The American Obesity Epidemic: Why the U.S. Government Must Attack the Critical Problems of Overweight & Obesity through Legislation

Benjamin Montgomery*

I. Obesity and Overweight: American Crises

Obesity is an escalating problem in America that has reached epidemic proportions, with up to 400,000 obesity-related deaths occurring per year. Obesity not only affects one’s physical appearance, but it is also linked to increased risks of hypertension, type 2 diabetes, sleep apnea, and depression. Some legislatures have taken notice of the epidemic. For example, in 2007 lawmakers in New York City

---

*J.D. Candidate, Suffolk University Law School, 2009; B.S., Boston University, 1999. Mr. Montgomery may be reached at benjamin.montgomery@gmail.com.

1 THE ENDOCRINE SOC’Y, THE ENDOCRINE SOC’Y WEIGHS IN – A HANDBOOK ON OBESITY IN AMERICA 14 (2005), available at ObesityinAmerica.org: Obesity Basics, at http://www.obesityinamerica.org/index.html [hereinafter HANDBOOK]. For example, occurrences of obesity increased in every age group between age 18 and 70, from 1991 – 2001. Id. at 25. See Stedman’s Online Dictionary, Online Medical Dictionary, http://www.stedmans.com/section.cfm/45 (search “Search Online Medical Dictionary” for “epidemic”) (last visited Mar. 19, 2008) (defining “epidemic”). An epidemic is “the occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy...” Id. Although the word was historically used to identify an occurrence of “diseases” within a region, “[b]y the late [twentieth] century the definition of epidemic had been extended to include outbreaks of any chronic disease or condition (e.g., heart disease or obesity).” See THE NEW ENCYCLOPEDIJA BRITANNICA Vol. 4 (15th ed. 2002) (under the entry “epidemic”) (defining epidemic).

2 See HANDBOOK, supra note 1, at 1, 6 (describing some of the affects obesity has on individuals).

introduced a bill prohibiting restaurants from using trans fats in the preparation of food.\textsuperscript{4} Healthcare reform, including the improvement of preventative care policies, has also become a focal point of each of the recent Presidential campaigns.\textsuperscript{5} Obese employees allegedly cost employers more than employees of normal weight do.\textsuperscript{6} According to some law makers, obese people are less likely to receive job offers compared to equally qualified candidates of normal weight and tend to make less than co-workers of normal weight, creating concern about a new form of discrimination in the work environment.\textsuperscript{7}

\begin{itemize}
  \item for prevention of chronic conditions…" such as obesity); \textit{see also} S. 418, 80th Leg. (Tex. 2007); \textit{see also} General Assemb. 1931, 213th Leg., 1st Reg. Sess. (N.J. 2008) (proposing “health care coverage for treatment of overweight and obesity”). This list is not exhaustive of all state legislative acts concerning obesity.
  \item \textit{See} S.B. 3831, 230th Leg. Sess. (N.Y. 2007), § 396-jj (amending the general business laws with a new section, specifically prohibiting restaurants from using trans fats). Trans fats do not have to be completely eliminated until July 2008. \textit{Id. See also} Philip McKenna, \textit{Can This Spread Be Stopped? Lawmaker Wants Schools to Put a Lid on Fluff}, BOSTON GLOBE, June 19, 2006, \textit{available at} http://www.boston.com/news/local/articles/2006/06/19/can_this_spread_be_stopped/ (reporting on a Massachusetts state senator’s efforts to make school lunch menus healthier). Recently, Massachusetts Senator Jarrett Barrios threatened to write a bill which would ban Cambridge’s inclusion of Marshmallow Fluff® on the school lunch menu. \textit{Id.} Although Barrios backed down from this demand Cambridge schools nonetheless took Fluff® off their menus. \textit{Id.}
  \item \textit{See} Mary Carmichael, \textit{Do We Really Need a Law to Protect Fat Workers? They Earn Less, Get Less Respect, and Score Fewer Promotions. That’s Why Massachusetts’s Proposed Discrimination Ban Might Make
This Note will examine the gravity of the increasing prevalence of obesity in America and evaluate forms of government intervention. Section I of this Note defines obesity, differentiates it from the classification “overweight,” and explores the health consequences associated with being overweight or obese. Section II addresses some of the measures taken by the legislature and medical community to combat obesity and overweight. Section III forecasts how obesity could be addressed in a uniform healthcare system. Section III also analyzes the possibility that corporations may redirect healthcare costs onto employees if the healthcare system remains unchanged, and possible legislative responses to this trend. Section IV distinguishes a particular need for legislative actions tailored to decreasing the incidence of overweight and obese American adults, regardless of the type of healthcare system in place. This Note concludes with the assertion that a law granting working Americans a right to reasonable access to physical exercise during the workday is essential to adequately improve the obesity and overweight problems among the adult population.

