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# Shame, Blame, and the Emerging Law of Obesity Control

*Lindsay F. Wiley*[*]

*In using law as a tool to combat the obesity epidemic, legal scholars and policymakers are drawing heavily on the lessons of tobacco control. This Article describes the resulting emergence of "obesity control law" and argues for a radical reorientation of it from a "denormalization" strategy based on the tobacco control experience to a "destigmatization" strategy based on the HIV prevention experience.*

*The war on obesity is nearing a political crossroads. Subsidies and food industry regulations aimed at making our environment more conducive to physical activity and healthy eating are in danger of losing out to cheaper and more politically palatable measures aimed at convincing obese individuals to lose weight without making it more feasible for them to do so. For example, recent legal reforms penalize obese employees and Medicaid recipients through higher out-of-pocket health-care costs, shame parents and kids by measuring and reporting students' body mass index through the school system, and demoralize obese patients by promoting unsolicited and ineffective weight loss counseling by physicians. These reforms threaten to further stigmatize obese people — and lead to worse*

[*] Copyright © 2013 Lindsay F. Wiley. Associate Professor of Law and Faculty Director, Health Law & Justice Program, American University Washington College of Law. The author wishes to thank Alena Allen, Heather Bednarek, Leo Beletsky, Rebecca Dresser, Rob Gatter, Kevin Outterson, Efthimios Parasidis, Elizabeth Pendo, Jesse Goldner, Christina Ho, Sandra Johnson, Elizabeth Weeks Leonard, Ted Ruger, Robert Schwartz, and Sidney Watson for their critical engagement with an early draft of this article during the 2012 Health Law Scholars Workshop at St. Louis University; Scott Burris, Robert Dinerstein, Larry Gostin, Binny Miller, Matt Pierce, Rebecca Puhl, and Rebecca Rausch for helpful discussions about this project; Jonas Anderson, Amanda Frost, Amanda Leiter, and Benjamin Leff for their invaluable feedback and support; Jamie Hennelly, Nick Masero, and Lauren Nussbaum for their fantastic research assistance; and Dean Claudio Grossman for his unflagging support of junior faculty scholarship.



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*health outcomes — by contributing to hostile work, school, and health-care environments.*

*The tobacco control experience provided a productive starting point for thinking about how to use labeling requirements, advertising restrictions, and taxes to make unhealthy food and beverage products less appealing. But tobacco control's denormalization strategy for discouraging unhealthy behaviors and stigmatizing unhealthy people is not appropriate for preventing obesity-related health problems. In contrast, the destigmatization strategy proposed in this Article would emphasize that health, not thinness, is the proper objective of public health law. It would dictate that interventions targeting unhealthy products and environments must take precedence over interventions targeting obese individuals. And it would aim to revive interest in anti-discrimination, anti-bullying, and privacy laws as tools for preventing the health problems associated with obesity.*

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## INTRODUCTION

"Warning: Chubby isn't cute if it leads to type-2 diabetes."[1] "Big bones didn't make me this way. Big meals did."[2] "It's hard to be a little girl if you're not."[3] These slogans appeared on billboards and internet ads as part of a campaign against childhood obesity.[4] In using shame to discourage unhealthy behavior and stigmatize unhealthy people, the anti-obesity campaign was employing a strategy widely used in tobacco control campaigns[5]: "denormalization."[6] The ads were aimed at debunking the idea that being chubby is "cute" or that overweight kids are simply "big-boned" — the kinds of things parents tell their kids to reassure them when they are being bullied. The point was to convey that it is not *normal* for kids to be overweight.[7]

[1] Gabrielle Siegel, *Harsh Obesity Ads Speak Naked Truth*, THE SOUTHERNER ONLINE (Mar. 6, 2012), http://thesoutherneronline.com/frontpage/?p=906.

[2] Dan DiBacco, *Startling Billboards for a Startling Problem*, ESSENTIALS OF NUTRITION (Sept. 12, 2011), http://essentialsofnutrition.com/2011/09/12/startling-billboards-for-a-startling-problem/.

[3] Emma Gray, *Georgia Anti-Obesity Ads Say "Stop Sugarcoating" Childhood Obesity*, HUFF. POST (Jan. 3, 2012), http://www.huffingtonpost.com/2012/01/03/georgia-anti-obesity-ads-stop-sugarcoating_n_1182023.html.

[4] Carrie Teegardin, *Grim Childhood Obesity Ads Stir Critics*, THE ATLANTA JOURNAL-CONSTITUTION (Jan. 1, 2012), http://www.ajc.com/news/grim-childhood-obesity-ads-1279499.html.

[5] *Id.* ("The [Georgia anti-obesity] ads . . . are modeled after blunt — but effective — campaigns attacking methamphetamine use and smoking.").

[6] *See* discussion *infra* Part I.A (discussing how denormalization techniques successfully portrayed tobacco consumption to deviant behavior resulting in fewer smokers).

[7] *See* Gray, *supra* note 3 ("The organization . . . made a point to specifically target parents. One TV spot shows a child looking miserable and asking his mother 'Mom, why am I fat?' His equally overweight mother sighs and looks ashamed."); Doug Hertz, *Obesity Ads Serve as Wakeup Call*, THE ATLANTA JOURNAL-CONSTITUTION (Jan.

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The campaign was eventually abandoned after months of controversy over whether shaming fat kids and their parents is an appropriate strategy for fighting childhood obesity.[8] The social media response to the ads included a Tumblr[9] counter-campaign, "I Stand Against Weight Bullying,"[10] which collected reader-submitted photos featuring size acceptance slogans: "I stand for never letting your size keep you from following your dreams."[11] "I stand for beautiful having no weight limit and love having no size restriction."[12] "I stand for learning to love your body for what it is and not hating it for what it is not."[13] The counter-campaign also highlighted an alternative public health message, one that was reminiscent of HIV "destigmatization" campaigns[14]: "Warning: Shame is Bad for Your Health."[15]

This Article describes the emerging law of obesity control, which moves beyond awareness-raising campaigns to employ taxes, subsidies, bans, and regulations as tools for preventing obesity-related health problems.[16] I argue that in using law as a tool to combat the

12, 2012), http://www.ajc.com/news/news/opinion/obesity-ads-serve-as-wakeup-call/nQQK8/ (opinion piece by the Chairman of the Board of Trustees of Children's Healthcare of Atlanta, which sponsored the ads, noting that "behavioral change will not occur until families are ready for it" and "discomfort can lead to change").

[8] *See* Teegardin, *supra* note 4 (noting that the controversial ads were the first phase of the Strong4Life campaign, which was planned to continue for five years); Annie Urban, *Georgia's Fat Shaming Child Obesity Billboards Coming Down*, CARE2 (Mar. 4, 2012), http://www.care2.com/causes/georgias-fat-shaming-child-obesity-billboards-coming-down.html.

[9] Tumblr is a short-form blogging platform. *See* TUMBLR, http://www.tumblr.com/about (last visited Oct. 6, 2013).

[10] *I Stand Against Weight Bullying*, TUMBLR, http://istandagainstweightbullying.tumblr.com/ (last visited Aug. 19, 2013).

[11] Lisa Papez, Post to *I Stand Against Weight Bullying*, TUMBLR, http://istandagainstweightbullying.tumblr.com/post/18453484765/i-stand-for-never-letting-your-size-keep-you-from#notes (last visited Aug. 19, 2013).

[12] Missy Conley, Post to *I Stand Against Weight Bullying*, TUMBLR, http://istandagainstweightbullying.tumblr.com/post/18363732448/i-proudly-stand-against-weight-bullying-and-i#notes (last visited Aug. 19, 2013).

[13] PHOTOS AND QUOTES FROM A WANNABE PRINCESS (Mar. 14, 2012), http://quotesfromawannabeprincess.tumblr.com/post/19293855366.

[14] *See* discussion *infra* Part I.B (discussing how denormalization techniques successfully reduced HIV spread where shaming techniques failed).

[15] Erin Browner, *S.F. Fat Activists Oppose Atlanta's Anti-Obesity Campaign*, S.F. WEEKLY (Feb. 3, 2012), http://blogs.sfweekly.com/exhibitionist/2012/02/fat_activists_chew_out_atlanta.php.

[16] Although it is often used as a more general label, the term "obesity" technically refers to a particular body mass index (BMI) category. An individual's BMI is derived by dividing his weight in kilograms by his height in meters squared. For adults, a BMI below 18.5 is classified as "underweight," between 18.5 and 24.9 is "normal weight,"

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obesity epidemic, legal scholars and policymakers are drawing heavily on the lessons of tobacco control, while entirely ignoring lessons that might be drawn from another recent public health experience: HIV prevention. The tobacco control experience provided a productive starting point for thinking about how to use labeling requirements, advertising restrictions, and taxes to make unhealthy food and beverage *products* less appealing. But tobacco control's denormalization strategy for discouraging unhealthy *behaviors* and stigmatizing unhealthy *people* is not appropriate for preventing obesity-related health problems.

The war on obesity is nearing a political crossroads. Subsidies and food industry regulations aimed at making our environment more conducive to physical activity and healthy eating are in danger of losing out to cheaper and more politically palatable measures aimed at convincing obese individuals to lose weight without making it more feasible for them to do so.[17] Public initiatives to build sidewalks[18] and recreation facilities[19] and increase health education and physical activity in schools[20] promise to improve population health without targeting obese people, but it is expensive to do them right. Big Gulp bans,[21] Happy Meal ordinances,[22] soda taxes,[23] and reform of school

between 25.0 and 30.0 is "overweight," and a BMI above 30.0 is categorized as "obese." For children, "overweight" is defined as a BMI between the 85th and 95th percentile on the U.S. Centers for Disease Control and Prevention (CDC) Growth Charts, while "obesity" is defined as a BMI at or above the 95th percentile. *See* CTR. DISEASE CONTROL, BODY MASS INDEX, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html (last updated Sept. 13, 2011).

[17] *See* discussion *infra* Part II.A.

[18] *See, e.g.*, White House Task Force on Childhood Obesity, *Solving the Problem of Childhood Obesity Within a Generation*, LET'S MOVE! 78 (May 2010), http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf (stating that community design and function may either promote or prevent physical activity in adults and children).

[19] *See, e.g.*, *id.* at 83 (stating that the presence of proper recreational facilities promotes physical and psychological development and providing recommendations to make such facilities accessible, particularly in low-income communities).

[20] *See, e.g.*, *id.* at 9 (stating that the availability of healthy foods, nutrition education, and more physical activity need to be a focal point for federal agencies).

[21] *See, e.g.*, Michael M. Grynbaum, *Soda Makers Begin Their Push Against New York Ban*, N.Y. TIMES (July 1, 2012), http://www.nytimes.com/2012/07/02/nyregion/in-fight-against-nyc-soda-ban-industry-focuses-on-personal-choice.html?pagewanted=all (discussing the political fight over New York City Mayor's push for a ban on certain sized sodas); Sarah Kliff, *Why New York City's Big Gulp Ban Could be a Big Success*, WASH. POST (May 31, 2012), http://www.washingtonpost.com/blogs/ezra-klein/post/why-new-york-citys-big-gulp-ban-could-be-a-big-success/2012/05/31/gJQAuvkJ4U_blog.html (arguing that the proposed ban "has a decent chance of actually working" based on research finding that portion size affects consumption, even when people

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lunch programs[24] have the potential to change our unhealthy food environment, but they threaten the interests of the politically powerful food, beverage, and agriculture industries.[25]

As proposals for environmental interventions fall by the political wayside or are watered down in implementation, what remains are cheaper, more politically palatable "personal responsibility" measures that put the onus on obese people to lose weight, without necessarily making it more feasible for them to do so. Recent state and federal reforms have encouraged employers, private health insurers, and Medicaid programs to penalize obese individuals by raising their out-of-pocket health-care costs.[26] State-level reforms have required

have the option of going back for more).

[22] *See, e.g.*, Sharon Bernstein, *Fast-Food Industry is Quietly Defeating Happy Meal Bans*, L.A. TIMES (May 18, 2011), http://articles.latimes.com/2011/may/18/business/la-fi-happy-meal-backlash-20110518 [hereinafter *Happy Meal Bans*] (discussing restaurant lobbyists' successful defeat of high-calorie meals with toys ban in Florida, Arizona, and Nebraska); Sharon Bernstein, *It's a Sad Day for Happy Meals in Santa Clara County*, L.A. TIMES (Apr. 28, 2010), http://articles.latimes.com/2010/apr/28/business/la-fi-happy-meals-20100428 [hereinafter *Santa Clara*] (discussing Santa Clara County's ban on fast-food meals that come with a toy unless the fast-food industry creates a menu with more nutritional value); Sharon Bernstein, *San Francisco Bans Happy Meals*, L.A. TIMES (Nov. 2, 2010), http://articles.latimes.com/2010/nov/02/business/la-fi-happy-meals-20101103 [hereinafter *San Francisco*] (discussing San Francisco board of supervisor's vote to ban giving toys with high-calorie, sugar, and fat meals effectively banning most McDonald's "Happy Meals").

[23] *See, e.g.*, Tim Craig, *D.C. Soda Tax Proposal Draws Opposition from Beverage Industry*, WASH. POST (May 14, 2012), http://www.washingtonpost.com/wp-dyn/content/article/2010/05/13/AR2010051305429.html (discussing a D.C. City Council one-cent-per-ounce soda tax proposal on bottled and canned soda that contains sugar); Karen Kaplan, *Soda Tax Could Prevent 26,000 Premature Deaths, Study Finds*, L.A. TIMES (Jan. 10, 2012), http://articles.latimes.com/2012/jan/10/news/la-heb-soda-tax-diabetes-obesity-20120110 (discussing a study published in the journal Health Affairs that stated "a tax of a penny per ounce of sugar-sweetened beverage would not only raise $13 billion a year but also save $17 billion in medical costs by reducing the incidence of heart disease and diabetes).

[24] *See, e.g.*, Ed Bruske, *To Make School Food Healthy, Michelle Obama has a Tall Order*, WASH. POST (Feb. 14, 2010), http://www.washingtonpost.com/wp-dyn/content/story/2010/02/12/ST2010021202636.html?sid=ST2010021202636 (discussing Michelle Obama's campaign against obesity's focus on school lunches).

[25] *See, e.g.*, Duff Wilson, *Special Report: How Washington Went Soft on Childhood Obesity*, REUTERS (Apr. 27, 2012), http://www.reuters.com/article/2012/04/27/us-usa-foodlobby-idUSBRE83Q0ED20120427?feedType=RSS&feedName=specialReports&utm_source=dlvr.it&utm_medium=twitter&dlvrit=354887 ("Lobbying records analyzed by Reuters reveal that the [food and beverage] industries more than doubled their spending in Washington during the past three years. In the process, they largely dominated policymaking — pledging voluntary action while defeating government proposals aimed at changing the nation's diet . . . .").

[26] *See* discussion *infra* Part II.B.

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measurement of student body mass index ("BMI")[27] in schools with reports sent home to parents.[28] And federal reforms have encouraged frequent weigh-ins and weight loss counseling by primary care physicians who are not well-equipped to provide this service effectively or appropriately.[29] These measures threaten to exacerbate stigma by contributing to discriminatory work, school, and health-care environments and by reinforcing the biased misconception that lasting weight loss is achievable by most people with normal willpower. By reinforcing the industry-promoted notion that obesity is a matter of "personal responsibility," they also threaten to further undermine political support for environmental interventions.

How might legal scholars and policymakers assess whether these kinds of measures are appropriate? Is shaming an effective way to combat obesity and promote health? Are some obesity control measures adopted under the banner of public health likely to generate stigma in ways that are detrimental to health? And if anti-fat stigma is bad for health, then what can be done to fight it?

Legal scholar Gregg Bloche has called for an anti-obesity policy that "builds on widely-held ideals about attractiveness"[30] as part of an "effort to recast overeating and sedentary living as unsexy and uncool."[31] This strategy, he argues, "should not shy from judicious use of shame: portraying obesity as a burden to others (medically and financially) and a sign of self-indulgence can lend force to calls for self-restraint."[32] He points to the denormalization of tobacco use as the model for such an approach: "Surgeon General reports, advertising bans, package warnings, and anti-smoking campaigns helped to turn smoking into a disapproved activity. Public health advocacy can and should do the same for sedentary living and risky eating."[33]

Similarly, bioethicist Daniel Callahan recently proposed what he calls "an edgier strategy" for obesity control.[34] Concerned by "the disturbingly low success rate in treating [obesity],"[35] and "mass

[27] *See* sources cited *supra* note 16 (discussing how BMI defines "obesity").

[28] *See* discussion *infra* Part II.B.

[29] *See* discussion *infra* Part II.B.

[30] *See* M. Gregg Bloche, *Obesity and the Struggle within Ourselves*, 93 GEO. L.J. 1335, 1350-51 (2005).

[31] *See id.* at 1350.

[32] *See id.* at 1354.

[33] *See id.*

[34] *See* Daniel Callahan, *Obesity: Chasing an Elusive Epidemic*, 43 No. 1 HASTINGS CTR. REPORT 34, 34 (Jan.–Feb. 2013) [hereinafter *Obesity*].

[35] *Id.*

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delusion in the United States about its rising weight,"[36] Callahan argues that health policy must "bring strong social pressure to bear on individuals, going beyond anodyne education and low-key exhortation . . . to persuade them . . . that excessive weight and outright obesity are not socially acceptable any longer."[37] Like Bloche, Callahan points to the success of public health's anti-smoking strategy: "The campaign to stigmatize smoking was a great success, turning what had been considered simply a bad habit into reprehensible behavior."[38]

Drawing on the tobacco control experience, it is easy to articulate the reasoning behind a "tough love" approach to obesity. Public health advocates see positive images of smokers (promoted by the tobacco industry) as a major obstacle to the message that smoking is bad for your health. It is not surprising, then, that some perceive a tension between encouraging weight loss and promoting positive body image among overweight and obese people.[39] "You walk a fine line," said one

[36] *Id.* at 35 (internal quotation omitted).

[37] *Id.* at 37. Callahan later published a clarification after several commentators criticized his proposal. *See* Daniel S. Goldberg & Rebecca M. Puhl, *Obesity Stigma: A Failed and Ethically Dubious Strategy*, 43 HASTINGS CTR. REPORT, May–June 2013, at 5; Lawrence O. Gostin, *"Enhanced, Edgier": A Euphemism for "Shame and Embarrassment"?*, 43 HASTINGS CTR. REPORTS, May–June 2013, at 3; D. Robert MacDougall, *National Obesity Rates: A Legitimate Policy Endpoint?*, 43 HASTINGS CTR. REPORT, May–June 2013, at 7; Harald Schmidt, *Obesity and Blame: Elusive Goals for Personal Responsibility*, 43 HASTINGS CTR. REPORT, May–June 2013, at 8; A. Janet Tomiyama & Traci Mann, *If Shaming Reduced Obesity There Would Be No Fat People*, 43 HASTINGS CTR. REPORT, May–June 2013, at 4; Jennifer K. Walter & Anne Barnhill, *Good and Bad Ideas in Obesity Prevention*, 43 HASTINGS CTR. REPORT, May–June 2013, at 6. In his response, Callahan wrote: "I made a dumb error in editing the manuscript, in its third revision. My main point was to use social pressure on those not yet obese or just a little overweight to induce them to stay that way; that is, deploy it as a prevention strategy. But I left in some sentences from earlier draft versions — before I changed my mind, influenced by Rebecca Puhl — that said stigma should be used on the obese and overweight. I noticed that mistake only after the article was in print. . . . In any case, let me say flatly that I do not favor stigmatizing the overweight or obese, and surely not discriminating against them." Daniel Callahan, *The Author Replies*, 43 HASTINGS CTR. REPORT, May–June 2013, 9-10. He went on, however, to note that "[i]f not represented in these comments, I also got a number of supportive comments. They urged me not to give up, to be steadfast in the face of the shellacking, and to continue pursuing the issue of personal responsibility, a topic that seems to bring out acute nervousness among the obesity 'can't help its.' That's what I intend to do, and thus enter what I will call Phase Two for me in the fray . . . ." *Id.*

[38] Callahan, *Obesity*, *supra* note 34, at 38.

[39] *See, e.g.*, L.J. Heinberg et al., *Body Dissatisfaction as a Motivator for Healthy Change: Is Some Distress Beneficial?*, *in* EATING DISORDERS: INNOVATIVE DIRECTIONS IN RESEARCH AND PRACTICE (R.H. Striegel-Moore & L. Smolak eds., 2001) (hypothesizing that "some degree of dissatisfaction may be helpful and necessary to motivate

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clinical researcher, "because you [do not] want people to necessarily have an unhealthy body image, but you also want people to understand that they need to lose weight."[40] Similarly, some perceive a tension between public health goals and legal prohibitions on weight- or appearance-based discrimination. As Deborah Rhode has suggested, permitting discrimination on the basis of weight "seems justifiable to those who believe that overweight individuals can and should modify their condition."[41] Experiencing shame and discrimination — so the argument goes — might provoke obese people (or the parents of obese kids) to take action.[42]

But the relationship between shame, weight, and health is far more complicated than the tough love argument suggests.[43] Research suggests that high levels of body dissatisfaction are associated with increased risk of weight *gain*.[44] There are also indications that positive

individuals to engage in healthy behaviors"). *See generally* E. Smith et al., *'Do I Care?' Young Adults' Recalled Experiences of Early Adolescent Overweight and Obesity: A Qualitative Study*, 37 INT'L J. OBESITY 303, 307 (2013), *available at* http://www.nature.com/ijo/journal/vaop/ncurrent/pdf/ijo201240a.pdf (concluding that the lack of body dissatisfaction observed by researchers among overweight teenagers poses an obstacle to weight reduction behaviors).

[40] Anne Harding, *Many Obese People See No Need to Lose Weight*, REUTERS (Oct. 13, 2010), http://www.reuters.com/article/2010/10/13/us-obese-people-idUSTRE69C5TY20101013.

[41] Deborah L. Rhode, *The Injustice of Appearance*, 61 STAN. L. REV. 1033, 1062 (2009).

