglio, *supra* note 40, at 473, 476; *Causes and Consequences*, *supra* note 33 ("Genetics and the environment may increase the risk of personal weight gain. . . . Science shows that genetics plays a role in obesity. Genes can directly cause obesity in [certain] disorders . . . . Some illnesses may lead to obesity or weight gain."); *Genomics and Health*, *supra* note 36 (noting "genes do play a role in the development of obesity").

[138] *See* McMenamin & Tiglio, *supra* note 40, at 473–76 (discussing how stress, nutrition, and culture contribute to the imbalance of the hormones leptin and ghrelin and how these hormones have an impact on obesity).

[139] *Genomics and Health*, *supra* note 36 (hypothesizing TGH is a mismatch between today's environment and energy-thrifty genes that multiplied in the past under different environmental settings).

[140] *Causes and Consequences*, *supra* note 33 ("Genes and behavior may both be needed for a person to be overweight. In some cases multiple genes may increase one's susceptibility for obesity and require outside factors; such as abundant food supply or little physical activity."); *Genomics and Health*, *supra* note 36 (noting "the same genes that helped our ancestors survive occasional famines are now being challenged by environments in which food is plentiful year round").

[141] *See* McMenamin & Tiglio, *supra* note 40, at 473–76 (discussing how the proportionate balancing of the hormones leptin, ghrelin, and others results in a lower BMI, decreasing the chance of becoming obese); *Causes and Consequences*, *supra* note 33 (realizing certain diseases, illnesses, and drugs lead to severe weight gain and can cause obesity); *Genomics and Health*, *supra* note 36

genetics and environment affecting a person's ability to function properly play a major role in alcoholism and drug addiction, just as genetics and environment play a substantial role in obesity.[142] Like alcoholism and drug addiction, obesity is classified as a condition.[143] Because the ADA was promulgated to end workplace discrimination against those with disabling diseases and conditions including AIDS, alcoholism, and drug addiction, obesity should receive the same protections.[144]

Furthermore, obesity produces considerable third party costs, which lead to the inefficient allocation of resources in healthcare.[145] Obesity discrimination through the implementation of workplace wellness programs perpetuates obesity because higher health insurance costs obstruct treatment, making unaffordable the very health insurance designed to reduce obesity.[146] As a consequence, obesity discrimination does not just harm its victims—it contributes to America's alleged obesity epidemic. Obesity discrimination is just as real as discrimination against alcoholics, drug addicts, or people with AIDS and harms a significantly larger population segment in America.[147] In fact, the obese account for nearly forty percent of the population.[148] Moreover, obesity discrimination is the fourth most common form of discrimination experienced by Americans after gender, age, and race discrimination and is increasing yearly while other forms of discrimination remain static.[149]

(determining that an individual's genetic predisposition to overeat due to poor regulation of appetite and larger food portions, combined with a diminished capacity to store body fat, contribute to obesity).

[142] *See* Volkow, *supra* note 133, at 1401–02 (concluding genetic factors contribute to addiction); *Is Alcoholism A Disease?*, *supra* note 131 (stating "the risk for developing alcoholism does indeed run in families"); *NIDA InfoFacts: Understanding Drug Abuse and Addiction*, *supra* note 133 ("Risk for addiction is influenced by a person's biology, social environment, and age or stage of development.").

[143] Volkow, *supra* note 133, at 1401–02; *Defining Alcohol-Related Phenotypes in Humans: The Collaborative Study on the Genetics of Alcohol*, *supra* note 131 ("alcoholism is a disease"); *Is Alcoholism A Disease?*, *supra* note 131 ("alcoholism is a disease"); *NIDA InfoFacts: Comorbidity: Addiction and Other Mental Disorders*, *supra* note 133 (identifying drug addiction as a comorbid condition that can lead to mental illness).

[144] 28 C.F.R. § 36.104(1)(iii) (2009) (including contagious and noncontagious diseases and conditions, such as AIDS, alcoholism, drug abuse, tuberculosis, and others).

[145] Lucy Wang, Note, *Weight Discrimination: One Size Fits All Remedy?,* 117 YALE L.J. 1900, 1920 (2008); *Economic Consequences*, *supra* note 50 (discussing the estimated costs of obesity state-by-state and nation wide).

[146] *See* Wang, *supra* note 145, at 1919; *see also Economic Consequences*, *supra* note 50 (estimating the increasing costs of obesity on individuals, employers, and insurance companies).