II. The Problems: Overweight and Obesity

“‘Overweight’ and ‘obesity’ are both [medical] labels for ranges of weight that are greater than what is generally considered healthy for a given height.” Each classification is determined relative to the body mass index (BMI) standard. BMI is calculated the same for adults and children. However, after a child’s BMI is determined, the data “is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking.” The term “overweight” may be confused with the adjective “overweight;” however, it is analogous to “obesity” being the medical condition designated for someone who is obese. The medical condition “overweight” can be both a noun and a verb. The term “overweight” can be both a noun and a verb.

---

8 See Department of Health and Human Services Centers for Disease Control and Prevention website, Overweight and Obesity, at http://www.cdc.gov/nccdphp/dnpa/obesity/index.htm [hereinafter, CDC website] (click “defining overweight and obesity”). In addition to its common adjective designation, the term “overweight” is used clinically as a noun to designate the condition wherein one is over his or her ideal weight. See id. The medical condition “overweight” may be confused with the adjective “overweight;” however, it is analogous to “obesity” being the medical condition designated for someone who is obese. Id. See also http://www.merriam-webster.com/dictionary (search for “overweight”) (defining overweight). The term “overweight” can be both a noun and a verb. Id.

9 Id. (defining overweight and obesity).

10 See HANDBOOK, supra note 1, at 2 (explaining what BMI is and how to calculate it). But see CDC website, supra note 8 at http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm (explaining that a BMI calculation must be interpreted differently for children ages two to nineteen). BMI is calculated the same for adults and children. Id. However, after a child’s BMI is determined, the data “is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking.” Id. “Healthy weight ranges” (as opposed to percentile ranking) for children through age nineteen cannot be calculated because “[a] Healthy weight ranges change with each month of age for each sex [and (b)] Healthy weight ranges change as height increases.” Id. To determine the percentile of a child’s weight it is
calculated by multiplying an individual's weight in pounds by 703 and dividing the result by the individual's height in inches, squared.\(^{11}\) An adult whose BMI is greater than or equal to twenty five (i.e., whose weight is twenty five percent heavier than the ideal standard for that individual's height) is considered 'overweight;' one whose BMI is greater than or equal to thirty is considered 'obese.'\(^ {12}\)

a. Consequences of Being Overweight

The majority of American adults are overweight.\(^ {13}\) The average American woman is approximately five feet four inches tall.\(^ {14}\) Therefore, if she weighs 146 pounds easiest to use a calculator designed specifically for determining a child's BMI, such as the free calculator available on the Centers for Disease Control and Prevention website. See CDC website, supra note 8 at http://apps.nccd.cdc.gov/dnpabmi/Calculator.aspx.

\(^{11}\) Specifically, BMI = (Weight (lbs) x 703) / height\(^ 2\) (inches). See HANDBOOK, supra note 1, at 2 (explaining what BMI is and how to calculate it). Waist circumference (measuring abdominal fat) is another method used to determine whether one is overweight or obese; however, this measurement is primarily only used for research purposes. Id. at 2-3. Using the metric system, BMI is calculated simply as weight (kg) / [height (m)]\(^ 2\). See CDC website, supra note 8, at http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm. BMI is not the only way to measure body fat; however, it is an inexpensive, easily calculable, and "a reliable indicator of body fatness for people." Id. "Other methods to measure body fatness include skinfold thickness measurements (with calipers), underwater weighing, bioelectrical impedance, dual-energy x-ray absorptiometry (DXA), and computerized tomography." Id. These methods are less available, more expensive and, for the purposes of this note, not necessary to determine whether an individual is generally overweight or obese. Id.

\(^{12}\) See HANDBOOK, supra note 1, at 2 (defining overweight and obesity against calculated BMI).

\(^{13}\) See HANDBOOK, supra note 1, at 23 (noting "an estimated 65.2 percent of U.S. adults, age 20 years and older, are overweight"). But see CDC website, supra note 8 at http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm (qualifying the parameters of overweight). Because the BMI does not directly measure body fat, an individual with excessive lean muscle could have a BMI greater than 25 and, therefore, be classified as overweight without actually having excessive body fat. Id. Additionally, the BMI-body fatness correlation can be affected by both race and gender. Id. Nevertheless, the correlation between BMI and body fat is a strong one. Id. For an interesting but alarming reality about the prevalence of obesity, see cnn.com/living, Are You Loving Your Pet Into an Early Grave?, http://www.cnn.com/2007/LIVING/wayoflife/09/24/fat.pets/index.html (last visited Feb. 10, 2008) (discussing the trend of overweight in Americans' pets). "A 2005 study from pet-food maker Purina found that 60 percent of pets in the U.S. were overweight." Id.

\(^{14}\) See http://www.cdc.gov/nchs/fastats/bodymeas.htm (providing the average heights of American male and female adults). This average was calculated based on measurements taken between 1999 – 2002; the current average height of either women or men, or both may have changed. Id.
or more, she would be considered overweight. Likewise, the average American man, who is five feet, nine inches, would be overweight if he weighed 170 pounds or more. According to the National Center for Health Statistics, the average American man and woman are 190 pounds and 163 pounds, respectively. In addition to an increased body mass, there are serious health risks and consequences attached to being overweight, including approximately twenty serious conditions and diseases such as type 2 diabetes, cardiovascular disease, stroke, hypertension, osteoarthritis, cancer, sleep apnea, and even psychological disorders such as depression.