[42] *See, e.g.*, Sophie Lewis et al., *How do Obese Individuals Perceive and Respond to the Different Types of Obesity Stigma that They Encounter in Their Daily Lives?: A Qualitative Study*, 73 SOC. SCI. & MED. 1349, 1350 (2011) ("[Using stigma to promote and sustain weight loss] has been seized upon by some health policy makers and professionals, who have promoted shame-based risk discourses as an effective way to motivate obese individuals to lose weight."); Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 AM. J. PUB. HEALTH 1019, 1020 (2010) ("Not only is weight stigma viewed as a beneficial incentive for weight loss, but it is also assumed that the condition of obesity is under personal control, implying that the social influence of weight stigma will be sufficient to produce change.").

[43] *See* Lewis et al., *supra* note 42, at 1350 ("Despite the increasing popularity of [using stigma to promote and sustain weight loss], there is very limited evidence to show that 'shame based' tactics are either effective or ethical in health promotion initiatives seeking to improve the health and wellbeing of obese individuals.").

[44] *See, e.g.*, Craig A. Johnston et al., *The Application of the Yerkes-Dodson Law in a Childhood Weight Management Program: Examining Weight Dissatisfaction*, 37 J. PEDIATRIC PSYCHOL. 674 (2012) (finding that children with moderate weight dissatisfaction lost weight while those with low and high levels gained weight over six months); Rebecca M. Puhl et al., *Internalization of Weight Bias: Implications for Binge Eating and Emotional Well-Being*, 15 OBESITY 19 (2007) (finding that obese individuals who internalize negative weight-based stereotypes may be more vulnerable to the

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interventions to improve the body image of obese people increase the likelihood of successful weight *loss*.[45] Not only does it appear that anti-fat stigma is making obese people fatter, more importantly it is also making them less healthy. Obese people who feel ashamed of their weight are less likely to be physically active or to eat a healthy diet[46] — and physical inactivity and poor diet are associated with poorer health at any size. Weight cycling (the "yo-yo" pattern of weight loss followed by regain that is the most common outcome of weight loss attempts) may be more harmful to the health of an obese person than maintenance of a steady (but obese) weight.[47] As a result of shaming and discrimination in health-care settings, many obese women are not receiving needed medical care — including routine gynecological exams, blood pressure screenings, and diabetes care — even when they have adequate financial access to it.[48]

I argue that the emerging law of obesity control must be reoriented in light of this evidence. Stigmatization of obesity is an entirely different kind of phenomenon than tobacco denormalization. Its impacts on health, well-being, and identity function more like those of racial stigma[49] or sexual identity stigma, or (to put it into public health context) HIV stigma. Drawing on lessons from HIV prevention, I argue that legal scholars, advocates, and policymakers concerned with public health and social justice should adopt a destigmatization strategy for obesity. My proposed strategy would emphasize that health — not thinness — is the appropriate objective of public health

negative impact of stigma on eating behaviors); K.R. Sonneville et al., *Body Satisfaction, Weight Gain and Binge Eating Among Overweight Adolescent Girls*, 36 INT'L J. OBESITY 944 (2012) (finding that while body dissatisfaction is common among overweight and obese girls, body satisfaction may protect against excessive weight gain and binge eating).

[45] *See* Elaina V. Carraca et al., *Body Image Change and Improved Eating Self-Regulation in a Weight Management Intervention in Women*, 8 INT. J. BEHAV. NUTRITION & PHYSICAL ACTIVITY 1, 1 (2011).

[46] *See* sources cited *supra* note 42.

[47] *See, e.g.*, Kelly D. Brownell & Judith Rodin, *Medical, Metabolic, and Psychological Effects of Weight Cycling*, 154 ARCHIVES OF INTERNAL MED. 1325 (1994) (concluding, *inter alia*, that weight cycling is linked to increased binge eating risks). *But cf.* Nat'l Task Force on the Prevention and Treatment of Obesity, *Weight Cycling*, 272 J. AM. MED. ASS'N 1196 (1994) (arguing that "currently available evidence is not sufficiently compelling to override the potential benefits of moderate weight loss in significantly obese patients").

[48] *See* discussion *infra* Part III.A.4.

[49] *See* Christian S. Crandall, *Prejudice Against Fat People: Ideology and Self-Interest*, 66 J. PERSONALITY & SOC. PSYCHOL. 882, 882 (1994) ("Fatism appears to behave much like symbolic racism, but with less of the negative social desirability of racism.").

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law and policy. It would demand that environmental interventions, which employ a wide range of legal tools to facilitate access to healthier food options and physical activity for all people, take precedence over individually-targeted behavioral interventions. And it would aim to revive interest in privacy, anti-discrimination, and anti-bullying laws as tools for addressing the problems associated with obesity.

Part I develops a framework for evaluating the use of shame-based public health interventions by examining the competing public health law strategies of denormalization and destigmatization that emerged in response to two very different public health challenges: tobacco control and HIV prevention. Part II describes the rapidly developing field of obesity control law in terms of a shifting political balance between two types of public health interventions: environmental interventions aimed at altering the built, food, and information environments that shape peoples' choices about eating and physical activity, and behavioral interventions aimed at encouraging individuals to lose weight. Part III evaluates the current state of obesity control law in light of the framework developed in Part I and concludes that behavioral obesity control interventions threaten to stigmatize obesity in a way that functions more like the stigmatization of HIV status than the denormalization of tobacco use. Part IV proposes a new strategy for preventing obesity-related health problems — one that emphasizes destigmatization as an essential objective of public health law and aims to achieve "health at every size."[50] The Article concludes with a discussion of the implications of the current and proposed approaches to obesity control law for the development of public health and the law more generally.

## I. STIGMA AND PUBLIC HEALTH: TWO RECENT EXPERIENCES

Many public health advocates are coming to the war on obesity armed with their experiences combating two other major public health threats: tobacco use and HIV/AIDS. Each of these three threats necessitated a departure from "old public health law" strategies relying

[50] Health at Every Size is a movement started by fat activists in response to the public health war on obesity. It emphasizes that even if obesity is a risk factor for disease, fatness itself is not a disease and a fat body is not necessarily an unhealthy one. The HAES movement focuses on health improvement as a goal, regardless of whether weight loss is achieved. It also emphasizes the importance of positive body image, regardless of size. *See* Deb Burgard, *What is Health at Every Size?*, *in* THE FAT STUDIES READER 41, 42-43 (Esther Rothblum & Sondra Solovay eds., 2009).

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on mandatory vaccination, treatment, quarantine, and isolation.[51] And each has been viewed by policymakers as primarily attributable to the behavior choices of afflicted individuals. Tobacco control and HIV prevention have generated two very different strategies for addressing the behavioral determinants of health: denormalization and destigmatization. The writings of sociologists, public health experts, and legal scholars assessing the two strategies provide a theoretical framework for evaluating the role of individually-targeted behavioral interventions in obesity control.

### *A. Denormalization as a Tobacco Control Strategy*

In 1964, when the U.S. Surgeon General first issued a report definitively linking smoking to lung cancer and heart disease, "the [United States] was a country where over 50% of adult males smoked; 46% of all Americans smoked; where smoking was accepted in offices, airplanes and elevators, and where even cartoon TV programs were sponsored by cigarette brands."[52] In the decades that followed, public health advocates changed that landscape dramatically. Tobacco control advocates made use of many strategies, but denormalization emerged as a particularly important one.[53] "[T]hose who smoked

[51] *See* Lindsay F. Wiley, *Rethinking the New Public Health*, 69 WASH. & LEE L. REV. 207, 215-16 (2012) [hereinafter *Rethinking*] (describing controversy over the transition from the "old" public health to the "new").

[52] *See* Gene Borio, *1964: First Surgeon General's Report*, TOBACCO.ORG, http://archive.tobacco.org/resources/history/1964_01_11_1st_sgr.html (last visited Aug. 21, 2013).

[53] *See, e.g.*, Benjamin Alamar & Stanton A. Glantz, *Effect of Increased Social Unacceptability of Cigarette Smoking on Reduction in Cigarette Consumption*, 96 AM. J. PUB. HEALTH 1359, 1362 (2006) (finding that states where smoking is socially unacceptable have lower rates of smoking and concluding that "[t]obacco control programs should . . . reinforce the nonsmoking norm"); David Hammond et al., *Tobacco Denormalization and Industry Beliefs Among Smokers from Four Countries*, 31 AM. J. PREVENTIVE MED. 225, 229 (2006) (finding that people who perceive high levels of social denormalization of tobacco use are more likely to quit smoking); Sei-Hill Kim & James Shanahan, *Stigmatizing Smokers: Public Sentiment Toward Cigarette Smoking and its Relationship to Smoking Behaviors*, 8 J. HEALTH COMM. 343 (2003) (finding that smoking rates are lower in states where the public sentiment toward smoking is more negative and that smokers who have experienced unfavorable public sentiment are more willing to quit smoking than those who have not); *see also* CAL. DEP'T OF HEALTH SERVS., TOBACCO CONTROL SECTION, A MODEL FOR CHANGE: THE CALIFORNIA EXPERIENCE IN TOBACCO CONTROL 3 (1998), http://www.cdph.ca.gov/programs/tobacco/Documents/CTCPmodelforchange1998.pdf ("The California Tobacco Control Program has sought to . . . denormalize smoking and other tobacco use. . . . Evaluation results indicate that this approach is working in California: people are smoking less and more people are protected from exposure to second-hand

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[became] targets of public health policies that at first inadvertently but then explicitly sought to utilize the power of denormalization and marginalization to reduce tobacco consumption."[54] This strategy makes use of the fact that "unfavorable public sentiment toward smoking . . . function[s] as an informal social control device that enforces behavioral conformity among smokers."[55] Denormalization influences smokers to quit (and others not to start) "not only to avoid hazardous health consequences or legal sanctions (such as cigarette taxes), but also to escape from such psychological punishments as social isolation or embarrassment."[56]

The denormalization strategy is readily apparent in advertising campaigns that emphasize the cosmetic effects of smoking (yellow teeth, bad breath, smelly clothes and hair, even impotence) or the idea that smoking will lead to rejection by potential romantic partners.[57] But denormalization has also been among the explicit goals of public health advocates in promoting tobacco control laws, such as bans on smoking in workplaces and restaurants,[58] taxes on tobacco products,[59] and disclosure requirements that mandate graphic warning labels on cigarette packs.[60]

Laws banning smoking in workplaces, restaurants, and other public places contribute to social denormalization "[b]y separating, albeit

smoke.").

[54] Ronald Bayer, *Stigma and the Ethics of Public Health: Not Can We But Should We*, 67 SOC. SCI. & MED. 463, 466 (2008) [hereinafter *Stigma*].

[55] Kim & Shanahan, *supra* note 53, at 349.

[56] *Id.*

[57] *See, e.g.*, Lisa K. Goldman & Stanton A. Glantz, *Evaluation of Antismoking Advertising Campaigns*, 279 J. AM. MED. ASS'N 772 (1998) (describing and evaluating these advertising strategies).

[58] *See, e.g.*, Ronald Bayer & James Colgrove, *Children and Bystanders First: The Ethics and Politics of Tobacco Control in the United States*, *in* UNFILTERED: CONFLICTS OVER TOBACCO POLICY AND PUBLIC HEALTH 8 (Eric A. Feldman & Ronald Bayer eds., 2004) (quoting Samuel Glantz, "clean indoor air legislation reduces smoking because it undercuts the social support network for smoking by implicitly defining smoking as an antisocial act"); Abraham Brown et al., *A Longitudinal Study of Policy Effect (Smoke-free Legislation) on Smoking Norms*, 11 NICOTINE & TOBACCO RES. 924 (2009) (finding that smoke-free legislation in Scotland and the United Kingdom influences smokers' quit intentions).

[59] *See* Lynne Maclean et al., *Obesity, Stigma and Public Health Planning*, 24 HEALTH PROMOTION INT'L 88, 90 (2009) (referring to "[r]ecent public marketing campaigns to 'denormalize' tobacco use through legislation, taxes and fines").

[60] *See* Hammond et al., *supra* note 53, at 231 (reporting research findings that suggest that graphic warning labels "may be a more powerful denormalizing force" than text warnings).

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temporarily," smokers from non-smokers.[61] They make smoking less visible as an activity integrated into everyday life, reducing the perception that smoking is a normal social activity.[62] At the same time, they put segregated smokers on public display, quite literally outing them to their peers.[63] Because they target "peer-oriented social settings,"[64] school and workplace interventions are particularly useful for denormalization.

The relationship between denormalization and legal restrictions on smoking has been mutually reinforcing. Evidence about the harms associated with exposure to secondhand smoke began to turn public opinion against smokers in the 1980s, making legal restrictions more politically feasible.[65] In turn, those restrictions played a role in further marginalizing smoking and thus bolstering political will for more stringent tobacco control measures. As smoking came to be seen as a deviant social behavior and smokers came to make up a smaller and smaller proportion of the electorate, broader restrictions became all the more politically feasible.

[61] *See* Deborah Ritchie et al., *"But It Just Has That Sort of Feel About It, A Leper" — Stigma, Smoke-Free Legislation and Public Health*, 12 NICOTINE & TOBACCO RES. 622, 622 (2010) (noting that the social separation of smokers from non-smokers that occurs as a result of smoke-free legislation "fostered self-labeling and self-stigmatization by smokers of their own smoking behavior, even when they were not smoking. While there was little reported direct discrimination, there was a loss of social status in public places"); *see also* Hammond et al., *supra* note 53, at 228 (finding that smokers who live in areas with more comprehensive restrictions on smoking in public places were more likely to perceive smoking as socially denormalized).

[62] *See* A. B. Albers et al., *Relation Between Local Restaurant Smoking Regulations and Attitudes Towards the Prevalence and Social Acceptability of Smoking: A Study of Youths and Adults Who Eat Out Predominantly at Restaurants in Their Town*, 13 TOBACCO CONTROL 347, 354 (2004); Nina L. Alesci, Jean L. Forster & Therese Blaine, *Smoking Visibility, Perceived Acceptability, and Frequency in Various Locations Among Youth and Adults*, 36 PREVENTIVE MED. 272, 272 (2003) (finding that bans on smoking in restaurants contribute to smoking denormalization and lower rates of smoking).

[63] *See* Ronald Bayer & Jennifer Stuber, *Tobacco Control, Stigma and Public Health: Rethinking the Relations*, 96 AM. J. PUB. HEALTH 47, 47 (2006) ("In any city, smokers can be found huddled outside office buildings no matter how inclement the weather.").

[64] *See* William B. Hansen, *School-Based Substance Abuse Prevention: A Review of the State of the Art in Curriculum*, 7 HEALTH EDUC. RES. 403, 411 (1992) (stating that denormalization interventions "are postulated to operate through lowering expectations about prevalence and acceptability of use and the reduced availability of substances in peer-oriented social settings").

[65] *See* Bayer & Stuber, *supra* note 63, at 48 ("Responding to changing public attitudes, local lawmakers throughout the country began to impose restrictions on where smoking could occur.").

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Over time, rules promoting smoke-free workplaces have evolved into employer-generated rules promoting *smoker*-free workplaces.[66] "Firms boldly announce that they will not employ and may even fire smokers, because of the additional cost of their medical care, or because smoking does not project the 'image' they want to project to the public."[67] Meanwhile, smoke-free regulations have expanded to encompass bans on smoking in outdoor areas, such as public parks or sidewalks, where the health risks of second-hand smoke exposure are negligible.[68] These increasingly discriminatory laws have also been linked to intentional denormalization by public health advocates.[69]

### *B. Destigmatization as an HIV Prevention Strategy*

In 1986, prominent conservative social commentator William F. Buckley proposed that "everyone detected with AIDS should be tattooed in the upper forearm, to protect common-needle users, and on the buttocks, to prevent the victimization of other homosexuals."[70] A British politician, and advisor to Margaret Thatcher, argued that the only way to stop AIDS was "to screen the entire population regularly and to quarantine all carriers of the disease for life."[71] AIDS panic built on the preexisting stigmatization of the groups among which the virus was most prevalent: men who have sex with men, injection drug users, and sex workers. Regulators readily turned to the infectious disease control tools of "old" public health law, including mandatory testing with reporting to public health authorities and sexual contacts of the infected, and regulation of private establishments like bath houses and gay bars.[72] More restrictive measures, like quarantine and isolation,

[66] *See* Wendy Koch, *Workplaces Ban Not Only Smoking, but Smokers Themselves*, U.S.A. TODAY (Jan. 6, 2013), http://www.usatoday.com/money/industries/health/story/2012-01-03/health-care-jobs-no-smoking/52394782/1 (discussing the increasing adoption of employer policies that prohibit the hiring of smokers).

[67] Bayer & Stuber, *supra* note 63, at 47.

[68] *See* Michael Siegel, *Lessons Learned in 2011: Reflections on the Year in Tobacco Control*, THE REST OF THE STORY: TOBACCO NEWS ANALYSIS AND COMMENTARY (Dec. 31, 2012), http://tobaccoanalysis.blogspot.com/2011/12/lessons-learned-in-2011-reflections-on.html (arguing that "policies which ban smokers from potential employment and policies which ban smoking in large, wide-open outdoor areas" are a consequence of intentional denormalization).

[69] *See id.*

[70] *See* William F. Buckley, *Crucial Steps in Combating the AIDS Epidemic: Identify all Carriers*, N.Y. TIMES, Mar. 18, 1986, at A27.

[71] *See* Christopher Monckton, *The Myth of Heterosexual AIDS*, THE AM. SPECTATOR, Jan. 1987, at 30.

[72] *See* Larry Gostin & William J. Curran, *Legal Control Measures for AIDS:*

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were proposed even though they were not well-suited to control a disease that scientists had established could not be spread through casual contact.[73]

In the midst of this panic, Jonathan Mann, director of the World Health Organization's Global Program on AIDS, called for a very different approach: destigmatization.[74] In a 1987 address to the United Nations General Assembly, he "underscored the significance of stigmatization and the social and political unwillingness to face the epidemic as being 'as central to the global AIDS challenge as the disease itself.'"[75] The stigma surrounding HIV/AIDS and the behaviors associated with it was "shap[ing] the behavior of infected individuals and . . . limit[ing] the effectiveness of prevention efforts."[76] "Fear of being harassed, of facing job discrimination, and of losing insurance coverage, for example, [was] deter[ring] individuals from being tested for HIV infection and seeking early treatment for symptoms" as well as "discouraging physicians from reporting cases."[77] Over time, "social disapproval of behaviors that can transmit AIDS" diminished political will for effective prevention efforts, as is evident from state and federal policies refusing to support safe-sex education and (more recently) legal prohibitions on needle exchange programs to provide clean needles for injection drug users.[78] A vocal group of public health experts who recognized these trends argued that "[s]tigma and

*Reporting Requirement, Surveillance, Quarantine, and Regulation of Public Places*, 77 AM. J. PUB. HEALTH 214, 214 (1987) (noting that "widespread publicity" of the HIV/AIDS epidemic "has charged the atmosphere of health policy debate and injected into it proposals for the application of compulsory legal powers").

[73] *See id.* at 216.

[74] Destigmatization has been, of course, only one component of comprehensive public health strategies for HIV/AIDS prevention. *See, e.g.*, WORLD SUMMIT OF MINISTERS OF HEALTH ON PROGRAMMES FOR AIDS PREVENTION, LONDON DECLARATION ON AIDS PREVENTION (1988), *available at* http://whqlibdoc.who.int/hq/1988/WHO_GPA_INF_88.6.pdf (emphasizing education and information programs as the most important component of AIDS prevention programs, but stating that "[d]iscrimination against, and stigmatization of HIV-infected people and people with AIDS and population groups undermine public health and must be avoided"). That said, when it comes to public health law, "the field of HIV and the law has traditionally been dominated by antidiscrimination, destigmatization and privacy principles." Noah Novogrodsky, *The Duty of Treatment: Human Rights and the HIV/AIDS Pandemic*, 12 YALE HUM. RTS. & DEV. L.J. 1, 12 (2009).

[75] *See* Bayer & Stuber, *supra* note 63, at 48.

[76] *See* Gregory M. Herek & Eric K. Glunt, *An Epidemic of Stigma: Public Reactions to AIDS*, 43 AM. PSYCHOLOGIST 886, 890 (1988).

[77] *Id.*

[78] *See id.*

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discrimination are the enemies of public health."[79] "By attacking AIDS-related stigma," they insisted, "we create a social climate conducive to a rational, effective, and compassionate response to this epidemic."[80]

Like tobacco denormalization, HIV destigmatization relied heavily on law and policy tools. The HIV destigmatization strategy emphasized the synergies between public health and human rights protections. At a special session in 2001, the United Nations General Assembly committed member states to adopt legislation "to eliminate all forms of discrimination against, and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups."[81] In the United States, the legal implications of the destigmatization strategy were twofold: First, destigmatization promoted the application of existing disability, privacy, confidentiality, and informed consent laws — as well as the adoption of new legal frameworks specific to HIV/AIDS — "to protect people with HIV from discrimination in employment, housing, and public accommodations; . . . to protect HIV-related medical information; and . . . [to] protect medical privacy and limit HIV testing in the absence of informed consent."[82] Second, the destigmatization strategy dictated "opposition to . . . coercive legal measures, such as mandatory testing and a whole range of criminal laws directed at conduct that was thought to contribute to the spread of the disease."[83]

### *C. Evaluating the Use of Shame-Based Public Health Interventions*

Public health ethicists Ronald Bayer and Jennifer Stuber have noted that the efforts of public health advocates to denormalize smoking apparently "run counter to" the view that had emerged in response to the HIV/AIDS epidemic — that it was the responsibility of public health advocates "to counteract stigmatization."[84] In 2006, they raised a provocative question: "Is it true that stigmatization always represents a threat to public health," or "[a]re there occasions when the mobilization of stigma may effectively reduce the prevalence of

[79] Gregory M. Herek, *Thinking About AIDS and Stigma: A Psychologist's Perspective*, 30 J. L. MED. & ETHICS 594, 604 (2002).

[80] Herek & Glunt, *supra* note 76, at 890.