[147] Wang, *supra* note 145, at 1919–21.

[148] *Id.* at 1919; *Data and Statistics*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/obesity/data/index.html (last updated Mar. 3, 2011); *NCHS Health E Stats, Table 1*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/data/hestat/overweight/overweight_adult.htm (last updated Dec. 23, 2009).

[149] Wang, *supra* note 145, at 1919–20.

C. *Workplace Wellness Programs Are Not Permissible Under the ADA and GINA*

PPACA's endorsement of workplace wellness programs violates the ADA by singling out the obese and forcing them to pay more for insurance premiums because of their weight. By rewarding healthy behaviors in an attempt to decrease health insurance costs, workplace wellness programs discriminate against non-participating employees by requiring the disclosure of specific genetic information in exchange for insurance premium discounts.[150] Many obese individuals spend over $700 more per year on medical premiums and earn less than their skinnier counterparts in the same profession.[151]

While the ADA expressly prohibits health related workplace discrimination based on a disability, it fails to specifically delineate which conditions are protected by providing only a nonexclusive list.[152] Yet under its third prong, the ADA protects an individual from discrimination who does not have an actual disability but is regarded as having a disability.[153] The example Congress used to illustrate the ADA's perceived as having a disability prong of coverage is that of a disfigured employee.[154] If an employer believes a disfigured individual will generate negative reactions from customers or employees, the disfigured individual is protected.[155] The example used by Congress confirms the *Cook* court reached the correct decision in holding a perceived disability is an ADA protected disability because, just as individuals with disabilities experience discrimination, those with perceived disabilities encounter discrimination as well.[156] The congressional example also demonstrates obesity is a disability deserving protection under the ADA because the obese are often seen as generators of negative reactions from customers or employees.[157] Additionally, Congress codified the *Cook* court's conclusion in 2008

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[150] Mark Rothstein & Heather Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part I—Efficacy*, 51 J. OCCUPATIONAL & ENVTL. MED. 867, 944 (2009) [hereinafter *Part I—Efficacy*].

[151] Byrd, *supra* note 4, at 303–04.

[152] 28 C.F.R. § 36.104(1)(iii) (2009) (including contagious and noncontagious diseases and conditions).

[153] 42 U.S.C. § 12102(2) (2006); H.R. REP. NO. 101-485, pt. 3, at 29–32 (1990). The third general prong of the ADA protects individuals being regarded as having a physical or mental impairment that limits one or more major life activities from discrimination. 42 U.S.C. § 12102(1)(C); 20 C.F.R. § 1630.2(g)(3).

[154] 42 U.S.C. § 12102(2); H.R. REP. NO. 101-485, pt. 3, at 30.

[155] 42 U.S.C. § 12102(2); H.R. REP. NO. 101-485, pt. 3, at 30.

[156] H.R. REP. NO. 101-485, pt. 3, at 30; *see* 42 U.S.C. § 12102(2) (providing legal protection for perceived disability discrimination); Cook v. R.I. Dep't of Mental Health, Retardation & Hosps., 10 F.3d 17 (1st Cir. 1993) (extending statutory protection against discrimination to obesity).

[157] Americans with Disabilities Act Amendments Act of 2008, Pub. L. No. 110-325, § 2, 122 Stat. 3553, 3553–54 (to be codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.); H.R. REP. NO. 101-485, pt. 3, at 29–31.

when it passed the ADAAA and overturned several Supreme Court decisions narrowly interpreting what constitutes an ADA protected disability.[158] In fact, the Supreme Court's imposition of a more rigorous standard for determining an ADA protected disability directly conflicted with Congress's original intent of ADA discrimination protection.[159]

By singling out and discriminating against the obese in the workplace based on genetic information and forcing them to pay more for insurance premiums because of their obesity, workplace wellness programs also violate GINA. Furthermore, PPACA's endorsement of workplace wellness programs violates GINA by requiring the involuntarily obese to participate in so-called voluntary wellness programs.[160] Workplace wellness programs discriminate against the obese by requiring the disclosure of specific genetic information in exchange for insurance premium discounts.[161] Employees are required to divulge specific protected genetic information before participating in a workplace wellness program.[162] For example, an employer requesting a family history violates GINA because such history is genetic information, albeit in a less precise form than a genetic test.[163] Family medical history includes information pertaining to

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[158] Americans with Disabilities Act Amendments Act, §§ 2–4, 122 Stat. at 3553–56; *see, e.g.*, Williams v. Toyota Motor Mfg., Ky., Inc., 534 U.S. 184 (2002) (holding the terms "substantially" and "major" must "be interpreted strictly to create a demanding standard for qualifying as disabled" under the ADA); Sutton v. United Air Lines, Inc., 527 U.S. 471, 488 (1999) (restricting ADA protection to uncorrectable diseases and conditions).