Energy imbalances can cause weight gain or loss. An energy imbalance occurs in an individual when the number of calories he or she consumes does not equal the number of calories he or she expends during a given period. Weight gain results from an individual’s consumption of more calories than he or she expends over an extended period of time. Physiological factors such as genetics and hormones can cause energy imbalances. For example, genetics may cause an individual to have a slow metabolism

---

15 See HANDBOOK, supra note 1, at 2-3 (providing the formula to determine BMI and statistics for the average man and woman).

16 Id.

17 See supra note 14 (providing the average weights of American male and female adults); see also HANDBOOK, supra note 1, at 2-3 (providing the formula to determine BMI and statistics for the average man and woman). The average female cannot gain more than eleven pounds beyond what is considered a healthy weight, and the average male cannot gain more than thirteen pounds beyond his healthy weight. Id.

18 See HANDBOOK, supra note 1, at 6-7 (listing the complications of overweight and obesity). The full grisly list also includes: dyslipidemia, hyperinsulinemia, insulin resistance, glucose intolerance, congestive heart failure, angina pectoris, cholecystitis, cholelithiasis, gout, fatty liver disease, respiratory problems, kidney stones, stress urinary incontinence, and death. Id. Females are additionally at risk for: pregnancy complications, fertility complications, and polycystic ovary syndrome. Id. See also HANDBOOK, supra note 1, at 88-92 (giving a description of each of these health conditions).

19 See CDC website, supra note 8 (click on “contributing factors”) (discussing the causal factors of body weight and overweight and obesity). For example, if an individual consumed a number of calories, \( X \) and expended \( X - 1 \) throughout the course of one day, that individual would have an energy imbalance of one calorie. Id. See also HANDBOOK, supra note 1, at 5.

20 See CDC website, supra note 8 (click on “contributing factors”) (discussing the causal factors of weight gain).

21 See CDC website, supra note 8 (discussing the causal factors of body weight and overweight and obesity). While an individual may have an excess of calories at the end of any given period, overweight and obesity are the results of such imbalances consistently occurring over an extended period of time. Id.

22 See CDC website, supra note 8 (discussing the causal factors of body weight and overweight and obesity).
which, in turn, could cause that person to gain weight. Additionally, hormones can affect the efficiency at which calories are processed. However non-physiological factors such as environment, culture, and individual behavior are also primary causes of energy imbalances. Environment and community may affect the decisions an individual makes; for example, an individual may choose not to walk to a store because of a lack of sidewalks. The most influential behavioral factor affecting weight gain is that most Americans lead a sedentary lifestyle. The expanding assimilation of technologies in American culture has adversely affected physical health.

23 See HANDBOOK, supra note 1, at 5 (discussing physiological causes of obesity).
24 Id. This condition is called “hypothyroidism.” Id. at http://www.obesityinamerica.org/roleofanendo.html. See also THE NEW ENCYCLOPÆDIA BRITANNICA Vol. 6 (15th ed. 2002) (under the entry “hypothyroidism”) (defining the term); see also THE NEW ENCYCLOPÆDIA BRITANNICA Vol. 18 (15th ed. 2002) (under the entry “endocrine system,” find section on “hypothyroidism” on page 307) (defining hypothyroidism); see also HANDBOOK, supra note 1, at 62 (discussing the hormone leptin). Leptin is a hormone secreted by fat cells and which controls appetite. See id. Studies have shown that overweight people may be resistant to leptin in that they do not stop eating despite elevated leptin levels. See id.
25 See CDC website, supra note 8 (discussing the causal factors of body weight and overweight and obesity); see also Jeffrey Kluger, How America’s Children Packed on the Pounds, TIME, June 23, 2008, at 68 [hereinafter Kluger, America’s Children] (discussing the innate human tendency to “gorge” food rather than eating only what they need). “Humans, like most animals, are hardwired not just to eat but to gorge, since living in the wild means never knowing when the next famine is going to strike.” Id.
26 See CDC website, supra note 8 (explaining how environmental, cultural, and behavioral factors may affect weight gain); see also Stephen Smith, Mass. Teens Watch TV, But Not What They Eat, BOSTON GLOBE, May 15, 2008, available at http://www.boston.com/news/local/articles/2008/05/15/mass_teens_watch_tv_but_not_what_they_eat/ [hereinafter Smith, Mass. Teens] (reporting that exercise may decrease as a result of safety concerns and lack of sidewalks). See generally Bryan Walsh, It’s Not Just Genetics, TIME, June 23, 2008, at 70-80 (reporting on the income, ethnic and geographic impacts on the incidence of obesity). There are higher incidences of obesity among low socio-economic communities, and among certain ethnicities and families with low individual incomes. Id. For example, the Oglala Sioux population in Pine Ridge, South Dakota is considered a poorer class, with little access to healthy foods. Id. at 72. Obesity is far more serious problem among this population than the citizens of Boulder, Colorado, a wealthier community with access to several outlets for physical recreation, and greater access to health food stores. Id.
27 See CDC website, supra note 8 (discussing how individual behavior may affect weight gain); see also Kluger, America’s Children, supra note 25, at 69 (noting the downward trend of physical education participation among U.S. high school students). The percentage of high school students participating in physical education has dropped from forty-two percent in 1991 to about twenty-five percent as of 2008. Id.
28 See CDC website, supra note 8 (explaining how technological advances have indirectly affected weight gain among Americans).
To give some obvious examples, a person can: drive to a store rather than ride a bicycle, use a dishwasher rather than wash dishes by hand, and play a video game of basketball rather than a real game. The bottom line is that two-thirds of Americans are considered overweight.