[81] U.N. GEN. ASSEMBLY, DECLARATION OF COMMITMENT ON HIV/AIDS 24 (2001), *available at* http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub03/aidsdeclaration_en.pdf.

[82] *See* Scott Burris, *Law and the Social Risk of Health Care: Lessons from HIV Testing*, 61 ALB. L. REV. 831, 835-36 (1997).

[83] *Id.*

[84] *See* Bayer & Stuber, *supra* note 63, at 47.

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behaviors linked to disease and death?"[85] Two years later, Bayer elaborated: "If the state may legitimately shape or control behaviors that increase the risk of disease and death by the exercise of explicitly coercive measures, if it can undertake health promotion campaigns that seek to change social norms and individual preferences, even desires," then, he questioned, "should it be permitted to adopt strategies that will incidentally but unavoidably stigmatize behaviors that pose a threat to the public health?" Or, to really press the matter, may the state "engage in efforts that have as their intended goal the stigmatization of such behaviors through campaigns that attempt to tap the power of shame and guilt to affect social norms?"[86]

Scott Burris, a legal scholar who had previously written about the relationship between stigma and public health,[87] published a response to Bayer in the same volume, arguing that it is never acceptable for a public health strategy to intentionally invoke "stigma's decentralized and visceral mode of social control."[88] But Burris was not convinced that "negative social marketing and a variety of behavioral interventions" aimed at tobacco control amounted to such an invocation.[89]

The disagreements between Burris and Bayer are important, but not so insurmountable as to bar an analysis that derives criteria from both approaches to evaluate the stigma potential of obesity control law. Both authors ultimately conclude that it *is* possible to distinguish between acceptable and unacceptable uses of shame as a public health tool. In doing so, they both rely on the writings of legal scholars like Dan Kahan, John Braithwaite, and Martha Nussbaum on the use of shaming sanctions in criminal law.[90] In particular, they both look to John Braithwaite's distinction between "shaming that is 'reintegrative'

[85] *Id.*

[86] *See* Bayer, *Stigma*, *supra* note 54, at 468.

[87] *See, e.g.*, Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J. L. MED. & ETHICS 179 (2002) [hereinafter *Disease Stigma*] (discussing stigma within sociological research to clarify the relationship between law and stigma in public health); Scott Burris, *Stigma and the Law*, 367 LANCET 529 (2006) (discussing legal protections against stigma laws, law and the propagation of stigma, and law and individual resistance to stigma).

[88] *See* Scott Burris, *Stigma, Ethics and Policy: A Commentary on Bayer's "Stigma and the Ethics of Public Health: Not Can We But Should We?"*, 67 SOC. SCI. & MED. 473, 475 (2008) [hereinafter *Stigma, Ethics and Policy*].

[89] *See id.* ("It remains unclear that smokers are stigmatized in that sort of framework.").

[90] *See* Bayer, *Stigma*, *supra* note 54, at 468-69 (discussing the work of Dan Kahan, John Braithwaite, and Martha Nussbaum); Burris, *Stigma, Ethics and Policy*, *supra* note 88, at 475 (discussing the work of Braithwaite and Nussbaum).

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— part of a process in which the relationship between the offender and the community is restored, and the offender's identity repaired" and "shaming that becomes stigmatization."[91] Burris and Bayer also draw heavily on the work of sociologists, including Erving Goffman, and Bruce Link and Jo Phelan.

From Burris's and Bayer's work, and the rich bodies of literature on which they rely, three key factors emerge: (1) the presence of a power differential between the stigmatized and the "normal" that makes possible (2) labeling, stereotyping, and categorization of the stigmatized as separate from the normal; and (3) the experience of status loss and discrimination by the stigmatized group that is enduring and engulfs the entire identity. Finally, a balancing of the negative impact of the purported stigmatization against the potential utility of shame-based sanctions (in terms of public health costs and benefits) *may* be appropriate.

Stigma is a function of decentralized social power. "Goffman treated stigma in social terms. It was not a characteristic of the person possessing the trait, or indeed even a characteristic of the trait itself, but a social relation between the stigmatized and the 'normal.'"[92] Stigma is a power dynamic that makes possible the labeling, stereotyping, and categorization of the stigmatized as separate from the normal.[93] It is a process whereby "people distinguish and label human differences, . . . dominant cultural beliefs link labeled persons to undesirable characteristics — to negative stereotypes, [and] labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them.'"[94] As a result of this process, "labeled persons experience status loss and discrimination that lead to unequal outcomes."[95]

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[91] *See* Burris, *Stigma, Ethics and Policy*, *supra* note 88, at 475 (quoting JOHN BRAITHWAITE, CRIME, SHAME AND REINTEGRATION 102 (1989)); *accord* Bayer, *Stigma*, *supra* note 54, at 469 (describing Braithwaite's distinction between the limited use of shame and the corrupting force of stigma).

[92] Burris, *Disease Stigma*, *supra* note 87, at 179 (quoting ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY 7 (1963)).

[93] *See* Burris, *Disease Stigma*, *supra* note 87, at 180-81 (quoting Bruce G. Link & Jo C. Phelan, *On Stigma and its Public Health Implications* (2001), http://www.stigmaconference.nih.gov/LinkPaper.htm (paper prepared for NIH International Conference on Stigma)).

[94] *See* Bruce G. Link & Jo C. Phelan, *On Stigma and its Public Health Implications* (2001), http://www.stigmaconference.nih.gov/LinkPaper.htm (paper prepared for NIH International Conference on Stigma).

[95] *Id.*

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The internalization of negative stereotypes by the stigmatized group and the extent to which those stereotypes become an inescapable feature of one's identity are crucial components of stigmatization. Burris points to: "[T]he shared recognition that the trait is, in a particular social context and relationship, discrediting. It was for Goffman a 'pivotal fact' that 'the stigmatized individual tends to hold the same beliefs about identity that we [normals] do.'"[96] Bayer also looks to the work of psychologist Gregory Herek, who has argued that "stigma must involve an enduring condition or attribute that 'engulfs the entire identity of the person . . . [and] does not entail social disapproval of merely one aspect of an individual . . . . The attribute is understood by all to signify that its bearer is a criminal, villain, or otherwise deserving of social ostracism, infamy, shame, and condemnation.'"[97] True stigma is "identity spoiling" in a way that, for Burris at least, makes its use as a public health tool flatly unethical.[98]

Applying these criteria to smokers, Burris has noted that: "One could argue that smokers are not really relegated to a 'them' status, that smoking does not supplant all other traits and is not automatically or durably associated with a range of negative stereotypes. Or one could argue that it satisfies all the criteria of stigma in a formal way, but that in none of the domains is the effect serious enough to rise to the level of stigma."[99] If, as Bayer has put it, shame-based intervention amounts to "segregation that is demeaning but not degrading," separation that is "temporary rather than enduring," involves "marginalization that can be shed," that "permits, even as its goal, the reintegration of those who have been shamed," then denormalization may be an appropriate strategy if its benefits outweigh its costs.[100]

It is important to note, however, that these factors are far from static. As population-level patterns of behavior and illness (and social attitudes about them) change, shame-based sanctions might become more or less appropriate or effective. Indeed, as the prevalence of smoking has decreased among socially-advantaged groups faster than it has among those with lower socioeconomic status (resulting in

[96] *See* Burris, *Disease Stigma*, *supra* note 87, at 179 (quoting ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY 7 (1963)).

[97] Bayer, *Stigma*, *supra* note 54, at 469 (emphasis omitted) (quoting Herek, *supra* note 79, at 14).

[98] Burris, *Disease Stigma*, *supra* note 87, at 179 (quoting ERVING GOFFMAN, STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY (1963)).

[99] *See* Burris, *Disease Stigma*, *supra* note 87, at 187.

[100] *See* Bayer, *Stigma*, *supra* note 54, at 470.

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widening disparities), some tobacco control advocates have called for a re-evaluation of the denormalization strategy.[101] Similarly, Bayer and others have called for an end to "HIV exceptionalism."[102] Commentators have argued that the nature of the epidemic has changed, such that there is no longer a need to be so wary of applying traditional public health law interventions to HIV (such as widespread surveillance, screening, and treatment without enhanced protections for confidentiality).[103]

## II. THE LAW AND POLITICS OF OBESITY CONTROL

As recently as the 1990s, discussions of "obesity and the law" focused almost exclusively on the movement to recognize obesity as a status with the potential to trigger anti-discrimination norms,[104] but

[101] *See* Kirsten Bell et al., *Smoking, Stigma and Tobacco 'Denormalization': Further Reflections on the Use of Stigma as a Public Health Tool: A Commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue*, 70 SOC. SCI. & MED. 795, 795 (2010) (suggesting that "stigmatizing smoking will not ultimately help to reduce smoking prevalence amongst disadvantaged smokers — who now represent the majority of tobacco users. Rather, it is likely to exacerbate health-related inequalities by limiting smokers' access to healthcare and inhibiting smoking cessation efforts in primary care settings"). It may also be the case that social disparities are what make the use of shame-based interventions politically feasible in the first place. *See* Bayer & Stuber, *supra* note 63, at 49 (noting that states with aggressive antismoking campaigns began to "embrace a strategy of denormalization" only after "the social class composition of smokers underwent a dramatic shift downward").

[102] *See* Ronald Bayer, *Public Health Policy and the AIDS Epidemic: An End to HIV Exceptionalism?*, 324 NEW ENGL. J. MED. 1500, 1504 (1991). For critiques of Bayer's argument, see Scott Burris, *Public Health, "AIDS Exceptionalism" and the Law*, 27 J. MARSHALL L. REV. 251 (1994), and Michael T. Isbell, *AIDS and Public Health: The Enduring Relevance of a Communitarian Approach to Disease Prevention*, 8 AIDS & PUB. POL'Y J. 157 (1993).

[103] *See* Lawrence O. Gostin & James G. Hodge, *The "Names Debate": The Case for National HIV Reporting in the United States*, 61 ALB. L. REV. 679, 686 (1998) ("We have changed our mind about named HIV reporting [which the authors had previously opposed on the grounds that privacy protections were essential to the public health law response to HIV], not because we have changed, but because the epidemic has changed.").

[104] A search of Westlaw's Journals and Law Reviews Database on July 14, 2012 for "obesity /s law" retrieved 517 documents. Among those, virtually every article, note, and comment published prior to 2002 that discussed obesity and the law discussed obesity in terms of anti-discrimination law. Result list on file with author. *See, e.g.*, Jane Byeff Korn, *Fat*, 77 B.U. L. REV. 25 (1997) (arguing that obesity should be considered a disability under the Americans with Disabilities Act); Robert Post, *Prejudicial Appearances: The Logic of American Anti-Discrimination Law*, 88 CALIF. L. REV. 1 (2000) (discussing prohibitions on discrimination based upon physical appearance and weight); Elizabeth E. Theran, *"Free to be Arbitrary and . . . Capricious":*

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that movement has come to a screeching halt.[105] As a legal and public policy issue, obesity has now been almost completely co-opted by public health.[106] It is increasingly viewed as a behavior or "lifestyle" choice that is dangerous for the individual's health and costly for society, akin to smoking, illicit drug use, or risky sexual behavior.[107]

### *A. The Evolution of Public Health Law in Response to Chronic Disease Threats*

Initially, control of obesity and the health problems associated with it was a project to which the law had very little relevance. Public health laws had played an important role in combating infectious disease threats in the nineteenth and early-twentieth centuries through industry regulation, compulsory vaccination, and other measures.[108]

*Weight-Based Discrimination and the Logic of American Antidiscrimination Law*, 11 CORNELL J.L. & PUB. POL'Y 113 (2001) (arguing that American antidiscrimination law incompletely addresses the range of human bias and stereotyping and that weight-based discrimination serves as a valid illustration of this underinclusivity). *But see* Glenn H. Reynolds & David B. Kopel, *The Evolving Police Power: Observations for a New Century*, 27 HASTINGS CONST. L.Q. 511, 529-30 (2000) (suggesting that recent cases curtailing the police power in the areas of "parenting, procreation, and sodomy" may have implications for "laws . . . against obesity and high-fat foods, currently foreshadowed by legislative efforts to declare that an individual's fatness is a 'disease' that harms 'public health'").

[105] *See* Jane B. Korn, *Too Fat*, 17 VA. J. SOC. POL'Y & L. 209, 209 (2010) (arguing that "[d]espite the intention of the [Americans with Disabilities Amendments Act] to provide a broad scope of protection, it will provide no more relief to people who are obese than the prior version of the Act. Obesity is being treated differently from other physical conditions because we blame the person for being obese"); Rhode, *supra* note 41, at 1034 (noting the "failure to address" appearance discrimination and "the unwillingness of so many legal scholars and policy makers to take that failure seriously").

[106] From the search described in note 104, *supra*, the great majority of publications since 2002 that have discussed obesity have focused primarily on its status as a public health problem. *See* Adam Benforado, Jon Hanson & David Yosifon, *Broken Scales: Obesity and Justice in America*, 53 EMORY L.J. 1645, 1649-52 (2004); Bloche, *supra* note 30, at 1335; Richard A. Epstein, *What (Not) to Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L. J. 1361, 1368 (2005); Ellen Fried & Michele Simon, *The Competitive Food Conundrum: Can Government Regulations Improve School Food?*, 56 DUKE L.J. 1491, 1492 (2007); Stephen D. Sugarman, *Fighting Childhood Obesity Through Performance-based Regulation of the Food Industry*, 56 DUKE L.J. 1403, 1403 (2007).

[107] *See* Maclean et al., *supra* note 59, at 89 ("As a health construct, being obese has often been framed as a risky behaviour with poor lifestyle choices, whereas being thin has often been framed as a product of good lifestyle choices.").

[108] Well-known constitutional law cases like *The Slaughterhouse Cases*, 83 U.S. 36 (1873) (upholding the efforts of the City of New Orleans to regulate slaughterhouse

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But shortly after World War II, when chronic diseases like heart disease and cancer overtook infectious diseases as the leading causes of death in the United States, the public health community found itself at a crossroads.[109] In response to research associating chronic diseases with behaviors like poor diet, physical inactivity, smoking, and sun exposure, public health scientists developed a "behavioral model" of public health that advocated individual behavior change as a preventive approach.[110]

During the 1980s and early 1990s, the tobacco control movement made law relevant to a "modern" public health threat for the first time in decades, as many jurisdictions adopted advertising restrictions, warning and disclosure mandates, smoking bans, and cigarette taxes.[111] But during this time, poor diet and physical inactivity were still treated almost exclusively as a matter for awareness-raising, private industry action, and individual doctor-patient counseling.[112] Government agencies confined their role to distributing copies of the "Dietary Guidelines for Americans"[113] and other educational materials

operations to control cholera), and *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (upholding mandatory vaccination for smallpox) provide a window into the importance of public health law during this period.

[109] *See* Mervyn Susser & Ezra Susser, *Choosing a Future for Epidemiology: I. Eras and Paradigms*, 86 AM. J. PUB. HEALTH 668, 670 (1996) ("Shortly after [World War II] ended, it was clear that, in the developed world, rising chronic disease mortality had overtaken mortality from infectious disease.").

[110] *See* Wiley, *Rethinking*, *supra* note 51, at 215-22 (describing the evolution of public health law through "four basic eras in the history of public health, each with an accompanying paradigm for understanding the determinants of health: the miasma model, the agent model, the behavioral model, and the ecological model").

[111] *See* discussion *supra* Part I.A.

[112] Healthy People 2010 (the U.S. Department of Health and Human Service's ten-year public health plan developed in 2000) included objectives aimed at expanding weight management programs offered through employers, encouraging medical weight loss counseling by primary care providers, reducing sources of unnecessary calories in school and restaurant meals, increasing nutrition labeling for food items, and improving access to community recreational facilities. But "[c]ompared to the tobacco objectives, the . . . obesity objectives focus[ed] on results rather than publicly-directed strategies for obtaining those results. There [were] no calls for state legislation, for example. While the report recognize[d] the growing importance of childhood obesity, governmental entities . . . [were] not given any special responsibility to protect children from risky foods." Mary Anne Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 AM. J.L. & MED. 363, 378 (2003).

[113] "The U.S. Department of Health and Human Services (HHS) and the U.S. Department of Agriculture (USDA) have jointly published the Dietary Guidelines every 5 years since 1980." *Dietary Guidelines for Americans*, HEALTH.GOV, http://health.gov/dietaryguidelines/ (last visited August 24, 2013).

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and encouraging the development of health education and fitness programs.[114] "Typically, these guidelines focused on individuals and tended to state the obvious."[115]

By the time former Surgeon General C. Everett Koop declared a "war against obesity" in 1995,[116] however, it was becoming clear that these strategies simply were not going to cut it. The prevalence of obesity rose sharply in the late 1980s and 1990s.[117] And a growing body of research associated obesity with the risk of many chronic diseases, including: type-2 diabetes, ischemic heart disease, stroke, gallbladder disease, sleep apnea, depression, osteoarthritis, and many cancers.[118] This data prompted policymakers to begin exploring new approaches to fighting the obesity epidemic. They also increasingly framed the problem in terms of obesity itself, rather than focusing directly on the diet and exercise behaviors — or health consequences — associated with it.[119]

Obesity control law began to emerge in the last decade or so as part of a broader "new public health law" movement.[120] Advocates began to

[114] *See* Marion Nestle & Michael F. Jacobson, *Halting the Obesity Epidemic: A Public Health Policy Approach*, 115 PUB. HEALTH REP. 12, 15 (2000).

[115] *Id.* at 14.

[116] *See* Russ Loar, *Doctor's Orders: Ex-Surgeon General Koop Calls for War Against Obesity*, L.A. TIMES (Mar. 18, 2005), http://articles.latimes.com/1995-03-18/local/me-44239_1_surgeon-general.

[117] *See, e.g.*, Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among U.S. Adults: 1999-2008*, 303 J. AM. MED. ASS'N 235 (2010) (finding that the prevalence of adult obesity increased in the United States throughout the period from 1976 and 2000, but that between 2000 and 2008, there was no significant change among women and only a slight increase in prevalence among men); Cynthia L. Ogden, *Prevalence of Obesity and Trends in Body Mass Index Among US Children and Adolescents: 1999-2010*, 307 J. AM. MED. ASS'N 483 (2012) (finding that the prevalence of childhood obesity increased in the 1980s and 1990s, but there were no significant changes in prevalence between 1999 and 2008).

[118] *See* Daphne P. Guh et al., *The Incidence of Co-Morbidities Related to Obesity and Overweight: A Systemic Review and Meta-Analysis*, 9 B.M.C. PUB. HEALTH, Mar. 25, 2009, at 1, *available at* http:// www.biomedcentral.com+1471-2458-9-88.pdf.

[119] In the *Healthy People 2000* report, a ten-year plan developed by the U.S. Department of Health and Human Services in 1990, physical activity and nutrition were given top billing among the public health issues that the plan addressed. The report included objectives aimed at promoting nutrition and fitness education in schools, workplaces, and communities. U.S. DEP'T HEALTH & HUM. SERVS., HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES (1990). Ten years later, the *Healthy People 2010* report replaced the term "Nutrition" with "Overweight and Obesity" as a top public health priority. U.S. DEP'T HEALTH & HUM. SERVS., HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH 28 (2001).

[120] *See, e.g.*, Wiley, *Rethinking*, *supra* note 51, at 219-25 (describing the new public health movement as characterized by a focus on non-communicable disease

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develop more sophisticated strategies for using law as a tool to support interventions based on the behavioral model. These include programs that provide financial incentives directly to individuals,[121] mandates and incentives for the creation of targeted health education programs in schools and workplaces,[122] and health-care coverage mandates to ensure access to preventive medical counseling.[123] At the same time, the new "ecological model" of public health that emerged at the end of the twentieth century opened up even more opportunities for the application of legal tools.[124]

The ecological model revolutionized the public health approach to so-called "lifestyle" diseases by placing individual behavior choices within a broader social context.[125] A growing body of research characterizes our current environment as "obesigenic," meaning, in simple terms, that "if you go with the flow you will end up overweight or obese."[126] Cheap, tasty, high-calorie food is readily available to most Americans, most of the time — in marketplaces, schools, workplaces, and homes.[127] We are surrounded by marketing that promotes fast

prevention and the social determinants of health and discussing the ecological approach to obesity prevention as an illustration).

[121] *See, e.g.*, Kathleen Miles, *Gun Buyback LA 2012: 1,650 Guns Turned into LAPD for Grocery Store Gift Cards*, HUFFINGTON POST (May 14, 2012), http://www.huffingtonpost.com/2012/05/14/gun-buyback-la-2012_n_1515105.html (describing program whereby city pays people who turn in assault weapons and firearms); *NYC Offering Prescription Drug Buy-Back Program*, C.B.S. N.Y. (Oct. 29, 2011), http://newyork.cbslocal.com/2011/10/29/nyc-offering-prescription-drug-buy-back-program/ (describing program whereby city pays people who turn in unused or expired prescription drugs).

[122] *See, e.g.*, *State Policies in Brief: Sex and HIV Education*, GUTTMACHER INSTITUTE (Aug. 2013), http://www.guttmacher.org/statecenter/spibs/spib_SE.pdf (surveying state-level education mandates).

[123] *See, e.g.*, U.S. DEP'T HEALTH & HUM. SERVS., STATE MANDATES FOR TREATMENT FOR MENTAL ILLNESS AND SUBSTANCE USE DISORDERS (2007), *available at* http://store.samhsa.gov/shin/content//SMA07-4228/SMA07-4228-A.pdf (surveying state-level mandates for coverage of mental illness and substance use disorders).

[124] *See* Wiley, *Rethinking*, *supra* note 51, at 221-22 (discussing the emergence of the ecological model of public health).

[125] *See, e.g.*, Phul & Heuer, *supra* note 42, at 1021 ("Public health efforts must address the multiple forces contributing to the development and maintenance of obesity and recognize that individual behaviors are powerfully shaped by the obesogenic environment. . . . There is increasing consensus that environmental change is essential to the solution of obesity.").