[159] Americans with Disabilities Act Amendments Act, § 2, 122 Stat. at 3553–54.

[160] *See* 42 U.S.C. § 300gg-1(a) (providing protection against discrimination based on genetic information); Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 3021, 124 Stat. 119, 263 (to be codified as amended in 42 U.S.C. § 300jj–51) (noting grants "shall" be awarded to employers to make workplace wellness programs available to their employees); *infra* notes 169–76 and accompanying text (discussing the voluntariness of workplace wellness programs).

[161] Hendrix & Buck, *supra* note 56, at 466 ("Recently, employers have begun to implement increasingly aggressive wellness programs that provide incentives to employees who meet certain health standards, while creating disincentives for those who fail to meet the standards."); *Part I—Efficacy*, *supra* note 150 ("HRAs are questionnaires completed by employees about their health practices, history, and status. The assessments are usually meant to provide a general understanding of that individual's modifiable risk factors.").

[162] Szwarc, *supra* note 56 ("[E]mployer wellness programs begin with a . . . detailed questionnaire which asks about their smoking, eating and exercise habits, lifestyles down to seat belt use, and personal and family medical histories."). *See generally supra* notes 96–112 and accompanying text (discussing GINA's broad statutory protection from the involuntary disclosure of family histories and other genetic information).

[163] 42 U.S.C. § 300gg-1(a)(2) (permitting an employer's collection of genetic information in compliance with the certification requirements of family and medical leave laws or through inadvertent lawful inquires under, for example, the ADA, so long as the employer does not use the information discriminatorily); *see also Part I—Efficacy*, *supra* note 150, at 954 ("[I]t is unlawful under GINA for an employer to request that an employee provide family health history, which might be part of an HRA."); Bakich, *supra* note 101 ("GINA may well prohibit programs that target people based on family history of a certain disease or condition. . . .").

the genetic composition generated throughout a person's ancestry.[164] A family history of heart disease increases a person's risk of heart disease and is a genetic precursor to heart disease.[165] Thus, offering premium discounts for participation in workplace wellness programs to the non-obese in exchange for legally protected genetic information, such as a family history, violates GINA.

While GINA provides two narrow exceptions for collecting genetic information, there are no reported cases discussing the exceptions in relation to workplace wellness programs.[166] Nevertheless, even if receipt of an employee's genetic information is lawful, the employer violates GINA if the genetic information is used to alter any term or condition of employment, including benefits compensation and insurance premiums.[167] By ignoring the scientific research that obesity is not purely a matter of choice but involves an individual's genetics, PPACA fails to provide specific and adequate protection against workplace obesity discrimination.[168]

While workplace wellness programs are allegedly voluntary, the financial incentives designed to induce and reward participation call this into question.[169] To increase participation in workplace wellness programs, employers offer financial

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[164] Bakich, *supra* note 101 ("The law defines 'genetic information' to include genetic tests and services, as well as family history of a disease or disorder."); *GINA Privacy Rules Would Require Revised Notices*, 8 No. 10 EMPLOYERS GUIDE TO HIPAA PRIVACY REQUIREMENTS NEWSL. 4 (Thompson Publ'g Grp., Inc., Tampa, Fla.), Nov. 2009, at 4.

[165] S. REP. NO. 110-48 (2007); *see also Part I—Efficacy*, *supra* note 150, at 954 ("[I]t is unlawful for an employer 'to request, require, or purchase genetic information with respect to an employee or family member of the employee.'"); Bakich, *supra* note 101 (discussing a link between genes and breast cancer); *cf.* JONES & SARATA, *supra* note 47, at 6 ("A genetic predisposition toward cancer or heart disease does not mean the condition will develop.").

[166] 42 U.S.C. § 2000ff-5(b). *See generally supra* note 112 and accompanying text (stating the two narrow exceptions allowing the collection of genetic information under GINA).