Despite the serious health risks that accompany it, the condition overweight may not be as serious an epidemic as previously believed. The prevalence of overweight may not be as serious an epidemic as previously believed.

29 See CDC website, supra note 8 (explaining how technology has decreased physical exertion).

30 See CDC website, supra note 8 (providing examples of how technology enables physical acts to be replaced by non-physical ones). All of the aforementioned tendencies result in the expenditure of fewer calories, which creates the adverse energy imbalance. Id. See Julie C. Lumeng, et al., Television Exposure and Overweight Risk in Preschoolers, 160, No. 4 ARCHIVES PEDIATRIC & ADOLESCENT MED., 417 (Apr. 2006), available at http://pubs.ama-assn.org/ (Search for “Television Exposure and Overweight Risk in Preschoolers” in the search bar; then click on the PDF link to that article title) (expanding on TV as a behavioral factor to weight gain).

“Excessive television (TV) viewing has been linked to a risk of overweight in school-aged [and preschool-aged] children.” Id. But see Elizabeth A. Vandewater & Xuan Huang, Parental Weight Status as a Moderator of the Relationship Between Television Viewing and Childhood Overweight, 160 No. 4, ARCHIVES PEDIATRIC & ADOLESCENT MED., 425 (Apr. 2006), available at http://pubs.ama-assn.org/ (Search for “Parental Weight Status” in the search bar; then click on the PDF link to the article title) (suggesting that increased television watching alone might not contribute to weight gain). “W]hen parental obesity is taken into account, television viewing hours do not significantly relate to increased odds of childhood overweight.” Id. In other words, at least in the case of adolescents who watched increasing amounts of television, the risk of childhood overweight was affected by whether at least one parent was overweight. See id.

31 NAT'L CTR. FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 2007 WITH CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS 40 (2007), available at http://www.cdc.gov/nchs/data/hus/hus07.pdf. [hereinafter NAT'L CTR. CHARTBOOK]; see also Smith, Mass. Teens, supra note 26 (reporting on one concerning collateral effect of the increased incidence of overweight and obesity). Researchers are concerned that even where, between 2001-2007, “the percentage of children who weighed too much remained essentially unchanged. Fewer [of them] viewed themselves as being overweight.” Smith, Mass. Teens, supra note 19. In other words, incidence of overweight could potentially continue to increase because children are adjusting their perception of what “overweight” is. Id.

32 See CDC website, supra note 11 (discussing the limitation of using solely a BMI calculation as the gauge for overweight). The BMI calculation for highly trained athletes and body builders could erroneously indicate either as being overweight. Id. See also Frontline: 1708 “Fat” (WGBH television broadcast Nov. 3, 1998) (profiling “fat” tri-athlete Dave Alexander), transcript available at http://www.pbs.org/wgbh/pages/frontline/shows/fat/etc/script.html. Dave Alexander is “5 foot, 8 and weights 250 pounds, [which is] 100 pounds more than the recommended ‘ideal’ for someone his height.” Id. However, “[i]n a typical week, Dave will swim five miles, run thirty [miles] and cycle 200 [miles]. He has completed 264 triathlons.” Id. Despite such athleticism, “David’s weight supposedly puts him in a life-threatening category known to doctors as ‘morbid obesity.”’ Id.
overweight in American adults has actually remained steady since 1960.33 Studies indicate that the Centers for Disease Control and Prevention overestimated overweight's rank among the deadliest preventable causes of death.34 Furthermore, overweight Americans are “eating better, exercising more, and managing their blood pressure better than they used to.”35 While being overweight increases the risks of health conditions, especially for children, the number of overweight Americans does not appear to have reached epidemic proportions.36 Nevertheless, because being overweight increases an individual's chances of becoming obese, the prevalence of overweight warrants legislative attention.37