[126] *See* Daniel DeNoon, *How Did the Nation Get So Fat?*, WEBMD (May 13, 2012), http://blogs.webmd.com/webmd-guests/2012/05/how-did-the-nation-get-so-fat.html (quoting CDC Director Tom Frieden).

[127] *See, e.g.*, *The Obesity Prevention Source: Toxic Food Environment*, HARVARD SCH. PUB. HEALTH, http://www.hsph.harvard.edu/obesity-prevention-source/obesity-

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food, sugary cereals, sodas, and energy drinks.[128] We eat out a lot, and when we do the portions put in front of us are far too large.[129] And to make matters worse, we live, work, learn, and play in ways that confine physical activity to a segregated (and often expensive) task, rather than integrating it into our daily lives.[130] "It is simply too easy to consume too many calories, and too difficult to expend those calories."[131]

In 2000, Marion Nestle and Michael Jacobson decried "the futility of current efforts"[132] and issued a call for a new ecological approach to the obesity epidemic: "What is needed is *substantial* involvement of and investment by government at all levels. . . . Communities, workplaces, schools, medical centers, and many other venues are subject to federal and other governmental regulations that could be modified to make the environment more conducive to healthful diet and activity patterns."[133] Drawing on this ecological approach, public health law scholars concerned about obesity have called for legal interventions aimed at altering the built environment (through zoning restrictions and public spending); the information environment (through disclosure requirements and advertising restrictions); and the food environment (through bans, taxes, and subsidies) — alongside behavioral interventions aimed at encouraging individuals to maintain a healthy weight.[134]

causes/food-environment-and-obesity/ (last visited Nov. 7, 2012) (arguing that the "toxic food environment" requires a multifaceted fix).

[128] *See, e.g.*, Jennifer L. Harris et al., *A Crisis in the Marketplace: How Food Marketing Contributes to Childhood Obesity and What Can be Done*, 30 ANN. REV. PUB. HEALTH 211 (2009) ("In the United States, more than 98% of the television food ads seen by children and 89% of those seen by adolescents are for products high in fat, sugar, and/or sodium.").

[129] *See, e.g.*, Lisa R. Young & Marion Nestle, *The Contribution of Expanding Portion Sizes to the US Obesity Epidemic*, 92 AM. J. PUB. HEALTH 246 (2002) (concluding that public heath efforts should focus on reducing portion sizes).

[130] *See, e.g.*, Ding Ding et al., *Neighborhood Environment and Physical Activity Among Youth: A Review*, 41 AM. J. PREVENTIVE MED. 442 (2011) (evaluating the relationship between environmental attributes and physical activity levels in youth).

[131] Kerry Trueman, *The Terrifying Truth About America's Obesity Epidemic*, ALTERNET (May 11, 2012), http://www.alternet.org/story/155398/the_terrifying_truth_about_america's_obesity_epidemic (quoting David Nathan, director of Massachusetts General Hospital's Diabetes Center).

[132] Nestle & Jacobson, *supra* note 114, at 23.

[133] *Id.* at 19.

[134] *See, e.g.*, Marice Ashe et al., *Assessing Coordination of Legal-Based Efforts Across Jurisdictions and Sectors for Obesity Prevention and Control*, 37 J.L. MED. & ETHICS 45 (2009) (focusing on horizontal and vertical coordination for legal-based obesity prevention and control efforts); William H. Dietz & Alicia S. Hunter, *Legal*

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### *B. The Emerging Law of Obesity Control*

The current state of obesity control law is best described in terms of five settings in which interventions have been implemented — marketplaces, communities, health care, workplaces, and schools — and in terms of a shifting balance between behavioral and environmental interventions. Public health law scholars have mostly emphasized the importance of environmental interventions to facilitate healthier choices about diet and exercise. But due to political influences, these interventions have not yet been widely adopted, or have been adopted but watered down in implementation. Meanwhile, more politically palatable behavioral interventions are thriving.

#### 1. Marketplace Interventions

In 2002 and 2003, a high-profile pair of class action suits against McDonald's jump-started discussion of obesity control as a legal issue and the food industry as a target.[135] Dozens of states and the federal government quickly responded by adopting or considering "Commonsense Consumption Acts" (dubbed "Cheeseburger Bills" by the Congressional Research Service) to grant immunity to food manufacturers and retailers from civil liability based on weight gain,

*Preparedness for Obesity Prevention and Control: The Public Health Framework for Action*, 37 J.L. MED. & ETHICS 9 (2009) (discussing the public health model's perspective on obesity and a rationale for leveraging law-based efforts as a tool to meet the public health model's goals); Judith Monroe et al., *Legal Preparedness for Obesity Prevention and Control: A Framework for Action*, 37 J.L. MED. & ETHICS 15 (2009) (arguing that public health legal preparedness has four core elements: 1) laws and legal authorities, 2) competency of public health professionals to apply laws and legal authorities, 3) coordination of legal-based interventions across jurisdictions and sectors, and 4) information on public health law best practices); Jennifer L. Pomeranz & Lawrence O. Gostin, *Improving Laws and Legal Authorities for Obesity Prevention and Control*, 37 J.L. MED. & ETHICS 62 (2009) (presenting action items for law and policymakers and public health practitioners at multiple levels of government).

[135] The suit filed on behalf of adults did not result in a published opinion because it was withdrawn shortly after filing. *See* Franklin E. Crawford, *Fit for Its Ordinary Purpose?: Tobacco, Fast Food, and the Implied Warranty of Merchantability*, 63 OHIO ST. L.J. 1165, 1218-19 (2002) (examining the potential liability of the fast food industry in light of "a recent class action lawsuit filed in New York by Caesar Barber in July of 2002, claiming damages for illnesses related to the over-consumption of fast food"). The 2003 suit, which resulted in a published opinion, was filed on behalf of children. *See* Pelman v. McDonald's Corp., 237 F. Supp. 2d 512, 516 (S.D.N.Y. 2003); Jeremy H. Rogers, *Living on the Fat of the Land: How to Have Your Burger and Sue it Too*, 81 WASH. U. L.Q. 859, 860-61 (2003) (discussing Barber's suit and a second suit, filed in 2003 by obese teenagers who alleged that eating at McDonald's had caused them to become obese and develop associated health problems).

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obesity, or associated health problems.[136] Meanwhile, a few pioneering state and local governments began to adopt innovative — and increasingly controversial — regulations aimed at altering the food environment. These have included bans on trans-saturated fats in restaurant food,[137] requirements that chain restaurants prominently display calorie counts on menu boards,[138] zoning restrictions on new fast food outlets,[139] and subsidies to promote the availability of healthier options.[140]

"Soda taxes," whereby state and local governments either impose a special tax on sugar sweetened beverages or simply revoke the regular sales tax exemption that applies to other food and beverage sales, have been adopted by several state and city governments.[141] But the tide appears to be turning against these measures, driven by "controversy over their effectiveness, their impact on the poor, general aversion to

[136] *See, e.g.*, LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW & ETHICS: A READER 221 (2010) (noting that the U.S. House of Representatives passed a federal version of the cheeseburger bill in 2005, but the bill died in the Senate); *Food Vendor Lawsuit Immunity*, NAT'L CONF. ST. LEGISLATURES (Feb. 2005), http://www.ncsl.org/issues-research/health/food-vendor-lawsuit-immunity.aspx (noting that as of October 2004, "bills on this topic had been introduced in 25 states and enacted in 13"); Erin Madigan, *"Cheeseburger" Bills Fill State Lawmakers' Plates*, STATELINE: THE DAILY NEWS SERVICE OF THE PEW CHARITABLE TRUSTS (Feb. 15, 2005), http://www.pewstates.org/projects/stateline/headlines/cheeseburger-bills-fill-state-lawmakers-plates-85899389923 (noting that 17 states considered similar bills in 2005).

[137] *See, e.g.*, Alice Park, *NYC's Trans Fat Ban Worked: Fast-Food Diners are Eating Healthier*, TIME HEALTH & FAMILY (July 17, 2012), http://healthland.time.com/2012/07/17/nycs-trans-fat-ban-worked-fast-food-diners-are-eating-healthier/ (describing a study that showed NYC's trans fat ban resulted in healthier food choices); *Trans Fat and Menu Labeling Legislation*, NAT'L CONF. ST. LEGISLATURES, http://www.ncsl.org/issues-research/health/trans-fat-and-menu-labeling-legislation.aspx (last updated Jan. 2012) (listing states that considered or enacted trans-fat bans from 2004 to 2009).

[138] *See, e.g.*, 21 U.S.C. § 343(q)(5)(H) (2012) (adopting a menu labeling requirement for chain restaurants with 20 or more locations); Paul Frumkin, *Revised NYC Menu-Labeling Law Reignites Fierce Debate*, NATION'S RESTAURANT NEWS (Feb. 3, 2008), http://nrn.com/article/revised-nyc-menu-labeling-law-reignites-fierce-debate (discussing NYC's menu-labeling law); NAT'L CONF. ST. LEGISLATURES, *supra* note 137.

[139] In 2008, Los Angeles City Council issued a one-year moratorium on the opening of any new fast food restaurants within a 32-mile radius. Also in California, Westwood Village's zoning plan limits the establishment of new fast food restaurants within less than 400 feet of each other. Phoenix has banned mobile street vendors within 600 feet of schools during school hours. Detroit similarly banned the opening of new fast food restaurants within 500 feet of schools. *See* Paul A. Diller & Samantha Graff, *Regulating Food Retail for Obesity: How far can Cities Go?*, 39 J.L. MED & ETHICS 89, 92 (2011).

[140] *Id.* at 91.

[141] *See* GOSTIN, *supra* note 136, at 31.

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increased taxes,"[142] as well as a well-financed lobbying campaign by the beverage industry.[143] Since 2010, new soda tax proposals have overwhelmingly met with political defeat,[144] and some states have even repealed previously adopted taxes.[145] A new federal tax on sugar sweetened beverages was proposed as part of health reform efforts in 2009, but the proposal was dropped after lobbying from the beverage industry.[146] At the same time, federal regulators have continued to ignore commentators' calls for restrictions on food and beverage advertising, deferring instead to industry self-regulation.[147]

Two particularly innovative approaches to regulating the configurations in which unhealthy food and beverage products may be sold have met with ire from both sides of the political spectrum: the "Happy Meal ordinance" and the sugary beverage portion rule, better known as the "Big Gulp ban." In 2010, the Boards of Supervisors for Santa Clara County and the City of San Francisco voted to prohibit the inclusion of toys in children's meals that contain unhealthy levels of calories, salt, or fat.[148] The so-called "Happy Meal bans" prompted an immediate political backlash from the food industry lobby. In 2011,

[142] *See* Monroe et al., *supra* note 134, at 18.

[143] *See, e.g.*, Wilson, *supra* note 25 (discussing the beverage industry's general success in defeating governmental efforts at passing "soda taxes").

[144] *See id.* ("[D]uring the past two years, each of the 24 states and five cities that considered 'soda taxes' to discourage consumption of sugary drinks has seen the efforts dropped or defeated."). *But see* Caroline Scott-Thomas, *D.C. Council Approves Soda Tax*, FOOD NAVIGATOR-U.S.A. (May 28, 2010), http://www.foodnavigator-usa.com/Regulation/D.C.-Council-approves-soda-tax (noting that the Washington, D.C. Council approved a measure including sweetened soft drinks in its six percent sales tax bracket in May 2010).

[145] *See* Joey Peters, *Soda Taxes Fizzle in Wake of Industry Lobbying*, WASH. POST (July 13, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/07/13/AR2010071303494.html.

[146] *See* Tom Hamburger & Kim Geiger, *Beverage Industry Douses Tax on Soft Drinks*, L.A. TIMES (Feb. 7, 2010), http://articles.latimes.com/2010/feb/07/nation/la-na-soda-tax7-2010feb07.

[147] *See, e.g.*, GOSTIN, *supra* note 136, at 33 ("Currently, the federal government does not systematically regulate or oversee marketing to children, although it does monitor misleading advertisements through the Federal Trade Commission. Similarly, neither the FTC nor any other government agency promotes counter advertising focusing on healthy eating."); Lisa L. Sharma et al., *The Food Industry and Self-Regulation: Standards to Promote Success and to Avoid Public Health Failures*, 100 AM. J. PUB. HEALTH 240 (2010) (describing and evaluating food industry self-regulation).

[148] *See* Bernstein, *San Francisco*, *supra* note 22; Bernstein, *Santa Clara*, *supra* note 22; *see also* Jennifer J. Otten et al., *Food Marketing to Children Through Toys: Response of Restaurants to the First U.S. Toy Ordinance*, 42 AM. J. PREVENTIVE MED. 56, 58 (2012) (finding that restaurants affected by the ordinance improved promotion of healthy meals).

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"lobbyists in Florida and Arizona backed successful efforts to take away the power to enact such bans from cities and counties."[149] The Florida law extended far beyond Happy Meals, by "prevent[ing] local control over 'all matters related to the nutritional content and marketing of foods offered' at public food and lodging establishments."[150] In 2012, the City of New York continued its role as an obesity control pioneer by announcing a proposed prohibition on the sale of sugar-sweetened beverages in cups larger than 16 ounces. The so-called "Big Gulp ban" has generated harsh criticism (and sarcasm) from progressive and conservative commentators alike.[151]

2. Community-Based Interventions

Several states have adopted "complete streets" laws to encourage bicycling and walking,[152] and development plans aimed at increasing the use of public transit.[153] In a promising development, the Affordable Care Act ("ACA") included a new competitive federal grant program to fund "evidence-based activities that promote individual and community health and prevent the incidence of chronic disease."[154] But state and local built environment initiatives require considerable public expenditure and may also increase costs for some private developers. They are facing an uphill battle in the current budgetary climate.[155] Wisconsin's Complete Streets Law, for example, directed

[149] *See* Bernstein, *Happy Meal Bans*, *supra* note 22.

[150] *See* Cara Wilking, *State Laws Prevent Local Control Over Much More than Just Happy Meal Toys*, PUB. HEALTH ADVOCACY INST. (May 18, 2011), http://www.phaionline.org/2011/05/18/state-laws-prevent-local-control-over-much-more-than-just-happy-meal-toys/.

[151] *See* Sarah Kliff, *Why Ban Soda When You Can Tax It?*, WONKBLOG (June 1, 2012), http://www.washingtonpost.com/blogs/ezra-klein/post/why-ban-soda-when-you-can-tax-it/2012/06/01/gJQAT27E7U_blog.html (noting that "[i]t's the rare idea that Jon Stewart and John Boehner can agree on").

[152] NAT'L CONF. ST. LEGISLATURES, PROMOTING HEALTHY COMMUNITIES AND PREVENTING CHILDHOOD OBESITY: TRENDS IN RECENT LEGISLATION 18-20 (2010), *available at* http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf57963 (noting that in 2009 ten states enacted legislation with this aim).

[153] *See id.* at 20-23 (describing measures with this aim adopted in 2009 in ten states).

[154] *See* Patient Protection and Affordable Care Act § 4201, 42 U.S.C. § 300u-13 (2012); *see also* Fazal Khan, *Combating Obesity Through the Built Environment: Is There A Clear Path to Success?*, 39 J.L. MED. & ETHICS 387, 388 (2011).

[155] *See, e.g.*, Sarah A. Rigg, *Controversial Ann Arbor Zoning Plans Aim to Create Walkability*, MLIVE (July 24, 2008), http://www.mlive.com/businessreview/annarbor/index.ssf/2008/07/controversial_ann_arbor_zoning.html (discussing a proposal that would impose maximum setback requirements on commercial buildings).

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the state's Department of Transportation to include accommodations for bicycles and pedestrians in all new construction and reconstruction projects, with limited exceptions.[156] But Republican Governor Scott Walker cut state funding for these accommodations, while also refusing federal funds for a high-speed rail project.[157]

3. Health-Care Interventions

In 2008, the National Center for Quality Assurance adopted new reporting policies requiring private health plans to report annually on the proportion of plan enrollees whose BMI is assessed, and who receive nutrition and physical activity counseling from their doctors.[158] In 2011, the federal Centers for Medicare & Medicaid Services ("CMS") issued a national coverage determination establishing Medicare coverage for intensive behavioral therapy for obesity when furnished in primary care settings.[159] More generally, CMS's recognition in 2004 that obesity may, in some cases, constitute an illness that warrants medical treatment has prompted several states to cover obesity treatment for Medicaid recipients.[160] Coverage by government health-care programs has already begun to prompt a response among providers interested in offering these kinds of services.[161]

[156] *See* WIS. STAT. ANN. § 84.01(35) (West 2012); WIS. ADMIN. CODE TRANS. § 75 (2010), *available at* https://docs.legis.wisconsin.gov/code/admin_code/trans/75; Khan, *supra* note 154, at 389.

[157] *See* Khan, *supra* note 154, at 389.

[158] *See* Dietz & Hunter, *supra* note 134, at 11-12.

[159] *See* Decision Memo for Intensive Behavioral Therapy for Obesity, CTRS. FOR MEDICARE AND MEDICAID SERVS. (Nov. 29, 2011), http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?&NcaName=Intensive%20Behavioral%20Therapy%20for%20Obesity&bc=ACAAAAAAIAAA&NCAId=253&. Medicare has also provided coverage for seventy-two hours of therapy of the "comprehensive lifestyle modification program" aspect of the Ornish program for medically supervised weight loss. *See* Amy Lynn Sorrel, *Medicare's New Approach to Familiar Diseases*, AM. MED. NEWS (May 14, 2012), http://www.ama-assn.org/amednews/2012/05/14/gvsa0514.htm (explaining how a multiyear Medicare demonstration project and other studies reviewed by CMS showed the Ornish program significantly reduced several cardiac risk factors, including blood pressure, cholesterol, and body mass index).

[160] *See* Monroe et al., *supra* note 134, at 18 (finding that, as of 2008, eleven state Medicaid programs showed "strong evidence that they provide reimbursement for nutritional and behavioral therapy to children with overweight and obesity" while in eight states, Medicaid programs covered "assessment and consultation, drug therapy, and bariatric surgery" for obese recipients).

[161] *See* Sorrel, *supra* note 159 (noting that, "[h]undreds of health professionals, hospitals, and clinics have expressed interest in training and certification [to provide

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In response to lobbying by medical associations, a few states have adopted recommendations that private health plans should cover bariatric surgery and other medical treatments for morbid obesity.[162] The ACA now requires private health plans to provide coverage (with no co-pay) for preventive services deemed necessary by the U.S. Preventative Services Task Force, including BMI screening and behavioral counseling by primary care physicians.[163] These and other reforms are prompting private health insurance plans to develop new weight loss screening and counseling programs.[164]

Several states have also adopted individually-targeted incentive programs for obesity prevention and control as part of their Medicaid programs.[165] For example, West Virginia provides an enhanced coverage plan with added benefits to Medicaid enrollees who agree to adhere to healthy behaviors.[166] The West Virginia program requires members to complete a Patient Improvement Plan with the assistance

the [Ornish weight loss] program to Medicare beneficiaries]"); *see also Institute of Medicine and HBO Call Out Obesity Epidemic MDPrevent Offers Immediate, Practical and Innovative Solution for Lifestyle Modification and Weight Loss Management*, PR NEWSWIRE (May 17, 2012), http://www.prnewswire.com/news-releases/institute-of-medicine-and-hbo-call-out-obesity-epidemic-mdprevent-offers-immediate-practical-and-innovative-solution-for-lifestyle-modification-and-weight-loss-management-151864085.html (announcement by a group practice of preventative medicine and primary care providers in Florida of a weight loss program developed in response to Medicare's new guidelines).

[162] *See* Jennifer S. Lee et al., *Coverage of Obesity Treatment: A State-by-State Analysis of Medicaid and State Insurance Laws*, 125 PUB. HEALTH REP. 596, 599 (2010); Vincent W. Vanek, *State Laws on Insurance Coverage for Bariatric Surgery: Help or a Hindrance*, 1 SURGERY FOR OBESITY & RELATED DISEASES 424, 429 (2005).

[163] *See Screening for Obesity in Children and Adolescents*, U.S. PREVENTIVE SERVS. TASK FORCE (Jan. 2010), http://www.uspreventiveservicestaskforce.org/uspstf/uspschobes.htm#summary; *U.S. Preventive Services Task Force Issues Two New Recommendations: Screening for and Management of Obesity in Adults, Behavioral Counseling Interventions to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults*, U.S. PREVENTIVE SERVS. TASK FORCE (June 26, 2012), http://www.uspreventiveservicestaskforce.org/press_releases/obesephysactivitybulletin.pdf.

[164] *See* Reed Abelson, *Learning to Be Lean*, N.Y. TIMES (Jan. 16, 2012), http://www.nytimes.com/2012/01/17/health/learning-to-be-lean.html?pagewanted=all; Judith Graham, *Doctors and Insurers Key to Fighting Obesity*, KAISER HEALTH NEWS (May 12, 2012), http://www.kaiserhealthnews.org/stories/2012/may/13/obesity-and-doctors.aspx; Allison Stevens, *Weight Loss Programs Covered by United Healthcare Insurance*, LIVESTRONG.COM (Sept. 4, 2011), http://www.livestrong.com/article/535205-weight-loss-programs-covered-by-united-healthcare-insurance/.

[165] *See* GOSTIN, *supra* note 136, at 33.

[166] *See* UniCare Health Plan of West Virginia, Inc., W. VA. PROVIDER MANUAL V. 4.0, at 10 (July 1, 2011), http://www.unicare.com/provider/noapplication/plansbenefits/medical/notertiary/pw_a090806.pdf.