[167] 42 U.S.C. § 2000ff-5(b); Mark Rothstein & Heather Harrell, *Health Risk Reduction Programs in Employer-Sponsored Health Plans: Part II—Law and Ethics*, 51 J. OCCUPATIONAL & ENVTL. MED. 867, 954 (2009) [hereinafter *Part II—Law and Ethics*] ("Even if receipt of the employee's genetic information is lawful, it violates GINA for the employer to use the information to alter any term or condition of employment.").

[168] *See Part II—Law and Ethics*, *supra* note 167, at 957 ("[S]o long as participation in the [program] is at least nominally voluntary, benefits under the plan do not discriminate against employees with disabilities, and plan-generated health information is not commingled with other employment records, then the [program] will pass legal muster.").

[169] *See* James G. Frierson, *EEOC Informal Guidance Letters (IGLS) Concerning the ADA—1994–2004*, 24 BNA EMP. DISCRIMINATION REP. 390 (2005), 2005 WL 705137 [hereinafter *EECO IGLS 390*] (defining the term "voluntary" as "acting on one's own free will without valuable consideration"); James G. Frierson, *EEOC Informal Guidance Letters (IGLS) Concerning the ADA—1994–2002*, 20 BNA EMP. DISCRIMINATION REP. 563 (2003), 2003 WL 1908541 [hereinafter *EECO IGLS 563*] ("Employer payment of the health insurance premiums obviously constitutes valuable consideration."); *see also* Mello & Rosenthal, *supra* note 61, at 192 ("Incentives can be

inducements such as a reduction in the employee's monthly contribution for health coverage, resulting in employee stratification based on income.[170] A considerable reduction in monthly insurance premiums may not be a sufficient incentive for higher paid employees.[171] Yet, even a small reduction in monthly insurance premiums is a substantial incentive to lower-income employees, making them more economically vulnerable to financial inducements.[172] The EEOC defines "voluntary" as acting on one's own free will without valuable consideration.[173] While the EEOC's informal guidance is not binding, it is persuasive and carries the weight of the administrative agency charged with interpreting and enforcing the ADA and GINA.[174] An employer's payment of health insurance premiums constitutes valuable consideration because the payment is exchanged for participation in a workplace wellness program.[175] Because workplace wellness programs impose specific requirements on participants in exchange for significant

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framed as rewards or penalties and may take the form of prizes, cash, or the waiver of payment obligations."); *Part I—Efficacy*, *supra* note 150, at 944 ("Higher paid employees are able to forego [wellness programs], or put another way, they can more easily afford to pay a 'privacy tax' and not have to share health information with the [wellness program] vendor and not be bothered at home by individualized interventions.").

[170] *See Part I—Efficacy*, *supra* note 150, at 944 (concluding that higher paid employees are able to afford non-participation in workplace wellness programs because the discounted health insurance premium constitutes a smaller amount of their overall compensation); *see also* Mello & Rosenthal, *supra* note 61, at 192, 197 (concluding most "health plans and employers now not only provide access to wellness programs but also offer incentives for participation" yet contemplating that the "size of the incentive required may vary depending on the behavior change sought" because "[e]mployees who are asked to make large lifestyle changes may demand commensurate compensation").

[171] *See* Mello & Rosenthal, *supra* note 61, at 192–94, 197 (discussing the incentives involved with workplace wellness programs and concluding "people are more likely to change their behavior if the stakes are higher"); *Part I—Efficacy*, *supra* note 150, at 944 ("A $20 or $30 per month reduction in monthly employee contributions is not a sufficient incentive for many higher paid employees to participate.").

[172] *Part I—Efficacy*, *supra* note 150, at 944 (noting that "[l]ower paid employees may be more economically vulnerable, and, thus, more likely to feel coerced into signing up to participate" in workplace wellness programs).

[173] *EECO IGLS 390*, *supra* note 169; *EECO IGLS 563*, *supra* note 169.

[174] Chevron U.S.A., Inc. v. Nat. Res. Def. Council, 467 U.S. 837, 843 (1984) (holding "considerable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer, and the principle of deference to administrative interpretations"); Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944) (holding that while an administrative body's "rulings, interpretations and opinions are not controlling upon the courts by reason of their authority," they "do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance").