33 See HANDBOOK, supra note 1, at 91 (defining “prevalence”). “Prevalence [is] the total number of cases of a disease in a given population at a specific time.” Id. Therefore, a thirty-two percent prevalence of overweight in America means thirty-two percent of the American population is overweight. Id. See NAT’L CTR. CHARTBOOK, supra note 31, at 40-41 (showing the prevalence of overweight in America from 1960 – 2004). “Since 1960-1962, the percentage of adults who were overweight but not obese has remained steady at thirty-two to thirty-four percent (age-adjusted),” Id. at 40. See CDC website, supra note 8 at http://wonder.cdc.gov/wonder/help/faq.html (defining age adjustment). “Age adjustment is a technique [which allows] meaningful comparisons across populations with different underlying age structures. For example, comparing the crude rate of heart disease in Florida with that of California is misleading, because the relatively older population in Florida leads to a higher crude death rate, even if the age-specific rates of heart disease in Florida and California were the same. For such a comparison, age-adjusted rates are preferable.” Id. But see CDC website, supra note 8 at http://www.cdc.gov/od/oc/media/pressrel/r50615.htm (noting “[o]verweight among children and teenagers has risen dramatically in recent years”).

34 See Carla K. Johnson, CDC Overstated the Dangers of Being Overweight, Study Finds, THE BOSTON GLOBE, Apr. 20, 2005, available at http://www.boston.com/news/nation/articles/2005/04/20/cdc_overstated_the_dangers_of_being_overweight_study_finds/. The CDC's estimate on the number of deaths caused per year from overweight was changed to 25,814, from the approximately 365,000 estimate it made four months earlier. Id. Overweight now ranks seventh among the leading causes of preventable death, after car crashes and guns. Id. (emphasis added). But see CDC website, supra note 8 at http://www.cdc.gov/od/oc/media/pressrel/r050615.htm (qualifying the studies that showed a lack of association between overweight and risk of death). “Being overweight as an adult increases the chances of getting type 2 diabetes and developing other health problems. Plus, overweight people are at a greater risk of becoming obese.” Id. There are serious risks for overweight children too. Id.

35 See Johnson, supra note 34.

36 See HANDBOOK, supra note 1, at 6 (listing the risks for overweight and obese people); see also CDC website, supra note 8 at http://www.cdc.gov/nccdphp/dnpa/obesity/childhood/index.htm (discussing specific consequences for children being overweight). Not the least of the worries is that “[o]verweight children and adolescents are more likely to become obese as adults.” Id.

37 See supra note 36 (identifying that an overweight individual bears an increased risk of becoming obese).
b. Detrimental Effect of Obesity on Employer, Employee, and Taxpayer

Obesity, however, is undoubtedly already an "epidemic." Unlike the overweight classification, obesity dramatically increased from 1960 to 2004. Though recent reports indicate that the prevalence of obesity has not increased significantly since 2003, currently over thirty percent of U.S. adults (twenty years of age and older) are obese. This is an increase of approximately twenty percent since 1960. One recent study identified the remarkable tendency of obesity to "spread" among social networks. According to this study of over 12,000 interconnected people, a person's
chances of becoming obese could increase by fifty-seven percent "if he or she had a friend who became obese," by forty percent if a "sibling became obese," and by thirty-seven percent if a "spouse became obese." The significance of this study is the inference that obesity could expand exponentially, because as the number of obese people increases, the likelihood of the connection to other people via friendship, relationship, or marriage increases.

In 2005, the New England Journal of Medicine (NEJM) published a special report asserting a threat that life expectancy in the U.S. could decline in the 21st Century. According to the research, though the "life expectancy of humans during the last thousand years has [steadily increased, obesity will], if unchecked, have a negative effect on life expectancy." The report made a conservative estimate that life expectancy would be higher by at least four months and as much as thirteen months if obesity did not exist. Dying a few months earlier may not seem dramatic; however, this estimate is conservative, and a decrease in life expectancy by even a few months "is larger than the negative effect of all accidental deaths combined."
In September 2007, the CDC released its “Deaths: Preliminary Data for 2005” report, which concluded that U.S. life expectancy had hit an all time high. However, according to the CDC’s website, the final data for 2005 shows American life expectancy unchanged from 2004. The final 2005 life expectancy for Americans was also lower than that of three dozen other countries.

The consequences of obesity extend beyond health risks. Financially, obese people, their employers and the American taxpayers are all adversely affected.

rates of death for obese people under 19 years of age (which forces the assumption that rates of death in this age range remained unchanged from the levels in 2000) leads to an underestimate of the overall effect of obesity on life expectancy.” Id. The reduction in life expectancy could approach “… and could exceed the negative effect that ischemic heart disease or cancer has on life expectancy.” Id. See NSC.org, http://downloads.nsc.org/pdf/StateByStateInjuryData.pdf (last visited Mar. 21, 2008) (providing a state by state breakdown of accidental deaths for 2005). According to the National Safety Council, homicide and suicide are not considered accidental deaths. Id. The National Safety Council (NSC) is a “non-for-profit, charitable, international public service organization dedicated to educating and influencing people to prevent accidental injuries and deaths.” Id. at http://www.nsc.org/about/about_us.aspx (last visited Oct. 3, 2008).

49 See CDC website, supra note 8 at http://www.cdc.gov/nchs/pressroom/07newsreleases/lifeexpectancy.htm. “A child born in the United States in 2005 can expect to live nearly 78 years (77.9).” Id.