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of their primary care physicians that addresses wellness, including weight management.[167] Idaho launched an incentive program in 2007 that offers $200 in vouchers to Medicaid enrollees who consult with a doctor about losing weight.[168] New federal grants established under the ACA are providing further support for these initiatives.[169] For example, Minnesota was awarded a one-year grant for its Medicaid Incentives for Prevention of Diabetes program targeting weight loss as a method of reducing diabetes and reducing health-care expenditures.[170]

4. Workplace Interventions

In the context of a federal health care reform package that significantly expanded public responsibility for ensuring access to health care and healthy living conditions, one set of provisions was added to the ACA with the explicit purpose of promoting "personal responsibility" for health: workplace wellness programs.[171] On average, employers who offer health insurance coverage as a benefit of employment pay about $11,000 per year for family coverage and $4,500 per year for single coverage, giving employers a direct interest in controlling rising health-care costs.[172] According to a 2011 survey,

[167] *See id.*

[168] *See* Aimee Miles, *Medicaid to Offer Rewards for Healthy Behavior*, KAISER HEALTH NEWS (Apr. 11, 2011), http://www.kaiserhealthnews.org/stories/2011/april/08/medicaid-incentives.aspx.

[169] The Medicaid Incentives for the Prevention of Chronic Disease ("MIPCD") grant program provides states with a total of $85 million over five years to test the effectiveness of providing incentives directly to Medicaid beneficiaries who participate in the MIPCD prevention programs and adopt healthy behaviors. The grants must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes. *See MIPCD: The States Awarded*, CTR. FOR MEDICARE & MEDICAID SERVS., http://innovation.cms.gov/initiatives/MIPCD/MIPCD-The-States-Awarded.html (last visited Aug. 16, 2013).

[170] *See MIPCD State Summary: Minnesota*, CTR. FOR MEDICARE & MEDICAID SERVS., http://www.innovations.cms.gov/Files/x/MIPCD-MN.pdf (last visited Aug. 16, 2013).

[171] *See* Janet L. Dolgin & Katherine R. Dieterich, *Weighing Status: Obesity, Class, and Health Reform*, 89 OR. L. REV. 1113, 1134 (2011) ("In this set of provisions, the health reform law pays obeisance to the notion that individuals bear responsibility for their own health but can be guided through a system of rewards and penalties to make the 'right' choices."); David S. Hilzenrath, *Misleading Claims about Safeway Wellness Incentives Shape Health-Care Bill*, WASH. POST (Jan. 17, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/01/15/AR2010011503319.html (noting that supporters of the workplace wellness amendment argued "that financial incentives encourage workers to take responsibility for their health").

[172] *See* KAISER FAM. FOUND. & HEALTH RES. & EDUC. TR., EMPLOYER HEALTH

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nearly two-thirds of employers that offer health insurance benefits offer some sort of wellness program.[173]

Workplace wellness programs generally employ some combination of education, counseling, and financial incentives aimed at altering health behaviors. Many target tobacco use and obesity. Public health researchers and advocates have argued in favor of workplace wellness programs that emphasize changes to the workplace environment — healthier food in the cafeteria, at meetings, and in vending machines, provision of an on-site gym, exercise classes, or shower facilities for those who bike to work. A few local governments have considered legislation promoting these kinds of environmental workplace policies.[174]

But a growing number of employers are eschewing these environmental policies, which put the onus on the employer to offer a healthier worksite, in favor of behavioral policies, which put the onus on the employee to improve his or her weight and health markers.[175] A recent survey indicated that "a growing number of employers are rethinking their current strategies and imposing tougher, more specific requirements for incentives."[176] The year 2011 saw a "twofold increase in incentive designs that pinpoint specific outcomes for weight control or cholesterol levels."[177] And an additional 33% of

BENEFITS: ANNUAL SURVEY 64 (2011), http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8225.pdf.

[173] *See id.* at 168.

[174] *See, e.g.*, District of Columbia Workplace Wellness Act of 2011, http://www.yaleruddcenter.org/resources/upload/docs/what/policy/legislation/Cheh_Workplace_Wellness_Act_of_2011.pdf (a bill that would have required the development of a workplace wellness policy for district government agencies, to "expand opportunities for employees to store lunches and other healthy foods in District buildings," encourage the provision of healthy foods by agencies, promote "the availability and consumption of water throughout the day," and setting forth nutritional standards for items sold in vending machines under the control of the district and calorie count labeling of those items).

[175] *See* GREENLINING INST. & PREVENTION INST., HEALTH, EQUITY AND THE BOTTOM LINE: WORKPLACE WELLNESS AND CALIFORNIA SMALL BUSINESSES 8 (2012), http://greenlining.org/wp-content/uploads/2013/02/GIWWPBrief.pdf (noting that the best workplace wellness programs make use of comprehensive, multifaceted strategies that focus on both individuals and their environment, including establishment of policies and practices to support healthy workplaces; but while ninety percent of workplaces report some sort of wellness activity, less than seven percent provide the multiple elements necessary for a truly effective approach).

[176] *See* TOWERS WATSON & NAT'L BUS. GRP. ON HEALTH, THE ROAD AHEAD: SHAPING HEALTH CARE STRATEGY IN A POST-REFORM ENVIRONMENT 15 (2011), http://www.thehortongroup.com/Files/41c8e753-70d4-b602-38db-15481ad7e12d.pdf.

[177] *See id.*

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employers reported that they planned to implement incentives tied to biometric markers in 2012.[178]

Two states, Alabama and North Carolina, have taken this approach to an extreme. In 2008, the State Employees Insurance Board of Alabama adopted regulations imposing a monthly surcharge on all state employees with a BMI over 30.[179] North Carolina created a similar program in 2009, but then repealed it in 2011 for reasons that were not reported.[180] Other states have considered similar measures.[181]

Inspired by reports of wellness programs developed by private employers,[182] Congress amended the ACA to expand provisions that were initially adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[183] Although HIPAA generally prohibits group health plans from charging some employees higher premiums than others based on health-status-related factors,[184] an exception allows plans to offer discounts as a financial incentive for meeting health-status goals or participating in health promotion programs.[185] The ACA codified HIPAA regulations interpreting this

[178] *See id.* (indicating that biometric standards-based incentives are becoming nearly as prevalent as incentives tied to tobacco-use status (with 22% of employers reporting a tobacco-use standards-based program in 2010, 8% adding such a program in 2011, and 21% planning to implement such a program in 2012)).

[179] *See* Rebecca L. Rausch, *Health Cover(age)ing*, 90 NEB. L. REV. 920, 931-33 (2012) (describing the Alabama program); *State Employees' Health Insurance Plan: Approved Premium and Benefit Changes*, ALA. ST. EMPS.' INS. BOARD (2009), http://www.alseib.org/PDF/SEHIPFY2010RateChange.pdf.

[180] 2009 N.C. Sess. Laws 2009-16 § 2(b), at 2, *repealed by* 2011 N.C. Sess. Laws 2011-85 § 1.5, at 4; Rausch, *supra* note 179, at 962 n.316 (describing the North Carolina program).

[181] *See* Rausch, *supra* note 179, at 934 (describing a proposal in Arizona); Obesity Society et al., *Joint Comments on Proposed Wellness Regulations* (Jan. 24, 2013), http://conscienhealth.org/wp-content/uploads/2013/01/Joint-Comments-on-Proposed-Wellness-Regulations.pdf (describing a proposal in South Carolina).

[182] *See* Hilzenrath, *supra* note 167 (describing how the Safeway program influenced the workplace wellness amendment and questioning the Safeway program's success); Steven A. Burd, *How Safeway Is Cutting Health-Care Costs*, WALL ST. J. (June 12, 2009), http://online.wsj.com/article/SB124476804026308603.html (a proposal by the CEO of Safeway, Inc. "to raise the federal legal limits" on workplace wellness incentives).

[183] *See* Health Insurance Portability and Accountability Act (HIPAA), Pub. L. 104-191, 110 Stat. 1936 (1996).

[184] *See* 29 U.S.C. § 1182(b)(1) (2012) (barring large-group health plans from "requir[ing] any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual").

[185] *See id.* §§ 1182(b)(2), 1182(b)(2)(B) ("[N]othing in paragraph (1) shall be

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exception. These regulations distinguish between "participation-only" programs and "standards-based" programs.[186] Participation-only programs offer an incentive to employees based solely on their participation in a wellness program (for example, Weight Watchers), regardless of the outcome.[187] The only federal restriction on these programs is that "participation must be made available to all similarly situated individuals."[188]

Standards-based programs, which condition the financial incentive on attaining (or maintaining) a particular health marker (for example, achieving a specified level of weight loss during the year, or maintaining a healthy BMI), are subject to additional regulations.[189] Under HIPAA, the combined reward for achieving all available wellness program standards may not exceed 20% of the employee's cost of coverage under the plan.[190] The ACA raised this cap to 30% and

construed — to prevent a group health plan . . . from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.").

[186] Proposed regulations currently under consideration refer to standards-based programs as "health-contingent wellness programs." *See* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70620 (proposed Nov. 26, 2012) (to be codified at 26 C.F.R. pt. 54).

[187] *See* 45 C.F.R. § 146.121(f)(1) (2013) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(2) (2012) (ACA codification). Examples of participation-only programs are provided in federal regulations. Programs that reimburse employees for the cost of a fitness club membership or a smoking cessation program are considered participation-only programs, provided that the smoking cessation reimbursement is not conditioned on whether the employee actually quits smoking. Other examples include: "[A] diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes," and "[A] program that provides a reward to employees for attending a monthly health education seminar." 45 C.F.R. §§ 146.121(f)(1)(i), 161.121(f)(1)(v).

[188] *See* 45 C.F.R. § 146.121(f)(1) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(2) (ACA codification). Participation-only programs must comply with employment and insurance laws that prohibit discrimination based on race, age, gender, religious beliefs and observances, and disability. A participation-only program that meets on Saturday mornings, for example, might be deemed to discriminate against members of certain religions. A participation-only program that requires particular physical activities might need to be adjusted to accommodate employees with physical disabilities. 45 C.F.R. § 146.121(f)(1).

[189] *See* 45 C.F.R. § 146.121(f)(2) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(2) (ACA codification). Examples include programs that provide a premium discount to employees who submit to an annual cholesterol test and achieve a cholesterol level below 200, waive the annual deductible for employees who have a BMI within a specified range, or impose a surcharge on employees who don't provide an annual certification that they have not used tobacco products within the last 12 months. 45 C.F.R. § 146.121(f)(2).

[190] *See* 45 C.F.R. § 146.121(f)(2)(i).

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gave the Secretaries of Labor, Treasury, and Health and Human Services additional authority to extend it to 50%.[191] A standards-based program must also be "reasonably designed to promote health or prevent disease."[192] A program satisfies this standard if it "has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease."[193]

In addition to codifying and expanding HIPAA's wellness-programs exception for employment-based health plans, the ACA provided federal grants for smaller employers to establish new workplace wellness programs[194] and directed the Department of Health and Human Services ("DHHS") to develop a demonstration project to extend wellness incentive programs to the individual insurance market where there is no employee-employer relationship.[195] The criteria for these programs fail to place significant emphasis on environmental policies to make worksites more conducive to healthy eating and physical activity.

As of this writing, the Department of Labor, the DHHS, and the Internal Revenue Service are considering regulations governing workplace wellness programs under the ACA.[196] Commentators have noted that the proposed regulations privilege incentive-based programs that penalize employees based on their failure to attain

[191] *See* 42 U.S.C. § 300gg-4(j)(3)(A).

[192] *See* 45 C.F.R. § 146.121(f)(2)(ii) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(3)(B) (ACA codification).

[193] 45 C.F.R. § 146.121(f)(2)(ii) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(3)(B) (ACA codification).

[194] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §10408(e), 124 Stat. 119, 978 (authorizing $200 million in grants for FY 2011 to 2015 for smaller employer workplace wellness programs). In FY 2011, DHHS made $10 million available in grants to employers with fewer than 100 employees that did not previously have a workplace wellness program in place. *See also $10 Million in Affordable Care Act Funds to Help Create Workplace Health Programs*, U.S. DEP'T. HEALTH & HUM. SERVS., NEWS RELEASE (June 23, 2011), http://www.hhs.gov/news/press/2011pres/06/20110623a.html.

[195] *See* 42 U.S.C. § 300g-4(l). Additionally, the Secretaries of Labor, HHS, and Treasury must submit a report to Congress within two years of the law's enactment assessing employer-based health policies and programs. *See* 42 U.S.C. § 280l-1 (2012).

[196] *See generally* Incentives for Nondiscriminatory Wellness Programs in Group Health Plans, 77 Fed. Reg. 70620 (proposed Nov. 26, 2012) (to be codified at 26 C.F.R. pt. 54).

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certain health markers and fail to encourage environmental policies that would create healthier workplaces.[197]

5. School-Based Interventions

Several states have undertaken efforts to improve the quality of foods available in schools[198] and, in 2010, the federal government got involved. The Healthy, Hunger-Free Kids Act sought to enhance federal oversight of school nutrition.[199] The Act directs the U.S. Department of Agriculture ("USDA") to establish national school nutrition standards that are consistent with the most recent Dietary Guidelines for Americans.[200] For school meals, the regulations specify requirements for fruit, vegetable, and whole-grain offerings,[201] and restrict saturated fat, sodium, and trans fat in school meals.[202] Notably, the Act also provides for regulatory authority over foods sold to students outside of the meal programs.[203]

Implementation of stringent nutrition standards has proven politically difficult, however. Critics have expressed concerns about the increased costs to schools,[204] the likelihood that much of the healthy food will simply be thrown away by kids,[205] and the possibility

[197] *See, e.g.*, Obesity Society et al., *supra* note 181 (describing how the programs can penalize employees); Carla Saporta & Jeremy Cantor, *Workplace Wellness Regulations: First, Do No Harm*, THE HILL'S CONGRESS BLOG (Jan. 18, 2013, 4:30 PM), http://thehill.com/blogs/congress-blog/labor/278079-workplace-wellness-regulations-first-do-no-harm (discussing the negative consequences of the proposed regulations).

[198] *See* Update, Trust for America's Health, Supplement to "F as in Fat: How Obesity Threatens America's Future, 2011" Obesity-Related Legislation Action in States, http://healthyamericans.org/assets/files/FasinFat2011LegislativeSupplement.pdf (noting that as of May 2011 — prior to the implementation of new regulations under the Healthy, Hunger-Free Kids Act of 2010 — twenty states and the District of Columbia had set requirements for school meals that exceed federal USDA standards).

[199] *See* 42 U.S.C. § 1779(a) (2012).

[200] *See id.* at § 1779(b)(1)(C).

[201] *See* 7 C.F.R. § 210.10(c)(2) (2013).

[202] *See id.* at § 210.10(f).

[203] *See* 42 U.S.C. § 1779(b)(1)(B) (applying agency regulations to "[a]ll foods sold (i) outside the school meal programs; (ii) on the school campus; and (iii) at any time during the day").

[204] *See, e.g.*, Isabelle Dills, *School Lunches will be Healthier, Cost More*, NAPA VALLEY REGISTER (July 13, 2012), http://napavalleyregister.com/news/local/school-lunches-will-be-healthier-cost-more/article_cb7b9226-cd4f-11e1-bfb1-001a4bcf887a.html (indicating that school lunch costs will increase).

[205] *See, e.g.*, Lauren Ritchie, *Wasted School Food will Increase Because of Federal Requirement*, ORLANDO SENTINEL (Feb. 22, 2012), http://articles.orlandosentinel.com/2012-02-22/news/os-lk-lauren-ritchie-wasted-school-food-20120222_1_school-lunch-hunger-free-kids-act-lunch-ladies (predicting that $75,000 worth of food will end up

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that some schools may opt out of the federal program to avoid its burdensome standards.[206] After intense lobbying by the food and beverage industry, Congress overturned some of the USDA standards, removing a restriction on how often potatoes could be used to meet daily vegetable requirements, delaying the implementation of limits on sodium and requirements for more whole grains, and ensuring that pizza would continue to count as a vegetable.[207]

There has also been an increased emphasis on health education and physical activity in schools. For example, in 2010, Massachusetts added obesity prevention programs to its school curriculum.[208] The same year, Louisiana adopted a measure to extend daily physical activity requirements to students in seventh and eighth grade, while Texas appropriated grants for physical education and fitness programs in the same age range.[209] Every state has some form of physical education requirements for students. But "these requirements are often limited or not enforced and many programs are inadequate with respect to quality."[210] Many schools are currently cutting back on physical education program spending in the context of ongoing budget concerns.[211]

Meanwhile, a majority of states now mandate some form of BMI, fitness, or other biometric measurement of students in schools.[212] Additional states recommend, but do not require these kinds of

in garbage cans).

[206] *See, e.g.*, Howard Fischer, *Legislation Would Allow Public Schools to End Free Lunches*, EAST VALLEY TRIB. (Jan. 17, 2012), http://www.eastvalleytribune.com/arizona/article_3b97e2dc-413a-11e1-a1d6-001871e3ce6c.html (stating that schools may opt out of the program to escape burdensome standards).

[207] *See, e.g.*, Ron Nixon, *School Lunch Proposals Set Off a Dispute*, N.Y. TIMES (Nov. 1, 2011), http://www.nytimes.com/2011/11/02/us/school-lunch-proposals-set-off-a-dispute.html?pagewanted=all&_r=0 (describing the USDA standards that Congress has overturned).

[208] NAT'L CONF. ST. LEGISLATURES, *supra* note 152, at 10.

[209] *See id.* at 15-16.

[210] *See* Trust for America's Health, *supra* note 198.

[211] *See generally* Rob Hotakainen, *Lawmakers Fear Nationwide PE Cuts are Too Steep*, THUMBS UP FIVE BLOG (Jan. 7, 2012), http://thumbsupfive.com/blog/?p=7 (discussing physical education cuts nationwide).

[212] Of the states that currently mandate physical assessments, a few have instituted the mandate via state-wide regulation, but most have enacted the mandate through legislation. Most states require screenings three or four times throughout a student's public education. Some require annual screenings, at least in certain grade-level ranges. *See* Lindsay F. Wiley, *"No Body Left Behind": Re-orienting School-based Childhood Obesity Interventions*, 5 DUKE FORUM L. & SOC. PROBLEMS 97, 115-16 (2013) [hereinafter *No Body Left Behind*].

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assessments.[213] And even in states that neither require, nor recommend assessments at the state level, many schools are implementing obesity and fitness assessment policies adopted at the district level.[214] At least ten states mandate that schools must provide reports of all students' physical assessment to parents.[215] Two states mandate reporting to parents only where a student's BMI poses a health concern.[216] Others require reporting to state agencies, but not to parents.[217] Most states allow parents to opt out of the screening,[218] though typically parents must take affirmative steps to have their children excluded.

### *C. "Personal Responsibility" and the Politics of Obesity Control*

The foregoing survey of the obesity control law landscape suggests a few significant trends. At a time when state and local budgets are extremely tight, and the federal government is focused on deficit control, adopting and maintaining community-based and environmental school-based measures has been challenging. The fact that political contributions from industry groups are at an all-time high has apparently turned the tide against marketplace regulations and reform of the food environment in schools. Public health advocates' emphasis on the mounting health-care costs associated with obesity has led to some significant political victories, but overall the obesity control law landscape is beginning to skew toward cheaper, more politically palatable behavioral interventions.

Behavioral interventions tend to be less expensive than environmental interventions. Federal law encourages private workplace wellness programs primarily through a regulatory exception, making it essentially free aside from negligible enforcement-related costs. BMI measurement can be costly,

[213] *Id.* (explaining that in Michigan, for example, the State Board of Education recommended (but did not mandate) BMI screening in 2001).

[214] *See, e.g.*, NEB. DEP'T OF HEALTH & HUM. SERVS., 2010-2011 YOUTH BMI SURVEILLANCE PROJECT REPORT (2011), *available at* http://dhhs.ne.gov/publichealth/Documents/2010-2011YouthBMISurveillanceProjectReport.pdf (indicating that approximately three-quarters of Nebraska public schools were routinely measuring student height and weight in the years prior to the adoption of a state-wide regulatory mandate, which was included in draft guidelines promulgated by the state's Department of Health and Human Services in 2011).

[215] *See* Wiley, *No Body Left Behind*, *supra* note 212, at 116.

[216] *Id.*

[217] *Id.* at 116 (noting that at least two states' mandates specifically require that this data be reported in de-identified form).

[218] *Id.*

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particularly if adequate precautions are taken to ensure student privacy, but not compared to the more significant expenses associated with well-designed physical education programs or improvements to school nutrition standards. Coverage mandates for the medical treatment of obesity require public expenditures in the context of Medicare and Medicaid programs, but for private plans (which cover the majority of Americans), those expenses are passed along to others.

Behavioral interventions are also more in keeping with biased cultural views that attribute obesity to the personal failures of obese people.[219] Survey data indicate that a great majority of Americans cite "personal choices about eating and exercising" as the main cause of the rising prevalence of obesity.[220] Fat people who suffer from chronic disease are generally assumed to be the "architects of their own ill health."[221] These cultural beliefs persist in spite of research that strongly suggests that the great majority of variation in BMI from one person to the next is attributable to genetic and environmental factors that are beyond the reach of individual choice or control.[222] "The embedded cultural attitude that obesity is a failure of willpower may be counter to scientific evidence, but it continues to be the prevailing social construction of obesity."[223]

Misconceptions about the extent to which a person's weight is within her personal control pervade the public health response to obesity.[224] "Two of the most important words in the national discourse about obesity are 'personal responsibility.'"[225] The idea that obesity

[219] *See* Benforado et al., *supra* note 106, at 1653 (arguing that cognitive biases that favor misattribution of obesity to the "personal choices" of the obese are influencing policy responses to obesity).

[220] REUTERS, REUTERS/IPSOS POLL: OBESITY'S STIGMA IN AMERICA, http://reuters.tumblr.com/post/22842024642/a-new-reuters-ipsos-online-poll-of-1-143-adults?utm_source=SNEB+Members+2012&utm_campaign=53ee438669-Weekly_Policy_Update05_28_12&utm_medium=email (last visited Nov. 7, 2012).

[221] Puhl & Heuer, *supra* note 42, at 1020.

[222] *See infra* Part III.A.4.

[223] Mary Madeline Rogge et al., *Obesity, Stigma, and Civilized Oppression*, 27 ADVANCES NURSING SCI. 301, 307 (2004).