[175] *See EECO IGLS 390*, *supra* note 169 (concluding workplace wellness programs are not truly voluntary if they provide some financial benefit to participating employees); *EECO IGLS 563*, *supra* note 169 (determining "differences in net pay based on weight, exercise, cholesterol and blood pressure" may be discriminatory).

financial benefits, workplace wellness programs do not fall within the EEOC's definition of voluntary.[176] Therefore, because workplace wellness programs are not voluntary, they violate GINA.

Meanwhile, the need for workplace wellness programs seems imperative from the employer's perspective because the state of every employee's health affects the company's productivity, healthcare costs, and bottom line.[177] American workers have more healthcare needs than ever before, especially considering the increased number of tobacco-related illnesses and deaths, the increasing amount of illnesses and disease requiring medical treatment, and the increasingly sedentary lifestyles of many Americans.[178] Moreover, American workers with unhealthy lifestyles often have problems that transfer into the workplace, which can decrease worker productivity and increase absences and healthcare costs.[179] Include the enormous governmental and societal pressure employers face to provide healthcare for their employees and it is no wonder workplace wellness programs have become the go-to solution for solving the aforementioned problems.[180]

Nevertheless, workplace wellness programs can violate GINA and discriminate against various groups of employees.[181] Workplace wellness programs violate GINA by requiring employees to submit HRAs as a condition to participation in the program.[182] Discrimination is perpetuated when financial inducements are offered for participation in the program and when employees unable to participate because of genetic causes are required to pay more for the same benefits offered to

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[176] *See EECO IGLS 390*, *supra* note 169 (defining voluntary as void of valuable consideration); *EECO IGLS 563*, *supra* note 169 ("Employer payment of the health insurance premiums obviously constitutes valuable consideration.").

[177] Jennifer D. Thomas, *Mandatory Wellness Programs: A Plan to Reduce Health Care Costs or a Subterfuge to Discriminate Against Overweight Employees?*, 53 HOW. L.J. 513, 523 (2010).

[178] *See* Gary G. Mathiason et al., *Employer Mandated Wellness Initiatives: Respecting Workplace Rights While Controlling Health Care Costs*, LITTLER REP. (Littler Mendelsen, P.C., New York, N.Y.), 2007, at 5, *available at* http://academic.research.microsoft.com/Paper/11234738.aspx (noting additional factors that contribute to rising costs include "the coming health care need of the baby boomer[s] . . . [and] a great worker shortage . . . especially in skilled positions.").

[179] *See CDC's LEAN* Works!—*Why Should I Create a Program?*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/leanworks/why/index.html (last updated Aug. 10, 2010) ("Obesity affects more than health care costs, it also has a significant impact on worker productivity because the more chronic medical conditions an employee has, the higher the probability of absenteeism or presenteeism.").

[180] *See* Thomas, *supra* note 177, at 524–25 (discussing employer justifications for implementing workplace wellness programs, which include governmental pressure).

[181] Thomas, *supra* note 177, at 522.

[182] Mello & Rosenthal, *supra* note 61, at 193–94; *Part II—Law and Ethics*, *supra* note 167, at 954.

participants.[183] Nevertheless, employers can avoid violating GINA and engaging in discriminatory practices while still implementing workplace wellness programs by not requiring an HRA before participation.[184] Additionally, employers can tailor their overall workplace wellness program to provide a variety of options to employees instead of implementing a generic plan requiring participation to receive the promised benefits.[185] By not requiring submission of an HRA before participation in workplace wellness programs and by offering a multitude of options for participation, compliance with GINA will be achieved and the possibility of discrimination against non-participating employees perpetrated through workplace wellness programs will be significantly decreased.

IV. CONCLUSION

Choice is inevitable in American society; yet, when an employer seeks to provide a choice to its employees resulting in the unequal allocation of benefits, discrimination is likely to occur.[186] Additionally, employer sponsored wellness programs requiring the disclosure of legally protected information violate federal employment law.[187] While workplace wellness programs offer great incentives, they discriminate against the obese by unequally distributing health insurance premiums among employees and they violate federal employment law by requiring the disclosure of legally protected information.[188] Thus, PPACA's sanction of workplace wellness programs discriminates against the obese and violates federal employment law.[189] Despite arguments advanced by both sides regarding whether ADA protection should be extended to the obese, the American image of obesity will likely remain unchanged for some time to come.[190]

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[183] *EEOC IGLS 390*, *supra* note 169; *EEOC IGLS 563*, *supra* note 169.