50 See CDC website, supra note 8 at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf (in the PDF document, search for “Table 8,” click on any Table 8 link to open an excel spreadsheet). The life expectancy in 2005 for all races, combined remained the same as in 2004 at 77.8. Id. The only increases in life expectancy between 2004 and 2005 were actually a .2 year increase in Black females, from a life expectance of 76.3 years in 2004 to that of 76.5 years in 2005. Id.


52 See HANDBOOK, supra note 1, at 42-43, 45 (discussing the economic consequences of obesity); see also Herper, supra note 6 (discussing economic consequences to employers of obese employees); see also Carmichael, supra note 7 (uncovering a trend in workplace discrimination against obese employees); see also Ken E. Thorpe et al., The Impact of Obesity on Rising Medical Spending, W4 HEALTH AFF. 480 (Oct. 20, 2004) (analyzing obesity’s affect on medical costs), at http://www.healthaffairs.org/ (Quick Search for Thorpe, 2004 under “Author” and “Date;” select first article)

53 See Carmichael, supra note 7 (noting that obese people earn less than people of normal weight).
Overweight employees, which includes obese employees, earn between one and six percent less than "their thinner counterparts" if the obese applicant even gets offered the job. Obese employees are also likely to bear more expensive health insurance premiums and higher medical expenses. Employers have suffered as well: cumulatively they have lost an estimated $4 billion in profits due to hiring obese employees. Finally, even non-obese tax-payers are saddled with costs attributed to obesity because Medicare and Medicaid have paid for approximately half of the expenditures attributable to obesity and overweight-related medical treatments which, by some estimates, amounts to over $39 billion.

Overweight—and necessarily obese—people "in service professions earn few[er] commissions and tips." Id. See also CDC website, supra note 8 at http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm (explaining affect of obesity on Medicare and Medicaid). See Carmichael, supra note 7 (describing circumstances under which overweight people are denied employment). Employers pass over obese applicants for jobs which require physical exertion, such as mail carriers or jobs that require heavy lifting because the obese, employers claim, are not physically fit enough to perform the job "adequately." Id. See also Herper, supra note 6. "Obese people are less likely to be given jobs." Id. See HANDBOOK, supra note 1, at 45 (discussing health insurance and medical costs for obese employees). According to one survey, having a BMI > 30 (i.e., being "obese") increases a person's expenses due to longer "hospital stays, the quantity and cost of outpatient visits, and pharmacy and lab costs." Id. Additionally, the health insurance plan for an individual with a BMI between 30-34.9 (i.e., Class I Obesity) will have an average cost twenty-five percent higher than a non-obese individual; the health insurance plan for an individual with a BMI of 35 or higher (i.e., Classes II and III Obesity) will be an average of thirty-five percent more than that of a non-obese individual. Id.

See Herper, supra note 6 (explaining the national financial impact of obese employees on the companies that hire them). "Obese people miss more work." Id. See also Carmichael, supra note 7 (expanding on the financial impact on companies who staff overweight and obese employees). Obese people who are hired for manual labor jobs end up taking more sick days and reporting more "back, knee, ankle, and shoulder pain." Id. This adversely affects the employers' disability costs. Id. See also HANDBOOK, supra note 1, at 43 (discussing costs attributed to obesity). "Obesity and obesity-related conditions or ailments [cost employers] $39.3 million in lost work days each year." Id.

See CDC website, supra note 8 at http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm (showing how much Medicare and Medicaid have expended for obesity and overweight related medical expenses). Both studies were from 1998; costs today would arguably be even higher. Id. One study indicated that the expenditure, in 1998, attributed to obesity and overweight related treatments was $78.5 Billion; another study indicated that such expenditure reached only $51.5 billion. Id. However, both studies calculated that Medicare and Medicaid paid about half of the respective totals, which would have been between, roughly, $25 and $40 billion. See Id.
III. Legislative History: Governmental Approach Thus Far

The obesity epidemic has roused the federal and state governments into legislative action. Although obesity has recently received significant legislative treatment, government concern for obesity is not new. Senators began a concerted effort to address obesity as early as 2002. In 2005, former body builder and current California Governor Arnold Schwarzenegger signed three bills designed to make both the food and beverage choices available to California students more nutritious. In 2007, New York City instituted a ban on trans fats in restaurants.

See supra note 3 (listing a small portion of state legislative actions in response to the obesity problem).

See H.R. 82, 102nd Cong. (1991) (proposing the “U.S. Commission on Obesity”). As early as 1991, Congress was looking to address obesity. Id.

See cbsnews.com, Senators Take Up Arms Against Obesity, http://www.cbsnews.com/stories/2002/07/30/health/main516956.shtml#top (last visited Feb. 9, 2008) (reporting on three senators’ proposal for increased spending on obesity targeted programs). The three senators introduced legislation which proposed spending $217 million in 2003, and more in the following years, on “a variety of programs to encourage proper nutrition and increased physical activity.” Id. Senator Bingham called obesity America’s “fastest rising public health problem.” Id. Senator Frist acknowledged that obesity is generally preventable, and Senator Dodd called a failure to address obesity immediately an endangerment to children. Id.