[224] *See, e.g.*, Maclean et al., *supra* note 59, at 89 ("[S]tigmatizing beliefs about obesity are pervasive and their influence on the emphasis of health service programs strong, despite flawed attributions about obesity characteristics and causes. For example, although 'one simply cannot explain high rates of obesity by biology or by positing a systematic, worldwide decline in [personal] responsibility', there remains a heavy emphasis on behavioural (lifestyle) approaches to obesity prevention both in health sciences curricula and in health service programs." (citation omitted)).

[225] Kelly D. Brownell et al., *Personal Responsibility and Obesity: A Constructive Approach to a Controversial Issue*, 29 HEALTH AFF. 379, 379 (2010).

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and the health problems associated with it are attributable to the personal failures of fat people has been a key theme in debates over everything from the ACA to Bloomberg's Big Gulp ban.[226] It is also closely linked to criticisms that government efforts to address obesity are inappropriately paternalistic.[227] "Obesity is dismissed as a personal failing . . . . Rather than working on a comprehensive plan to address the obesity epidemic, policymakers have mainly focused efforts on education of those afflicted."[228]

Finally, behavioral interventions are also supported by industry interests. The food and beverage industry frequently turns to the language of personal responsibility in its campaigns to defeat environmental interventions, much as the tobacco industry once did.[229] At the same time, behavioral interventions are supported by the substantial industry that has grown up around dieting, exercise, and medical weight loss treatments. Coverage mandates for medical obesity treatments can be costly for government insurance programs and private health plans, but they can be quite lucrative for health-care providers.[230] Workplace wellness programs often directly incorporate payments for independently-operated weight loss programs like Weight Watchers.[231] And even where an employer does not directly

[226] *See, e.g.*, Jonathan Chait, *Sink or Swim*, NEW REPUBLIC (Mar. 5, 2010), http://www.tnr.com/article/politics/sink-or-swim ("[R]epublican health care plans reflect the party's increasingly widespread belief that good health, like other forms of prosperity, is a matter of personal responsibility."); Michael Kirsch, *Soda Ban is a Slippery Slope that Discourages Personal Responsibility*, MEDCITY NEWS (June 17, 2012), http://medcitynews.com/2012/06/soda-ban-is-a-slippery-slope-that-discourages-personal-responsibility/ (discussing Bloomberg's soda ban); Kathleen Parker, *Health Reform and Obesity: Eat Drink and Watch Out*, WASH. POST (May 20, 2011), http://www.washingtonpost.com/opinions/health-reform-and-obesity-eat-drink-and-watch-out/2011/05/20/AFoQ427G_story.html ("[I]t seems clear that the real solution to obesity isn't more government regulation but more personal responsibility.").

[227] *See* Epstein, *supra* note 106, at 1363-64.

[228] Puhl & Heuer, *supra* note 42, at 1024.

[229] *See, e.g.*, Brownell et al., *supra* note 225, at 379 ("[T]he food industry script is clear. A *Wall Street Journal* op-ed piece opposing taxes on sugared beverages by Coca-Cola's chief executive officer stated, 'Americans need to be more active and take greater responsibility for their diets.'").

[230] *See, e.g.*, Shawn Tulley, *How Rich Health Care Mandates Could Bust the Budget*, CNN MONEY (May 4, 2011), http://finance.fortune.cnn.com/2011/05/04/how-rich-health-care-mandates-could-bust-the-budget/ (noting that "medical groups are furiously lobbying HHS Secretary Kathleen Sebelius to get their treatments covered under the [ACA]").

[231] *See* Luann Heinen & Helen Darling, *Addressing Obesity in the Workplace: The Role of Employers*, 87 MILLBANK Q. 101, 111 (2009). For an example of how Weight Watchers markets its workplace wellness services directly to employers, see ABOUT

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contract with a weight loss counseling provider, the financial incentives (or penalties, depending on how you look at them) are quite likely to encourage employees to consume more of the products and services offered by the diet and weight loss industry.[232]

## III. STIGMA AND OBESITY CONTROL LAW

Public health advocates are facing an uphill battle when it comes to the politics of obesity control. The environmental interventions strongly favored by the majority of public health experts have been elusive. In the face of recent failures, public health advocates might be tempted to point to wellness programs, BMI screening, and expanded access to medical treatments for obesity as successes — even if they have qualms about the likely effectiveness of individually-targeted behavioral interventions. But the wrong kind of something can be worse than nothing.

Anti-fat bias (and industry-influenced political support for it) helps to explain the current orientation of obesity control law toward a denormalization strategy that emphasizes behavioral interventions. And in turn, law and policy interventions that target obese individuals are further reinforcing that bias,[233] particularly when they are designed and implemented with an eye toward minimizing expense and infringement upon industry interests. If obesity control law continues to be skewed toward politically palatable interventions with high stigma potential, it may do more harm than good.[234]

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WEIGHT WATCHERS HEALTH SOLUTIONS, http://www.weightwatchers.com/templates/marketing/marketing_utool_1col.aspx?pageid=1317711 (last visited Aug. 17, 2013).

[232] *See* Abigail C. Saguy & Kevin W. Riley, *Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity*, 30 J. HEALTH POL., POL'Y & L. 869, 876 (2005) (noting that antiobesity researchers "[a]dvocate for . . . higher prioritization of obesity as a health crisis" and that organizations of medical professionals specializing in weight loss "[h]ave a professional interest in raising public concern over obesity").

[233] *Cf.* Burris, *Disease Stigma*, *supra* note 87, at 181 ("[T]he power of stigma derives, in the familiar post-modern view of social control, from its decentralized and internalized operation. Although law may support and enforce it . . . ultimately stigma operates through the attitudes and behaviors of individuals.").

[234] *See* Dolgin & Dieterich, *supra* note 171, at 1128 ("Several state and local initiatives, aimed at controlling behaviors and ameliorating conditions (such as obesity) associated with poor health, are as likely to stigmatize the behaviors and conditions at issue as to limit or eviscerate them."); Peter D. Jacobson et al., *Assessing Information on Public Health Law Best Practices for Obesity Prevention and Control*, 37 J.L. MED. & ETHICS 55, 55 (2009) (noting that a proposal in the state legislature of Mississippi to "ban restaurants from serving obese customers" demonstrates how policymakers can misuse information about obesity to generate "ill-conceived legal interventions").

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### *A. "Personal Responsibility" and the Stigmatization of Fatness*

In a 2011 study, an interdisciplinary group of researchers applied insights from Goffman, Link and Phelan, and others (many of the same sociologists whose work was applied to HIV prevention and tobacco control by Bayer and Burris) to argue that "[o]besity stigma — strictly defined — is present within a range of institutions and cultural settings."[235] Furthermore, they concluded, "[t]he majority of current research also highlights the negative impact that obesity stigma has on health and social behaviors and outcomes."[236] Their report addressed Bayer's suggestion that stigma may be effective in "stimulating behaviour change," and concluded that "[d]espite the increasing popularity of [the denormalization strategy for obesity], there is very limited evidence to show that 'shame based' tactics are either effective or ethical in health promotion initiatives seeking to improve the health and wellbeing of obese individuals."[237]

But how can obesity be stigmatized, one might ask, when it has become so prevalent?[238] Approximately one-third of the American population is classified as obese, and when added to the one-third of the population classified as overweight, these Americans reach a majority. Rebecca Puhl and Kelly Brownell, who have studied obesity stigma and advocated for anti-discrimination laws as a solution, have acknowledged this potential counterargument: "With the prevalence of obesity so much higher now, and with greater exposure to obese persons in everyday life, one could speculate that the stigma would be diminished."[239] But, they note, research indicates that weight bias is increasing even as the prevalence of obesity has risen.[240] In 2003, for example, researchers who replicated a famous study from the 1960s demonstrating implicit anti-fat bias among children found that the bias in children is "even stronger" now than then.[241]

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[235] Lewis et al., *supra* note 42, at 1350.

[236] *Id.*

[237] *Id.* (citation omitted).

[238] *Cf.* Smith et al., *supra* note 39, at 306 (arguing that "the increased prevalence of obesity has led to it becoming normalised").

[239] Rebecca M. Puhl & Kelly D. Brownell, *Psychosocial Origins of Obesity Stigma: Toward Changing a Powerful and Pervasive Bias*, 4 OBESITY REVS. 213, 214 (2003).

[240] *See id.*; *accord* Tatiana Andreyeva et al., *Changes in Perceived Weight Discrimination Among Americans, 1995–1996 Through 2004–2006*, 16 OBESITY 1129, 1129 (2008) (reporting that "[w]eight/height discrimination is highly prevalent in American society and increasing at disturbing rates" and that "its prevalence is relatively close to reported rates of race and age discrimination . . . .").

[241] *See* Janet D. Latner & Albert J. Stunkard, *Getting Worse: The Stigmatization of Obese Children* 11 OBESITY RES. 452, 454 (2003).

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1. Fat Stigma and Social Power

The power dynamic that makes true stigmatization possible appears to be in effect with regard to obesity.[242] Researchers have classified "the pervasive pattern of ongoing, daily denigration and condemnation that constitutes living as an obese person"[243] as a form of "civilized oppression."[244] Burris's statement that "[a]t its strongest, stigma is hegemonic — accepted as natural and sensible, without reflection,"[245] well describes the persistence of "personal responsibility" as the dominant cultural, social, and political norm with regard to obesity, even in the face of scientific evidence to the contrary.

Part of the explanation for the paradoxical increase in weight bias at a time when obesity has become more common may be that the stigmatization of fatness interacts with gender, race, class, and sexual orientation bias in complex ways.[246] "For stigmatized conditions such as obesity that are correlated with other forms of marginalization, such as poverty, disability, racial or cultural discrimination, many people experience a 'layering' of stigma. Such people have to cope with multiple stigmas, for example being poor and from a visible ethnic minority, as well as being obese."[247] The relationship between obesity and low socio-economic status is increasingly fraught, as obesity becomes a "disease" of poverty rather than a sign of financial security.[248] As David Musto wrote of HIV/AIDS, "[w]hen an epidemic illness hits hardest at the lowest social classes or other fringe groups, it provides that grain of sand on which the pearl of moralism can form."[249]

[242] *See, e.g.*, Rogge et al., *supra* note 223, at 306-07 (describing how obesity "subordinates an individual in a relationship").

[243] Maclean et al., *supra* note 59, at 89 (citation omitted).

[244] Rogge et al., *supra* note 223, at 306-07 (citing JEAN HARVEY, CIVILIZED OPPRESSION (1999)).

[245] Burris, *Disease Stigma*, *supra* note 87, at 182.

[246] *See, e.g.*, Maclean et al., *supra* note 59, at 90-91 ("The impact of stigmatization on self-esteem appears to vary by gender and by culture partly depending on protective factors in subgroups, as well as on the combined negative impacts of multiple layers of stigma." (citation omitted)).

[247] *Id.* at 90 (citation omitted).

[248] *See, e.g.*, Dolgin & Dieterich, *supra* note 171, at 1116 (arguing that "[t]he nation's ambivalent response to expanding health care coverage" is tied to "[c]onflated images of poverty and obesity").

[249] *See* Bayer, *Stigma*, *supra* note 54, at 465.

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2. Labeling, Stereotyping, and Separation

The power dynamic that is essential to stigmatization enables the labeling, stereotyping, and categorization of fat people as separate from the normal. Public health has played a major role in labeling and categorizing people according to their weight — creating somewhat arbitrary distinctions between "normal weight," "overweight," and "obesity" on the BMI scale that are not based on data regarding health outcomes.[250] In turn, these distinctions are being used to convey to parents that their children are abnormal and to impose financial penalties on employees and insureds.

But these relatively recent, mathematically-derived designations belie social and cultural attitudes about fatness that vastly predate the public health war on obesity. In the dominant Western cultural view, "obesity represents the outward manifestation of self-indulgence and spiritual imperfection, exemplifying the biblical admonition 'the spirit is willing but the flesh is weak.'"[251] Attitudes toward fat people are "overwhelmingly negative."[252] Studies have demonstrated that children as young as three associate negative stereotypes with images of fat people — regarding them as mean, stupid, ugly, unhappy, and lazy.[253] Many obese people internalize these attitudes to the extent that they express agreement with the moral judgments and negative stereotypes that pervade their daily lives.[254]

The attribution of obesity to "personal responsibility" is intimately connected to these stereotypes. As a general matter: "Those who are considered deviant are those who are represented as being able to take personal responsibility and control for the 'defects' that deviate from an acceptable social norm. This construction places responsibility for deviance on the individual, and implies that that stigma 'just happens' to those who are different."[255] Viewing the condition of another

[250] *See* sources cited *supra* note 16 and accompanying text.

[251] Rogge et al., *supra* note 223, at 305.

[252] Lewis et al., *supra* note 42, at 1350.

[253] *See* Puhl & Brownell, *supra* note 239, at 214.

[254] *See* Rogge et al., *supra* note 223, at 312 ("[W]ithout a second thought, obese people passively agree with the major construction of obesity as their own fault, because that is how they have been inculcated socially. They rarely publicly challenge the social construction that weight is the result of personal weakness and that their obesity is the product of self-gratification and moral failure."); *accord* S.S. Wang et al., *The Influence of the Stigma of Obesity on Overweight Individuals*, 28 INT'L J. OBESITY 1333, 1333 (2004) (finding that overweight and obese patients exhibited significant anti-fat bias across several stereotypes on an implicit association test and endorsed the explicit belief that fat people are lazier than thin people).

[255] Lewis et al., *supra* note 42, at 1350.

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person's life as the consequence of internal, controllable causes — rather than sheer chance — is comforting.[256] Attribution of fatness to the personal failures of fat people "[s]erves a symbolic, or value-expressive function . . . , reinforcing a world view consistent with a belief in a just world, self-determination, the Protestant work ethic, self-contained individualism, and the notion that people get what they deserve."[257] This self-serving world-view supports a negative emotional reaction to fat people,[258] while also negating any feelings of guilt that otherwise might attach to one's own discriminatory actions and biased attitudes.[259]

3. Status Loss, Discrimination, and Identity Spoiling

Labeling and stereotyping also contribute to "enacted stigma"[260] in the form of discrimination. People who are fat experience social isolation, status loss, and discrimination in the workplace, in schools, within their families, in doctor's offices, in grocery and clothing stores, and in virtually any other kind of social interaction, often beginning in childhood.[261] Rather than "entail[ing] social disapproval of merely one aspect of an individual" (à la smoking denormalization),[262] the stigmatization of fatness is pervasive, inescapable, and identity spoiling. "Passing"[263] is not an option for an obese person in the way that it may be possible for a smoker or even someone who is HIV positive. A smoker may be able to "pass" as a nonsmoker, except when actually holding a cigarette. Similarly, someone who is HIV-positive

[256] *See, e.g.*, Claudia Sikorski et al., *The Stigma of Obesity in the General Public and Its Implications for Public Health — A Systematic Review*, 11 B.M.C. PUB. HEALTH 661 (2009) (describing the role of attribution theory in obesity stigma); Puhl & Brownell, *supra* note 239, at 216 ("[T]he 'just world bias' also portrays the world as a predictable environment in which personal effort and ability lead to desired outcomes.").

[257] Christian S. Crandall & Rebecca Martinez, *Culture, Ideology, and Antifat Attitudes*, 22 PERSONALITY & SOC. PSYCHOL. BULL. 1165, 1166 (1996) (citation omitted).

[258] *See, e.g.*, Sikorski et al., *supra* note 256, at 662 ("Causal beliefs about the controllability of the condition lead to an emotional response (e.g. stigmatization attitudes). Behavioral consequences in the form of discrimination result.").

[259] *See* Puhl & Brownell, *supra* note 239, at 216.

[260] Graham Scambler & Anthony Hopkins, *Being Epileptic: Coming to Terms with Stigma*, 8 SOC. OF HEALTH & ILLNESS 26, 33 (1986).

[261] *See* Puhl & Brownell, *supra* note 239, at 214; Puhl & Heuer, *supra* note 42, at 1019; Rogge et al., *supra* note 223, at 308. *See generally* WEIGHT BIAS: NATURE, CONSEQUENCES, AND REMEDIES (Kelly D. Brownell et al., eds., 2005) (for a collection of articles discussing the stigma associated with obesity).

[262] Bayer, *Stigma*, *supra* note 54, at 469.

[263] *See* Kenji Yoshino, *Covering*, 111 YALE L.J. 769, 772 ("[P]assing means the underlying identity is not altered, but hidden.").

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can hide that status in everyday social interactions. In contrast, a fat person does not have the option to "pass" as a thin person. "The physical visibility of the fat body . . . means that th[e] negative public gaze is inescapable . . . ."[264]

The stigmatization of obesity does not involve "marginalization that can be shed," as Bayer has described tobacco denormalization.[265] Advocates of a denormalization strategy for obesity may believe that because successful weight loss will reclassify the targets of denormalization as "normal" and "healthy," their strategy "permits, even as its goal, the reintegration of those who have been shamed."[266] But that belief is misguided. Obesity is generally framed as "a problem about *losing* weight,"[267] and "most obese individuals can — and do — lose weight."[268] But "[f]or the person who is obese, but who has lost weight, the moral advantage his or her weight loss should provide is often denied to him or her." The appearance-based stigmatization of obesity persists beyond the point where an individual has achieved purely health-related goals: "Even when patients do succeed in meeting the recommendation to improve their risk of other chronic illnesses by losing 5% to 10% of their total body weight, they often remain overweight or obese" and may still be subjected to stigmatization.[269] Furthermore, obesity is "a problem not of losing weight but of *sustaining* weight loss."[270] The reality is that only a small percentage of obese people successfully maintain weight loss over the long term.[271] And the experience of weight regain is associated with additional shame and self-punishment.[272] To put it another way, not only is passing off the table for most obese people, conversion is as well.[273]

[264] Lewis et al., *supra* note 42, at 1349-50.

[265] Bayer, *Stigma*, *supra* note 54, at 470.

[266] *Id.*

[267] Rogge et al., *supra* note 223, at 305.

[268] *Id.* at 305-06.

[269] *Id.* at 307.

[270] *Id.* at 306.

[271] *See id.* ("[T]he evidence that only a small percentage of obese individuals can successfully lose weight and maintain the weight loss over several years has been carefully documented, but is absent from the broader social construction of this condition.").

[272] *See id.* at 310 ("[T]he person comes to view the weight recovery as a personal failure, and the exigency to lose the weight is unrelenting.").

[273] *See* Yoshino, *supra* note 263, at 772 ("[C]onversion means the underlying identity is altered.").

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4. The Health Impact of Fat Stigma

The potential effectiveness of individually-targeted behavioral interventions aimed at encouraging obese people to lose weight is entirely dependent on the ability of individuals to respond to that encouragement by converting to a healthy weight. Evidence regarding the determinants of individual BMI and the lack of safe and effective medical weight loss interventions strongly suggests that individually-focused, shame-based interventions are unlikely to have a positive impact on health. Although most people assume that personal choices are the most significant cause of obesity,[274] the reality is that willpower — or lack thereof — does not actually explain most of the variation in BMI from one person to the next. Scientists agree that the current obesity epidemic is largely attributable to "genetic factors [that] strongly modulate the impact of the modern environment on each individual."[275] A multitude of scientific studies have converged on the finding that about 70% of variation in adult BMI is explained by genetic factors.[276] Heritability does not, however, equal genetic determinism; highly heritable traits can also be highly responsive to environmental influences.[277] Essentially, some of us have genes that allow us to tolerate our obesigenic environment better than others.[278]

[274] *See* REUTERS/IPSOS POLL, *supra* note 220 (finding that sixty-one percent of Americans cite "personal choices about eating and exercising" as the main cause of the obesity epidemic).

[275] Cristen J. Willer et al., *Six New Loci Associated with Body Mass Index Highlight a Neuronal Influence on Body Weight Regulation*, 41 NATURE GENETICS 25, 29 (2008).

[276] Heritability estimates range between forty to ninety percent. *See* Shwetha Ramachandrappa & I. Sadaf Farooqi, *Genetic Approaches to Understanding Human Obesity*, 121 J. CLINICAL INVESTIGATION 2080, 2080 (2011). The wide range of heritability estimates may be explained by the fact that the heritability of BMI varies over the life course. *See* Claire M.A. Haworth et al., *Increasing Heritability of BMI and Stronger Associations With the FTO Gene Over Childhood*, 16 OBESITY 2663, 2663 (2008). Studies generally converge around a seventy percent heritability estimate for adult BMI. *See* P. Russo et al., *Heritability of Body Weight: Moving Beyond Genetics*, 20 NUTRITION, METABOLISM & CARDIOVASCULAR DISEASES 691, 692 (2010).

[277] *See* Mike the Mad Biologist, *Obesity Makes People Stupid…About Heritability*, SCIENCEBLOGS (Aug. 4, 2009), http://scienceblogs.com/mikethemadbiologist/2009/08/04/obesity-makes-people-stupidabo/ (explaining the meaning of heritability and its role in explaining obesity in lay terms).

[278] Ruth Loos and Claude Bouchard describe four levels of genetic contribution to obesity: First, those with genetically determined obesity. A small percentage (around one to three percent) of people who are obese possess a single genetic mutation that leads to obesity regardless of the environment in which they live (short of extreme restraints on their access to nutrition). Second, those with a strong genetic predisposition toward obesity. These people are likely to be overweight if they live in a non-obesigenic environment (like the environment of thirty or forty years ago). But if

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Furthermore, evidence regarding the impact of obesity stigma on health suggests that a denormalization approach to obesity may actually contribute to poor health outcomes. Studies suggest that experiencing stigma, shame, and discrimination "may worsen obesity through dynamics such as fear of going out, fear of ridicule while exercising, cycles of emotional eating and the development of eating disorders."[279] Stigmatization of obese people causes psychological stress, depression, low self-esteem, and body dissatisfaction, which in turn may contribute to poor physical health.[280] Some researchers have argued "that the high degree of psychological stress experienced by obese persons as a result of weight stigma contributes to the pathophysiology associated with obesity, and that many of the adverse biochemical changes that are associated with [the presence of body fat] can also be caused by the psychological stress that accompanies the experience of frequent weight-based discrimination."[281] In other words, at least some of the increased illness associated with being obese may be caused by the social response to obesity, rather than by the presence of body fat itself.