[184] *See generally* Hendrix & Buck, *supra* note 56 (discussing the various forms of discrimination perpetuated by workplace wellness programs); Mello & Rosenthal, *supra* note 61 (outlining the discriminatory and legal boundaries of workplace wellness programs); *Part II—Law and Ethics*, *supra* note 167 (contemplating the legal and ethical limits of workplace wellness programs).

[185] *See, e.g.*, Michael Barton, *Reforming Health Care in America*, 22 J. COMPENSATION & BENEFITS 4, at 11 (2006), *available at* http://www.willis.com/Documents/Publications/Services/Employee_Benefits/August_2006_Journal_ of_Compensation_and_Benefits.pdf (discussing Black & Decker as an example of a company that has implemented a variety of specific plans to avoid required employee participation, required disclosure of legally protected information in exchange for financial inducements, and employee discrimination).

[186] *See supra* notes 53–66, 113–85 and accompanying text.

[187] *See supra* notes 160–85 and accompanying text.

[188] *See supra* notes 53–66, 113–85 and accompanying text.

[189] *See supra* notes 113–85 and accompanying text.

[190] *See supra* notes 1–8 and accompanying text.

Until either the Supreme Court or Congress resolves the ambiguities of obesity discrimination in workplace wellness programs, both federal and state courts will continue producing inconsistent rulings leading to additional confusion for employers and employees.[191] The obese are therefore left to wonder whether the laws of their particular state have or will bridge the gap in discrimination law until something to protect them from discrimination is done.[192] Unfortunately, for those suffering in silence from genetically or environmentally caused obesity, Congress has yet to provide any concrete protection against employer based obesity discrimination through workplace wellness programs. Thus, many Americans will likely remain at the butt of discrimination for decades to come.

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[191] *E.g.*, Greene v. Union Pac. R.R. Co., 548 F. Supp. 3 (W.D. Wash. 1981) (promulgating company-wide medical standards for employment seekers or employees transferring across job categories determined reasonable); Cassista v. Cmty. Foods, Inc., 856 P.2d 1143 (Cal. 1993) (interpreting that both federal and state statutes "reject the argument that weight unrelated to a physiological, systemic disorder constitutes a handicap or disability"); Gimello v. Agency Rent-A-Car Sys., Inc., 594 A.2d 264 (N.J. Super. Ct. App. Div. 1991) (contemplating "that an obese person may be considered 'handicapped under [New Jersey] statute'"); State Div. of Human Rights on Complaint of McDermott v. Xerox Corp., 480 N.E.2d 695 (N.Y. 1985) (noting "that if a person suffers an impairment, employment may not be denied because of any actual or perceived undesirable effect the person's employment may have on disability or life insurance programs"); Krein v. Marian Manor Nursing Home, 415 N.W.2d 793 (N.D. 1987) (stating "the mere assertion that one is overweight or obese is not alone adequate to make a claimant one of the class of persons afforded relief"); Civil Serv. Comm'n of Pittsburgh v. Human Relations Comm'n, 591 A.2d 281, 282 (Pa. 1991) (indicating obesity does not fit into one or more of the categories of being regarded as having a physical or mental impairment, physiological disorder, cosmetic disfigurement, or anatomical loss affecting on of the body systems); Phila. Elec. Co. v. Human Relations Comm'n, 448 A.2d 701, 703 (Pa. Commw. Ct. 1982) (concluding obesity may be a handicap or disability deserving statutory protection, but the condition of "obesity, alone, is not such a handicap or disability").

[192] Federal law has yet to cover obesity under discrimination laws, and Michigan is the only state that has proactively included obesity as a disability providing the obese with some limited legal protection. *See* MICH. COMP. LAWS § 37.2202(1)(a) (2011) (forbidding Michigan employers from discriminating based on height or weight). However, local ordinances in various cities have promulgated obesity discrimination laws. *See, e.g.*, S.F., CAL., POLICE CODE art. 33 (2010) (prohibiting height and weight discrimination); SANTA CRUZ, CAL., MUN. CODE § 9.83.010 (2010) (protecting against discrimination based on height, weight, or physical characteristics); BINGHAMTON, N.Y., CODE § 45-3 (2011) (safeguarding against weight and height discrimination); D.C. Human Rights Act, D.C. CODE §§ 2-1401.01 to -1431.08 (2011).