See Press Release, Office of the Governor, Governor Schwarzenegger Signs Landmark Legislation to Combat Childhood Obesity (Sept. 15, 2005) (explaining three bills that address nutrition of food and beverages available in California schools), available at http://gov.ca.gov/index.php?/press-release/1424/. One bill “sets food nutrition standards for food served and sold in K-12 public schools.” Id. Another “provides a framework to implement the $18.2 million in the Governor’s budget to include more fresh fruits and vegetables in school meal programs.” Id. The third bill “extends the ban on the sale of soda currently available in middle schools to public high schools...” Id. See also Cal. Educ. Code § 49431.5 (2006) (providing further legislative declaration). The legislature is particularly concerned about sweetened carbonated beverages. Id. “Each additional daily serving of sugar-sweetened soda increases a child’s risk for obesity by sixty percent.” Id. The legislature has found that “[t]eenage boys consume twice the recommended amount of sugar each day,” and girls three times as much. Id. Forty percent of that consumption for teenage girls comes from soda (forty-four percent for boys). Id. For an interesting comparison between school lunches circa 1950, and a modern school lunch, see Carolyn Sayre, School Cuisine, TIME, June 23, 2008, at 82-85 (providing a side by side comparison of “typical” lunches from each time period). A standard school lunch in 1950, before much of the research about nutrition had been conducted, consisted of approximately 936 calories and thirty-three grams of fat. Id. A modern school lunch, however, can contain up to 1,173 calories and over forty-five grams of fat. Id.

See supra note 4 and accompanying text (detailing the ban on trans fats to take effect in July 2008). But see msnbc.com, New York City Passes Trans Fat Ban, http://www.msnbc.msn.com/id/16051436/ (last visited Feb. 9, 2008) (discussing the details of Manhattan’s ban) [hereinafter Trans Fat Ban]. The ban, right now, only applies to oils and shortening. Id. See also Stephen
In 2007, bills were introduced in the Massachusetts Legislature providing for the expansion of health education as listed in the Massachusetts General Laws relating to "statewide educational goals and academic standards." The proposed amendments would require age appropriate health education and increase the minimum provisions of health education to include instruction in "growth and physical development, physical activity and fitness, [and] nutrition."

Another modern method of attacking obesity uses city zoning laws to restrict or prohibit fast food and "formula" restaurants from opening chains or constructing drive-through service windows in certain geographic areas. According to the Zoning and Obesity Project, "[s]everal courts have upheld zoning laws that restrict fast food outlets

Majors, States Slow to Ban Restaurant Trans Fats, BOSTON GLOBE, Nov. 27, 2007, available at http://www.boston.com/news/health/articles/2007/11/27/states_slow_to_ban_restaurant_trans_fats/ (explaining general resistance from other states to the ban). The director of the National Restaurant Association has indicated that "[t]he ban is not as easy as just dumping in a new oil." Id. The New York legislature has been trying since 2004 to get the trans fat ban into law, but technically has not done so yet. Id. "[I]n the 14 states that have so far proposed a ban or restriction, not a single bill has been passed as [2007 drew] to a close.” Id. See Trans Fat Ban, supra (expanding on the terms of the New York City trans fat ban). In addition to the already relaxed deadline for banning of trans fat (to July 2008), there are other exceptions to the ban, for example, restaurants will be allowed to “serve foods that come in the manufacturer's original packaging.” Id. But see Stephen Smith, Boston Moves Towards Trans Fats Ban, The BOSTON GLOBE, Jan. 11, 2008, available at http://www.boston.com/news/local/articles/2008/01/11/boston_moves_toward_trans_fats_ban/. (reporting on Boston's likely ban of trans fats in late 2008). The transformation to trans fat free may not as tedious as previous claimed. Id. When the ban had taken effect in Manhattan chain eateries, such as McDonald's and Starbucks, eliminated trans fats from the menus of all retail outlets, because “it made little economic sense to keep using the substance everywhere but New York.” Id. Many other purveyors of food have eliminated trans fats voluntarily due to consumer preference for healthier options. Id. As such, legislators were expecting to face the same resistance from restaurateurs they received during the smoking ban campaign. Id. However the trans fat bans have “faced little opposition.” Id.


or upheld decisions made by zoning officials applying such laws.\textsuperscript{66} Legislative action has also been taken in favor of fast food companies, however.\textsuperscript{67} In 2005, a bill was passed in the House (though it expired in the Senate) in response to a class action suit against McDonald's, wherein the plaintiffs alleged that McDonald's should be held liable for the plaintiffs' becoming obese.\textsuperscript{68} The bill was re-submitted in 2007.\textsuperscript{69} However, the Commonsense Consumption Act of 2007, as it is titled, is not intended to imply that overweight and obesity are not serious issues; rather, it was introduced because "fostering a culture of acceptance of personal responsibility is one of the most important ways to promote a healthier society."\textsuperscript{70}

Finally, the obesity epidemic received significant attention during the

\textsuperscript{66} Id. at 54 (discussing the outcomes of several court cases between fast food chains and cities). According to the report, however, the decisions were not made on the basis of reducing obesity per se, rather, to ensure pedestrian safety or to maintain neighborhood aesthetic, which the courts felt would be compromised if the restaurants—including chains to Wendy's, McDonald's, Burger King, Dunkin' Donuts, and Bess Eaton Donuts—were allowed to open chains or construct drive-through windows. Id. Summaries of the cases can be found on pages 55-63.