Discriminatory actions by health-care providers may also contribute to poor health outcomes for obese individuals. Health-care providers exhibit high levels of implicit and explicit bias against fat people — similar to levels found in the general population — including views that obese patients are lazy, lacking in self-discipline, dishonest, unintelligent, annoying, and noncompliant with treatment.[282] In studies, health-care providers exhibit "overestimation of the actual caloric intake of the majority of obese people; lack of awareness of the metabolic and other biologic functions which predispose and perpetuate obesity; and 'anachronistic preconceptions' that weight is easily controlled through decisions at the individual level to exercise

they are exposed to our current environment, they are likely to be obese. Third, those with a slight genetic predisposition, which leads to normal weight in a non-obesigenic environment and overweight in an obesigenic environment. And finally, those who are genetically resistant to obesity. These are people who enjoy protective genetic factors and thus are able to maintain a normal weight in spite of their exposure to an obesigenic environment. For further information, see R.J.F. Loos & C. Bouchard, *Obesity — Is it a Genetic Disorder?*, 254 J. INTERNAL MED. 401 (2003).

[279] Maclean et al., *supra* note 59, at 89 (citation omitted).

[280] *See id.* at 89.

[281] Puhl & Heuer, *supra* note 42, at 1023.

[282] *See* Betty E.A. Petrich, *Medical and Nursing Student's Perceptions of Obesity*, 12 J. ADDICTIONS NURSING 3, 12 (2000); *see also* Melanie Jay et al., *Physicians' Attitudes about Obesity and Their Associations with Competency and Specialty: A Cross-Sectional Study*, 9 B.M.C. HEALTH SERVS. RES. 106, 106 (2009) (discussing a study on physicians' attitudes about obesity).

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more and eat less . . . ."[283] These biased and inaccurate beliefs lead to the dominance of "individually focused 'boot-strap approaches'" to medical treatment in spite of the fact that there is very little evidence for the long-term success of such approaches.[284] Notably, explicit bias is significantly higher among primary care physicians than among doctors specializing in the care of obese patients.[285] And specialists are also more likely to be well informed about the true causes of obesity and best practices in weight loss counseling.[286]

Health-care providers, on average, spend less time with obese patients than similarly situated non-obese patients.[287] In some situations, their treatment decisions may also be influenced by a patient's obesity based on implicitly held beliefs about obese patients' compliance, capacity for self-care, and fundamental worth. Additionally, experiences of shame in health-care settings may influence obese patients to forgo available health care to avoid stigmatizing encounters.[288] In one survey of overweight and obese women, for women at the highest levels of obesity, more than 80% reported that their weight prevented them from receiving appropriate health care, while nearly 70% specifically reported that they had delayed seeking health care based on their experience of "disrespectful treatment and negative attitudes from [health-care] providers, embarrassment about being weighed, receiving unsolicited advice [from health-care providers] to lose weight," and the fact that "gowns, examination tables, and other medical equipment were too small to be functional for their body size."[289] Overall, there is significant evidence that obese patients — particularly women — are less likely to receive

[283] Maclean et al., *supra* note 59, at 89 (citation omitted).

[284] *Id.*

[285] *See* B.A. Teachman & Kelly D. Brownell, *Implicit Anti-Fat Bias Among Health Professionals: Is Anyone Immune?*, 25 INT'L J. OBESITY 1525, 1525 (2001) (finding that health professionals who specialize in obesity treatment exhibit lower levels of implicit anti-fat bias than the general population).

[286] *See, e.g.*, Jason P. Block et al., *Are Physicians Equipped to Address the Obesity Epidemic?: Knowledge and Attitudes of Internal Medicine Residents*, 36 PREVENTIVE MEDICINE 669 (2003) (discussing the qualifications of physicians and specialists in treating obesity); Sarah L. Goff et al., *Barriers to Obesity Training for Pediatric Residents: A Qualitative Exploration of Residency Director Perspectives*, 18 TEACHING & LEARNING MED. INT'L J. 348 (2006) (exploring the topic of obesity training in pediatric residencies).

[287] *See* Puhl & Heuer, *supra* note 42, at 1023.

[288] *See* Rogge et al., *supra* note 223, at 313 (suggesting that "obese patients may choose to forego early or preventive health care so as to avoid oppressive encounters with clinicians").

[289] Puhl & Heuer, *supra* note 42, at 1024.

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routine gynecological exams, pap smears, blood pressure screening, and diabetes care, even when they have financial access to it.[290]

### *B. Obesity Control's Contribution to Stereotypes*

Another possible reason for rising levels of obesity discrimination in spite of rising prevalence may be pervasive messaging about the social costs of obesity.[291] Public health authorities "have a significant influence on what society thinks about obesity."[292] Messages equating obesity with poor health and high mortality risk "contribute to our understanding of obesity as unnatural, abnormal, and unhealthy" and "reinforce the social understanding of obesity as a disease . . . that can be prevented or corrected by personal effort."[293] The "[c]onstruction [of obesity] by health policy makers as an issue of personal responsibility which can be controlled through the sheer exercise of will power and commitment categorises [obese people] as deviant."[294]

Behavioral interventions to control obesity reinforce precisely the same world-view that is associated with anti-fat bias. Sophisticated advertising campaigns spreading the public health message have become ubiquitous: eat less, be more active, and take better care of your children. The message that healthier choices are within one's personal control may be misleading in light of the scientific evidence described above. But public health advocates may worry that exposure to information about the genetic causes of obesity could cause obese people to feel less empowered to attempt weight loss. They may be well-intended, but those "empowering" messages also imply that people who are fat must *not* be making the right choices, contributing

[290] *See id.* at 1023.

[291] *See* Rogge et al., *supra* note 223, at 305 ("[I]n the United States, the National Institutes of Health (NIH), the United States Public Health Service (USPHS) and the Centers for Disease Control and Prevention (CDC), along with major organizations such as the American Heart Association and the American Diabetes Association, and healthcare providers are major contributors to the social construction of obesity."); *see also* Lewis et al., *supra* note 42, at 1349 ("The construction of thinness as a health and social ideal has been perpetuated by a range of agencies including the media, the weight loss industry, the fashion industry, government policy, academia, and the medical profession. . . . [W]hile each of these agencies reinforces the 'thin ideal' in different ways, it is the interplay between them that is thought to have led to an intensification of obesity stigma." (citation omitted)).

[292] Rogge et al., *supra* note 223, at 305.

[293] *Id.*; *accord* Sophie Lewis et al., *"I Don't Eat a Hamburger and Large Chips Every Day!" A Qualitative Study of the Impact of Public Health Messages about Obesity on Obese Adults*, 10 B.M.C. PUB. HEALTH 309, 309 (2010).

[294] Lewis et al., *supra* note 42, at 1350.

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to stereotypes of fat people as lazy and lacking self-control. Indeed, experimental studies indicate that when people are exposed to information about behavioral causes of obesity (diet and exercise) their expressions of bias against fat people increase.[295]

A personal narrative used by Bloche to introduce his proposal for a social denormalization approach to obesity provides a window into the response of a thin person to anti-obesity campaigns:

> As I loaded my squash onto the supermarket checkout counter, four fudgy brownies vied for my attention. They looked longingly at me from the cover of *Family Circle*. . . . The busy cover promised that these 'One-Bowl Brownies' were 'fast and easy' — and that the 'Super Diet' in the same issue 'fights fat and boosts energy.' . . . As I reached for my wallet to pay for my squash — and for my chocolate biscotti — I began worrying about whether I'd have time to go for a run.[296]

The experience of many thin people is that in their own lives, they must exercise restraint. They can not just go with the flow and not pay any attention to what they eat. Sure, the great majority of Americans, regardless of their size, are not exactly following the standard public health guidelines to the letter. But it is easy for thin people to feel like they are doing something right. And to look at the fatter people around them and mistakenly assume that if those other people could simply exercise the same degree of restraint, they too could be healthy. In fact, most people assume that obese people are consuming more calories than they actually are and getting less exercise than they actually do.[297]

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[295] *See* Robin J. Lewis et al., *Prejudice Toward Fat People: The Development and Validation of the Antifat Attitudes Test*, 5 OBESITY RES. 297, 297 (1997); Kerry S. O'Brien et al., *Reducing Anti-Fat Prejudice in Preservice Health Students: A Randomized Trial*, 18 OBESITY 2138, 2139 (2010).

[296] Bloche, *supra* note 30, at 1335; *cf.* Benforado, *supra* note 106, at 1648-49 ("[S]ecure in our coastal enclaves, we buy our Organo-Flakes at Whole Foods, melt away extra calories at evening Pilates sessions, and only step into a McDonald's if to use the facilities on the long drive out to the summerhouse. It is with self-satisfied eyes we watch as the Surgeon General calls obesity a 'catastrophe' and a more 'pressing issue in health' than terrorism or weapons of mass destruction. Not us. . . . We all had the choices before us — be healthy or unhealthy, live in the moment or live long — and we chose wisely. Rejoice, fellow beanpoles, for we are safe. We are immune.").

[297] *See* Crandall, *supra* note 49, at 883 (noting that studies examining the hypothesis that obesity is primarily caused by overeating have found that, on average, obese subjects consume the same amount or less than normal weight subjects); I-Min Lee et al., *Physical Activity and Coronary Heart Disease in Women*, 285 J. AM. MED. ASS'N 1447, 1450 (2001) (indicating that the average weight difference between the

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### *C. Obesity Control's Contribution to Discrimination*

Some obesity control laws explicitly sanction disparate treatment weight discrimination while others create discriminatorily hostile environments. Many of these measures are being implemented in social contexts — schools, workplaces, and doctor's offices — where fat stigma is already causing significant harm. This is no accident. Because denormalization interventions "are postulated to operate through lowering expectations about prevalence and acceptability [of an unhealthy behavior] in peer-oriented social settings,"[298] the more coercive the social context, the more successful denormalization will be. When that "behavior" is actually a status — and one that very few individuals are able to change in a lasting way — denormalization becomes true stigmatization.

#### 1. In the Workplace

With regard to an early workplace wellness proposal, one advocate somewhat naively asserted that "[t]he organized support and encouragement of fellow workers can constitute an unprecedented stimulus for weight loss."[299] Evidence regarding employment discrimination and hostile work environments experienced by obese people would undermine that optimism.[300] The law attempts to accommodate obese employees who can obtain a doctor's certification that it would be medically inadvisable or unreasonably difficult for them to attempt to attain the target weight,[301] but "disadvantaged people with multiple coexisting conditions may refrain from making such petitions, seeing them as degrading or humiliating."[302] While

most sedentary and the most active study participants was about 1.5 BMI units).

[298] William B. Hansen, *School-Based Substance Abuse Prevention: A Review of the State of the Art in Curriculum, 1980-1990*, 7 HEALTH EDUC. RES. 403, 411 (1992).

[299] Albert J. Stunkard, *Obesity and the Social Environment: Current Status and Future Prospects*, 300 ANNALS N.Y. ACAD. OF SCI. 298, 317 (1977).

[300] *See* Puhl & Brownell, *supra* note 239, at 214 ("[N]egative perceptions of obese persons exist in employment settings where obese employees are viewed as less competent, lazy, and lacking in self-discipline. These attitudes have a negative impact on wages, promotions and decisions about employment status.").

[301] A "reasonable alternative standard" must be made available to any individual for whom it is "unreasonably difficult" to meet the standard "due to a medical condition," or for whom it is "medically inadvisable" to attempt to meet the standard. *See* 45 C.F.R. § 146.121(f)(2)(iv) (2013) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(3)(D)(i) (2012) (ACA codification). The plan may "seek verification, such as a statement from an individual's physician." 45 C.F.R. § 146.121(f)(2)(iv)(B) (HIPAA regulations); 42 U.S.C. § 300gg-4(j)(3)(D)(ii) (ACA codification).

[302] Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform — Problems with*

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"[p]roponents emphasize that wellness incentives are voluntary[,] . . . voluntariness can become dubious for lower-income employees, if the only way to obtain affordable insurance is to meet the targets. To them, programs that are offered as carrots may feel more like sticks."[303] The American Heart Association and dozens of other patient advocacy organizations have concluded that under existing provisions, "a wellness program may consist of nothing more than charging higher premiums to individuals . . . with health conditions whose causes may be linked in part to lifestyle choices as an incentive to get better with no other programs or activities offered within the worksite to help individuals improve their health status."[304] The potentially steep price differential between obese employees and non-obese employees may even be enough to drive obese employees out of the health plan — or off the employer's payroll — altogether.[305]

2. In Schools

School-based obesity control programs are particularly concerning in light of the fact that children are especially vulnerable to the psychological effects of obesity stigma.[306] Fat kids and adolescents already experience pervasive stigmatization in schools: "For fat

*Wellness Incentives*, NEW ENG. J. MED. e3(1), e3(2) (2010), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp0911552.

[303] *Id.* at e3(3); *see also* Roni Caryn Rabin, *Could Health Overhaul Incentives Hurt Some?*, N.Y. TIMES (Apr. 12, 2010), http://www.nytimes.com/2010/04/13/health/13land.html?_r=1&emc=tnt&tntemail0=y ("[M]any consumer advocates worry that premiums will be raised significantly across the board first, and then individual discounts will be applied.").

[304] *Close the Loophole to Medical Underwriting in the Senate Health Care Reform Bill*, ASS'N UNIV. CTRS. ON DISABILITIES 1 (Dec. 21, 2009), http://www.aucd.org/docs/HIPAA%20wellness%20Sign-On%2012-18-09%20(FINAL).pdf.

[305] *Cf.* Kristin Voigt & Harald Schmidt, *Wellness Programs: A Threat to Fairness and Affordable Care*, HEALTH CARE COST MONITOR (Jan. 13, 2010, 6:16 PM), http://healthcarecostmonitor.thehastingscenter.org/haraldschmidt/wellness-programs-a-threat-to-fairness-and-affordable-care/#ixzz2170hDpHA ("Wellness programs can make health coverage significantly more expensive for those who cannot meet the targets stipulated by employers. This is illustrated by the wellness consultant Benicomp. The company's Advantage plan implements wellness programs not by raising premiums, but by increasing deductibles for all employees covered under the health plan. Reductions are then offered to those workers who meet specific health targets. As the company explains, one way that such a scheme leads to savings for the employer is that individuals who cannot gain reimbursements under the scheme might be 'motivated to seek other coverage options.'").

[306] *See* Maclean et al., *supra* note 59, at 89 ("[S]tigma can also be internalized and its messages become part of the person's self concept. It has been suggested that children are especially vulnerable to this impact.").

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students, the school experience is one of ongoing prejudice, unnoticed discrimination, and almost constant harassment . . . . [They] experience ostracism, discouragement, and sometimes violence. Often ridiculed by their peers and discouraged by even well-meaning education employees, fat students develop low self-esteem and have limited horizons."[307] In one study, nearly 30% of all adolescent girls and 25% of adolescent boys reported being teased by their peers about their weight. Nearly as many reported being teased by family members as well.[308] Among teens whose BMI put them in the ninety-fifth percentile, nearly two-thirds reported that they had experienced weight-based teasing.[309]

Some public health advocates have argued that: "[O]besity prevention initiatives for children often inappropriately label large numbers of children as overweight or 'fat.' Such initiatives may 'result in unprecedented levels of body hatred, unhealthy and inappropriate weight loss attempts, fears of food, increased susceptibility to media messages, eating disorders, nutritional deficits, and weight discrimination.'"[310] One study of state-mandated BMI screening and parent notification found that some parents responded to reports by directing "negative weight-related comments or behaviors" at their children — including some children whose weight was classified as normal.[311] Adults who were fat as children report being humiliated by classmates and teachers during these screenings.[312]

[307] Michelle Stover, *"These Scales Tell Us That There Is Something Wrong with You": How Fat Students are Systematically Denied Access to Fair and Equal Education and What We Can Do to Stop This*, 83 S. CAL. L. REV. 933, 938 (2010) (quoting NAT'L EDUC. ASS'N, REPORT ON SIZE DISCRIMINATION (1994), *available at* http://www.lectlaw.com/files/con28.htm).

[308] *See* Dianne Neumark-Sztainer & Marla Eisenberg, *Weight Bias in a Teen's World*, *in* WEIGHT BIAS, *supra* note 261, at 69.

[309] *See id.*

[310] Maclean et al., *supra* note 59, at 90 (citation omitted); *see also* J. Ogden & C. Evans, *The Problem with Weighing: Effects on Mood, Self-Esteem and Body Image*, 20 INT'L J. OBESITY & RELATED METABOLIC DISORDERS 272, 272-77 (1996) (describing the negative impact of weighing and classifying weight on self-esteem and body image); Allison J. Nihiser et al., *BMI Measurement in Schools*, 124 PEDIATRICS 589, 591 (2009) (discussing how BMI-screening programs may intensify stigmatization already felt by obese youth).

[311] *See* Jenna M. Kaczmarski et al., *State-Mandated School-Based BMI Screening and Parent Notification: A Descriptive Case Study*, 12 HEALTH PROMOTION PRAC. 797, 797 (2011).

[312] *See* Stover, *supra* note 307, at 935-36, 941-43 (chronicling several narratives of stigmatizing experiences during fitness tests and in-school weighings).

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Experts recommend that if obesity screening is conducted in schools, it should be done so only with careful attention to how measurements are taken, and by whom.[313] But only a few states address these issues.[314] Ideally, nurses or other health professionals should conduct screenings, to "increase[] the likelihood that this task will be carried out in a caring and sensitive manner."[315] But because of budgetary constraints, in many cases the screenings are being performed by teachers, teaching assistants, and volunteers.[316] Experts have cautioned that "[w]idespread discriminatory attitudes and actions toward obese children and adults pose a barrier to establishing the 'inclusive, respectful climate' called for by [federal school health screening recommendations]."[317]

Poorly designed or implemented physical education programs can also exacerbate discrimination against fat children in schools. "'For some fat students, the act of exercising itself opens them up to peer taunting' which students and school staff rate as 'among the predominant barriers to students fully participating in physical education class.'"[318] Although many physical education teachers are caring and sensitive, some can be cruel. Teachers as a whole exhibit similar levels of bias to those found in the general population,[319] but physical education teachers in particular exhibit higher levels of bias than the general population after undergoing physical education training.[320]

[313] *See id.* at 940-44.

[314] Most states' mandates do not place any restrictions on who can perform the school-based screening or the conditions under which it shall be performed. A few states have adopted comprehensive guidelines (but not statutory mandates) regarding safeguards that should be put into place prior to conducting a weight or BMI screening. *See* Wiley, *No Body Left Behind*, *supra* note 212, at 116-17.

[315] Joanne P. Ikeda et al., *BMI Screening in Schools: Helpful or Harmful*, 21 HEALTH EDUC. RES. 761, 764 (2006).

[316] *See id.*

[317] *Id.* at 765.

[318] Stover, *supra* note 307, at 951 (quoting Neumark-Sztainer & Eisenberg, *supra* note 308, at 71).

[319] *See* Dianne Neumark-Sztainer et al., *Beliefs and Attitudes About Obesity Among Teachers and School Health Care Providers Working with Adolescents*, 31 J. NUTRITION EDUC. 3, 7 (1999).

[320] *See* K.S. O'Brien, *Implicit Anti-fat Bias in Physical Educators: Physical Attributes, Ideology and Socialization*, 31 INT'L J. OBESITY 308, 308 (2007); *see also* Christy Greenleaf & Karen Weiller, *Perceptions of Youth Obesity Among Physical Educators*, 8 SOC. PSYCHOL. EDUC. 407, 419 (2005).

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3. In Health Care

Access to medical care to treat obesity would seem to be an entirely harmless intervention, but given the considerable potential for discrimination and stigmatization by health-care providers, these interventions merit greater attention.[321] Controversy in June 2013 over the American Medical Association's ("AMA") decision to describe obesity as a "disease" is instructive in this regard. In adopting the policy[322] at issue, the professional association's House of Delegates disregarded the recommendation of its own Council on Science and Public Health (to which the proposal had been referred for a report prior to a vote). The scientific council examined the proposed policy in light of "the definitions of obesity and disease, the limitations of those definitions," and "possible implications for provider reimbursement, public policy, and patient stigma,"[323] and ultimately recommended against designating obesity as a disease.[324] In voting to adopt the policy against the advice of the scientific council, the House of Delegates may have been influenced by the view of policy proponents that "neither provider reimbursement nor research into effective treatments will be adequate until obesity is considered a disease." Concerns about the arbitrariness of BMI as the basis for defining obesity and about "increasing stigmatization of obese individuals"[325] was apparently insufficient to sway the delegates. As one critic put it after the new policy was announced:

> Individuals of high body weight are already less inclined to seek medical attention because of the discrimination we face. Declaring us diseased without regard to our actual health is not likely to improve our health. My fear: how is this going to impact my relationship with my physician? Can I be forced to

[321] *See, e.g.*, Travis Saunders, *AMA Declares Obesity a "Disease" — Good or Bad Idea?*, PLOS BLOGS: OBESITY PANACEA (June 24, 2013), http://blogs.plos.org/obesitypanacea/2013/06/24/ama-declares-obesity-a-disease-good-or-bad-idea/ (describing "obesity-related bias" and "fat shaming" as the "downsides" of treating obesity as a disease).

[322] *See* AM. MED. ASS'N, D-440.971, RECOMMENDATIONS FOR PHYSICIAN AND COMMUNITY COLLABORATION ON THE MANAGEMENT OF OBESITY, *available at* http://www.ama-assn.org/resources/doc/PolicyFinder/policyfiles/DIR/D-440.971.HTM (last visited Sept. 6, 2013).

[323] *See* AM. MED. ASS'N, REPORT OF REFERENCE COMM. D 4 (2013), *available at* http://www.ama-assn.org/assets/meeting/2013a/a13-refcomm-d-annotated.pdf.

[324] *See* AM. MED. ASS'N, REFERENCE COMM. D ADDENDUM, REPORT OF THE COUNCIL ON SCI. AND PUB. HEALTH 6 (2013), *available at* http://www.ama-assn.org/assets/meeting/2013a/a13-addendum-refcomm-d.pdf.

[325] *See id.* at 2.

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> accept "treatment" (such as dieting or weight loss surgery) I don't want?[326]

The AMA's decision has limited legal effect,[327] but the concerns that it has generated are likely implicated by the laws described in section II(B)(3), above.

Federal laws promoting obesity screening and treatment by primary care physicians[328] are based on a flawed assumption that non-specialists are well-suited and adequately trained to provide this service appropriately. This assumption is perhaps based on the widely held misconception that weight loss is a simple matter of understanding diet and exercise guidelines and having the self-control to act on them.[329] Unsurprisingly, primary care physicians "view obesity as largely a behavioral problem and share our broader society's negative stereotypes about the personal attributes of obese persons."[330] Perhaps of even greater concern, the majority of primary care physicians do not view themselves as well-qualified to provide obesity treatment.[331]

Incentives for primary care physicians and pediatricians to measure every patient's BMI (as an indicator of the quality of patient care) and

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[326] Peggy Howell, *How I Went From Fat and Healthy to Diseased Overnight*, DEBATE CLUB (June 27, 2013), http://www.usnews.com/debate-club/should-the-american-medical-association-have-classified-obesity-as-a-disease/how-i-went-from-fat-and-healthy-to-diseased-overnight.

[327] The AMA is a private professional association, not a government entity. It does, however, have considerable legal influence. AMA authorities may be incorporated into the law by regulators (for example, many state medical boards have adopted the AMA Code of Medical Ethics and the Centers for Medicare and Medicaid Services incorporates the Current Procedural Terminology codes developed by the AMA into its reimbursement formulas), and some AMA policies have been cited as persuasive authority by courts in a variety of contexts. *See, e.g.*, Stenberg v. Carhart, 530 U.S. 914, 934 (2000) (quoting an AMA policy on late-term pregnancy termination techniques); Commonwealth v. Mikulan, 470 A.2d 1339, 1342 (Pa. 1983) (quoting an AMA policy on blood alcohol levels unsafe for driving).

[328] *See supra* Part II.B.3.

[329] *See supra* Parts III.A.2, III.A.4.

[330] Gary D. Foster et al., *Primary Care Physicians' Attitudes About Obesity and Its Treatment*, 11 OBESITY RES. 1168, 1168 (2003).

[331] *See* Sara N. Bleich et al., *National Survey of US Primary Care Physicians' Perspectives About Causes of Obesity and Solutions to Improve Care*, 2 B.M.J. OPEN 1, 4 (2012) (finding that more than half of primary care physicians felt that other professionals, including nutritionists and behavioral psychologists, were more qualified than primary care physicians to help obese patients lose or maintain weight, and that only twenty-three percent stated that they received good obesity-related training in medical school, while only thirty-five percent stated that they received good obesity-related training in residency).

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engage in weight loss counseling (as a reimbursable service)[332] may contribute to a health-care delivery environment that is hostile to fat patients. Obese women already report that being weighed and receiving unsolicited weight loss advice influences them to forgo needed medical care, even for conditions that have nothing to do with their obesity.[333] In the absence of significant initiatives to increase provider education[334] and decrease anti-fat bias among providers, these initiatives are quite problematic.

Additionally, critics have argued that Medicaid reforms based on personal responsibility are: "[A]t odds with current models of the doctor-patient relationship. Physicians and patients negotiate treatment, taking into account the dynamic tension between desirable behaviors and achievable ones. . . . An exploration of the reason [for a missed appointment or noncompliance with treatment recommendations] may improve future behavior, whereas humiliation and punishment may result in decreased adherence to treatment."[335] Critics have also noted that incentive programs put physicians in the position of enforcers.[336] This can have a negative effect on the doctor-patient relationship, and may also open the door for physician bias to play a role in determining which patients lose their benefits as a result of noncompliance and which do not.

## IV. A DESTIGMATIZATION STRATEGY FOR OBESITY

Public health authorities tend to discuss stigma, discrimination, teasing and bullying, social marginalization, and low self-esteem as "consequences of obesity."[337] They are generally blind to the role that some obesity control efforts are playing in exacerbating those negative consequences. And with very few exceptions,[338] they have not advocated for destigmatization measures like anti-discrimination laws.

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[332] *See supra* Part II.B.3.

[333] *See supra* Part III.A.4.

[334] *See* Bleich et al., *supra* note 331, at 1 (finding that the majority of surveyed primary care physicians supported the need for additional obesity-related training).

[335] Gene Bishop & Amy C. Brodkey, *Personal Responsibility and Physician Responsibility — West Virginia's Medicaid Plan*, 355 N. ENG. J. MED. 756, 757 (2006).

[336] *See id.*

[337] *See, e.g.*, COMM. ON ACCELERATING PROGRESS IN OBESTIY PREVENTION ET AL., ACCELERATING PROGRESS IN OBESITY PREVENTION: SOLVING THE WEIGHT OF THE NATION 35 (2012) (including "stigma," "negative stereotyping," "discrimination," "teasing and bullying," "social marginalization," "low self-esteem," "negative body image," and "depression" among the psychosocial consequences of obesity).

[338] *See, e.g.*, Maclean et al., *supra* note 59, at 90 ("[W]e would contend that much the same concerns [raised by Burris with regard to stigma and public health] can be

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If anti-fat stigma is so bad for the health of obese people, why are more public health experts not advocating for a destigmatization strategy? Because stigma is not driving the obesity epidemic underground in the way that it did for HIV. Passing is not a viable strategy for most obese people.[339] Neither is conversion, whereby an obese person loses enough weight to comply with the norm of thinness.[340] Instead, the more common strategy for coping with anti-fat stigma is covering, whereby the fat individual publically rejects and downplays her fatness by engaging in fruitless and potentially harmful weight loss attempts.[341] The negative health effects of "fat covering" — harmful weight cycling, depression, disengagement with health-care and public health interventions — are more subtle than the effects of HIV passing. Perhaps these factors explain why victims of anti-fat stigma have not found allies in the public health community as readily as victims of anti-HIV stigma have.

At the same time, victims of weight discrimination do not have a powerful industry ally like victims of anti-smoking discrimination do. About half of the states have enacted "smokers' rights" laws that prohibit employers from discriminating against smokers for off-the-job smoking, and several states have broader statutes barring employers from discriminating against employees based on lawful, off-the-job activities or consumption of lawful products.[342] Some are drafted

applied to the stigmatization of obesity and the practitioner would contribute substantially to de-stigmatizing interventions through attending to these emergent issues."); Pomeranz & Gostin, *supra* note 134, at 71 (suggesting that states should revise their anti-discrimination laws to include weight as a protected class); Puhl & Brownell, *supra* note 239 (advocating for anti-discrimination laws to protect individuals from weight bias).

[339] For an interesting narrative about an exception to this general statement, see S. Bear Bergman, *Part-Time Fatso*, *in* THE FAT STUDIES READER, *supra* note 50, at 139 (describing the transgendered author's experience with being subject to anti-fat stigma when the author is perceived by others to be a woman, but not when the author is perceived to be a man).

[340] *See supra* Part III.A.3.

[341] *See* Rausch, *supra* note 179, at 949-57 (describing "fat covering" as a consequence of financial penalties imposed by the state of Alabama on obese state employees).

[342] *See* Stephen D. Sugarman, *"Lifestyle" Discrimination in Employment*, 24 BERKELEY J. EMP. & LAB. L. 377, 418 (2003) ("'[S]mokers' rights' laws swept through more than two dozen legislatures in the early 1990s as a result of the combined lobbying of the American Civil Liberties Union (ACLU) and the tobacco industry. These laws were provoked primarily by reports that a significant number of firms already refused to hire smokers and a fear that the trend was growing. At the urging of the ACLU and others, once smokers' rights proposals got into the legislative process, they were broadened in some jurisdictions, in the ways already noted, to cover alcohol, to cover

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broadly enough to also prohibit discrimination based on off-the-job eating or physical inactivity, but none would prohibit discrimination based on obesity itself.[343] The tobacco industry has backed these measures as a way of supporting consumption of tobacco products.[344] In contrast, the fast food industry is unlikely to back anti-discrimination measures to protect its fat customers, because it is still denying that fast food made them that way.[345] The food and beverage industry vehemently opposes market-based interventions (such as the Big Gulp ban, the Happy Meal ordinance, or soda taxes) by supporting precisely the same "personal responsibility" vision of obesity that has been used to promote stigmatizing behavioral interventions.[346]

Powerful forces are aligned in favor of stigmatizing obesity, but public health should not be among them. The health problems associated with obesity are very real, but it is far from clear that combating obesity itself is an effective or appropriate strategy for addressing them. In light of the evidence that anti-fat stigma does more harm than good for the health of obese people, this Article proposes that the public health response should be realigned toward destigmatization. This Part identifies three key components of the strategy[347]: First, it would emphasize health — not thinness — as the

all legal products, to cover other specific behavior, as in New York, and to cover all off-work behavior, as in North Dakota and Colorado.").

[343] *See, e.g.*, COLO. REV. STAT. § 24-34-402.5 (2013) ("[I]t shall be a discriminatory or unfair employment practice for an employer to terminate the employment of any employee due to that employee's engaging in any lawful activity off the premises of the employer during nonworking hours . . ."); N.Y. LAB. § 201-d (McKinney 2013) (listing four broad categories of off-duty conduct that employers generally may not use in making employment decisions: legal recreational activities, consumption of legal products, political activities, and membership in a union); N.D. CENT. CODE § 14-02.4-03 (2013) ("[I]t is a discriminatory practice for an employer to fail or refuse to hire a person; to discharge an employee; or to [otherwise discriminate with respect to] . . . participation in lawful activity off the employer's premises during nonworking hours . . .").

[344] *See* Sugarman, *supra* note 342, at 418.

[345] Indeed, McDonald's was the defendant in a high-profile obesity discrimination case. *See, e.g.*, Connor v. McDonald's Restaurant, No. 3:02 CV 382 SRU, 2003 WL 1343259 (D. Conn. Mar. 19, 2003) (finding that factual issues existed as to whether McDonald's Restaurant regarded a job applicant who weighed 420 pounds as disabled under the Americans with Disabilities Act and whether the applicant had a chronic impairment so as to constitute a disability under the Connecticut Fair Employment Practices Act).

[346] *See, e.g.*, CTR. FOR CONSUMER FREEDOM, AN EPIDEMIC OF OBESITY MYTHS (2005) (publication by "a nonprofit coalition supported by restaurants, food companies, and consumers, working together to promote personal responsibility and protect consumer choices").

[347] For concrete applications of these strategies in specific contexts, see Wiley, *No*

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appropriate goal for public health interventions. Second, it would privilege environmental interventions over behavioral interventions to the extent that public health advocates would be extremely wary of supporting any behavioral intervention without thoroughly evaluating its stigma potential. Third, it would recognize anti-discrimination, anti-bullying, and privacy laws as tools for protecting and promoting the health of obese people.

### *A. Health, Not Thinness*

"Health is not a number, but rather a subjective experience with many influences. Stepping onto a scale cannot prove a person healthy or unhealthy."[348] Obesity alone does not reduce life expectancy.[349] A sedentary thin person has a higher risk of dying prematurely than a physically fit obese person.[350] Research suggests that only a relatively small proportion of a person's risk of developing obesity-related illnesses (such as type-2 diabetes or ischemic heart disease) is attributable to obesity itself, as opposed to being attributable to poor diet, physical inactivity and other factors.[351] Epidemiological studies of the association between obesity and chronic disease rarely control for

*Body Left Behind*, *supra* note 212 (applying the destigmatization strategy to school- and workplace-based interventions); Lindsay F. Wiley, "Access to Health Care as an Incentive for Healthy Behavior?" (Mar. 8, 2013) (unpublished presentation from the University of Indiana McKinney School of Law's symposium, "The Untrustworthy Patient: Models of Responsibility, Consumerism, and Blame") (on file with author) (applying the destigmatization strategy to health-care-based interventions).

[348] Marylin Wann, *Foreword*, *in* FAT STUDIES READER, *supra* note 50, at xiii.

[349] *See* Linda Bacon & Lucy Aphramor, *Weight Science: Evaluating the Evidence for a Paradigm Shift*, 10 NUTRITION J. 1, 2 (2011) ("[E]xcept at statistical extremes, body mass index (BMI) — or amount of body fat — only weakly predicts longevity. Most epidemiological studies find that people who are overweight or moderately obese live at least as long as normal weight people, and often longer."); Katherine M. Flegal et al., *Cause-Specific Excess Deaths Associated with Underweight, Overweight, and Obesity*, 298 J. AM. MED. ASS'N 2028, 2036 (2007) (finding that overweight individuals and normal weight individuals have the same risk for death from all cancers and cardiovascular disease and have significantly reduced mortality from causes other than cancer and cardiovascular disease).

[350] *See generally* M. Fogelholm, *Physical Activity, Fitness and Fatness: Relations to Mortality, Morbidity and Disease Risk Factors. A Systematic Review*, 11 OBESITY REVS. 202 (2010) (finding that "[t]he risk for all-cause and cardiovascular mortality was lower in individuals with high BMI and good aerobic fitness, compared with individuals with normal BMI and poor fitness").

[351] *See* Burgard, *supra* note 50, at 43 (noting that "studies show that correlations between health problems and BMI" typically indicate "that about [nine percent] of the outcome of whether someone has a health problem or not is somehow related to BMI (correlated to it but not necessarily caused by it)").

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classic confounding variables like fitness, physical activity levels, calorie intake, weight cycling, or socioeconomic status.[352] "When studies do control for these factors, increased risk of disease disappears or is significantly reduced" except at statistically extreme weights.[353] "It is likely that these other factors increase disease risk at the same time they increase the risk of weight gain."[354] Essentially, our obesigenic environment is killing most of us, while also making some of us obese.

Based on these principles, size-acceptance advocates working within the health sciences have recently proposed a "paradigm shift" in the way we think about the relationship between health and obesity.[355] The "Health at Every Size" ("HAES") movement: "[S]hifts the focus from weight management to health promotion. The primary intent of HAES is to support improved health behaviors for people of all sizes without using weight as a mediator; weight loss may or may not be a side effect."[356] The HAES message combats anti-fat stigma, rather than promoting it. It focuses on improving the health behaviors of all people, rather than targeting those who are fat.

### *B. Environmental Interventions Over Behavioral Interventions*

Public health advocates generally recommend environmental interventions over behavioral interventions. But they have not generally advocated *against* individually-focused behavioral interventions. And, in some cases, they have pointed to these interventions as positive policy developments in the war against obesity. Scholars concerned about the stigmatization of obesity, however, have taken a stronger stand — preferring environmental interventions as "less stigmatizing, more effective and more supportive of health for all over a longer time period [because] they deal with the population level determinants that affect health . . . . [A]ll people are considered as beneficiaries of an intervention, and specific groups are not 'targeted' for 'fixing.'"[357]

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[352] *See* Bacon & Aphramor, *supra* note 349, at 3.

[353] *Id.*

[354] *Id.*

[355] *See* Burgard, *supra* note 50, at 42 (describing Health at Every Size as "a grassroots movement opposing [the use of health issues to oppress people of size] among healthcare workers and health researchers [who], in collaboration with activists and consumers, have been evolving an alternative public health model for people of all sizes").

[356] Bacon & Aphramor, *supra* note 349, at 1.

[357] Maclean et al., *supra* note 59, at 90; *see also* Puhl & Heuer, *supra* note 42, at

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In theory, it might be possible to denormalize unhealthy eating and activity behaviors for all without stigmatizing fat people specifically, but it is a very fine line to walk. For example, Bloche frames his denormalization proposal in terms of stigmatizing "sedentary living and risky eating,"[358] but he argues that this approach will be successful precisely because it draws on "widely-held ideals about attractiveness"[359] — suggesting that fatness itself is meant to be stigmatized as a proxy for unhealthy behaviors. Interventions aimed at denormalizing unhealthy products, rather than people or their behaviors are promising, but not politically palatable. For example, environmental interventions have the potential to denormalize large portion sizes through measures like the Big Gulp ban, but those interventions face significant industry-backed political opposition. And, in some cases, that political opposition has focused on the idea that thin people, who can enjoy soda or unhealthy food without packing on the pounds, should not have to suffer because of the sins of fat people who do not know when to stop.[360]

### *C. Anti-Discrimination, Anti-Bullying, and Privacy Laws as Tools for Health Promotion*

Until quite recently, the primary focus of scholarship on obesity and the law was on the applicability of anti-discrimination frameworks. Public health law has laid claim to obesity, pushing anti-discrimination discussions onto the back burner. Bearing in mind that health impacts of obesity are moderated through stigmatization, a destigmatization strategy would aim to revive interest in anti-discrimination, anti-bullying, and privacy laws as tools for addressing the health problems associated with obesity. Strengthening these legal frameworks should be a top priority for public health advocates, particularly to the extent that targeted behavioral interventions for obesity continue to be implemented.

1025 ("[E]fforts to create environmental changes that support responsible behaviors will serve to improve health and reduce health disparities for all Americans, regardless of their weight.").

[358] Bloche, *supra* note 30, at 1354.

[359] *Id.* at 1351.

[360] *See, e.g.*, Edward L. Glaeser, *Demonizing, and/or Taxing, Soda*, ECONOMIX: EXPLAINING THE SCIENCE OF EVERYDAY LIFE (Sept. 22, 2009, 7:15 AM), http://economix.blogs.nytimes.com/2009/09/22/demonizing-andor-taxing-soda/?_r=0 ("[A]ll soda drinkers, even the rail-thin ones, suffer when soda consumption is either taxed or vilified. The costs imposed on them need to be weighed against the benefits of reducing obesity.").

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Rather than being framed by an exception to prohibitions on health-status-related discrimination, workplace wellness programs should only be implemented within the context of strong anti-discrimination provisions. Those provisions would naturally channel programs toward environmental interventions in the workplace (such as healthier food options and increased time and facilities to encourage physical activity), which are less stigmatizing and have the potential to improve the health of all employees at risk for chronic disease, not just the fat ones. Surveillance, screening, and treatment programs — whether based in schools or doctor's offices — should be implemented within a protective framework of strong privacy and confidentiality protections for information about weight and BMI. School-based interventions that target obese students in any way probably should not be implemented at all, in light of their enormous stigma potential. Instead, school-based programs should emphasize the importance of healthy diet and physical activity for people of all sizes. Public health advocates concerned about childhood obesity should also find a seat at the table in ongoing discussions about how best to reduce bullying in schools.

## CONCLUSION: THE IMPLICATIONS OF OBESITY CONTROL FOR THE LAW AND POLITICS OF PUBLIC HEALTH

Bioethicist Daniel Callahan sparked controversy[361] in January 2012 when he called for a health education campaign against obesity aimed at "induc[ing] people who are overweight or obese to put some uncomfortable questions to themselves." [362] These questions include:

> If you are overweight or obese, are you pleased with the way you look? . . . Are you pleased when your obese children are called "fatty" or otherwise teased at school? Fair or not, do you know that many people look down upon those excessively overweight or obese, often in fact discriminating against them and making fun of them or calling them lazy and lacking in self-control?[363]

[361] *See, e.g.*, Cavan Sieczkowski, *'Fat-Shaming' Strategy Pushed By Bioethicist Daniel Callahan to Curb Help Obesity*, HUFF. POST (Jan. 29, 2013, 4:05 PM), http://www.huffingtonpost.com/2013/01/24/daniel-callahan-fat-shaming-curb-obesity_n_2543270.html (summarizing the controversy); *see also* Lindsay Abrams, *A Case for Shaming Obese People, Tastefully*, THE ATLANTIC (Jan. 23, 2013), http://www.huffingtonpost.com/2013/01/24/daniel-callahan-fat-shaming-curb-obesity_n_2543270.html (also discussing the controversy sparked by Callahan).

[362] *See* Callahan, *Obesity*, *supra* note 34, at 39.

[363] *See id.*

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Several public health advocates spoke out in opposition to this approach.[364] But their comments, like Callahan's, focused exclusively on the use of government-sponsored messaging campaigns.

At a time when individually-targeted, "personal responsibility" approaches are beginning to dominate the obesity control *law* landscape, public health advocates need to recognize that denormalization has never been solely about public messaging. Legal interventions were a crucial component of the strategy to denormalize smoking, and they are apparently playing a role in the stigmatization of obesity as well. The public health community must recognize that incentive- and penalty-based wellness programs, BMI screening in schools, and efforts to increase the medical treatment of obesity as a disease can be just as stigmatizing as — and perhaps even more damaging than — the billboards quoted in the opening lines of this Article.[365]

The war on obesity is nearing a crossroads. The tobacco control and HIV prevention experiences of the 1980s and 1990s each had profound effects on the development of public health law. Tobacco control made the law relevant again to public health efforts to address the determinants of chronic disease. HIV prevention inextricably linked public health to human rights protections in ways that are still being explored by scholars and practitioners alike. The new war on obesity has similar potential to influence the practice and theory of public health law for decades to come. The key question is what that influence will be.

Several commentators have pointed out the importance of combating obesity, but not obese people.[366] But this "love the sinner, hate the sin" approach is not a valid one in the context of a bodily state that is already stigmatized and made all the more so by public health strategies that equate the "sin" of unhealthy eating and physical inactivity with the status of being fat. The true target in the fight against chronic diseases associated with poor diet and physical inactivity should be environmental conditions and industry actions that make a twenty-one-ounce, two-hundred-ten-calorie soda the default accompaniment to a meal eaten outside the home, and that make bicycling for transportation a hazardous proposition. The

[364] *See* sources cited *supra* note 37.

[365] *See supra* notes 1-7 and accompanying text (describing shame based slogans used in campaigns against childhood obesity).

[366] *See, e.g.*, Teegardin, *supra* note 4 ("[W]e need to fight obesity, [] not obese people." (quoting Marsha Davis, a researcher at the University of Georgia College of Public Health)).

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enormous economic, social, and personal burden of diabetes and cardiovascular disease demand the very best that public health experts can offer. And we can do better than buying into stigmatizing behavioral interventions that target obese people.

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