\textsuperscript{68} See cnn.com, ‘Cheeseburger Bill,’ supra note 67; see also Pelman v. McDonald's Corp., 237 F. Supp. 2d 512 (S.D.N.Y. 2003) (providing the opinion of the case against McDonald's). The plaintiff's alleged that McDonald's should be liable for plaintiff's obesity because McDonald's: 1) failed to disclose ingredients and health effects of eating McDonalds; 2) engaged in marketing techniques designed to induce children to eating McDonald's; 3) negligently sold food that is "high in cholesterol, fat, salt and sugar when studies show that such foods cause obesity"; 4) failed to warn consumers about the levels of cholesterol, fat, salt and sugar; and 5) negligently marketed foods "that were physically and psychologically addictive." Id. at 520. All claims were dismissed. Id. at 543. But see Pelman ex rel. Pelman v. McDonald's Corp., 452 F. Supp. 2d 320 (S.D.N.Y. 2006) (providing the opinion in a recent appeal of the original case). The United States District Court for the Southern District of New York has denied McDonald's motion to dismiss the plaintiff's second amended complaints. Id. at 327.

\textsuperscript{69} See generally Commonsense Consumption Act, supra note 67.

\textsuperscript{70} See Commonsense Consumption Act, supra note 67, at § 2 (discussing the rationale behind introducing the act).
Presidential primaries. Had she been elected, former Presidential candidate Hillary Clinton intended to institute a healthcare plan featuring a public, universal healthcare option similar to the healthcare systems in Canada and England. As Senator, Ms. Clinton is still actively trying to institute her goals of reducing healthcare costs while providing healthcare coverage to every American. The first element listed on her seven-step strategy to achieve that goal is to install a national prevention initiative to reduce the incidence of obesity and other diseases that generate financial costs.

With the health and financial consequences associated with overweight and obesity escalating, the federal and state governments must intervene by enacting legislation designed to combat these critical problems. While governments have initiated the legislative foundation to improve the obesity and overweight problems

71 See Hillary Clinton, Speech on Healthcare, supra note 5 (providing Clinton’s agenda to lower health care costs); see also Barack Obama’s website and John McCain’s website, supra note 5 (providing the candidates’ stance on healthcare).


74 See Press Release, Hillary Clinton, Hillary Clinton Announces Agenda to Lower Health Care Costs for All Americans, (May 24, 2007), available at http://www.hillaryclinton.com/news/release/view/?id=1787. The full seven-step strategy to reduce healthcare costs is as follows:

1. Install a Groundbreaking National Prevention Initiative to Reduce the Incidence of Obesity and Diseases Such as Diabetes and Cancer that Impose Huge Human and Financial Costs

2. Institute a New "Paperless" Health Information Technology System

3. Transform Care of Today’s Chronically Ill Population to Improve Outcomes

4. End Insurance Discrimination to Help Reduce Administrative Costs

5. Create an Independent "Best Practices" Institute to Empower Consumers, Providers and Health Plans to Make the Right Care Choices and Invest in Research for New Treatments

6. Implement Smart Purchasing Initiatives to Constrain Excess Prescription Drug and Managed Care Expenditures

7. Put in Place Common-Sense Medical Malpractice Reforms.

Id.

75 See generally infra sections II.A. through IV.A. (presenting the various consequences associated with the conditions overweight and obesity).
among school-aged children, legislative measures directed at reducing the prevalence of these problems within the adult population are needed.76

IV. Analysis: Piecemeal Legislative Approach Versus a Uniform Healthcare System

Many of the statutes addressing obesity are inadequate.77 Some merely create groups designed to address obesity, but do not provide any guidelines for these newly created commissions.78 Other resolutions have been limited to addressing only the morbidly obese.79 A research team at the University of Baltimore has been studying obesity, and its causes and effects since 2002.80 In 2006, the University’s research team released its third annual “report card” for each of the United States, grading each on its legislative achievements in “passing obesity control measures.”81 The team calculated grades by comparing the presence of eight different categories of legislation within each

76 See generally infra section III (recognizing the legislative measures taken to decrease the prevalence of obese and overweight children). See also infra section V. (outlining the need, and presenting recommendations on how to improve these problems among adults).
78 See generally H.R. 2423, 82d Leg., Reg. Sess. (Kan. 2007) (creating Kansas’s obesity task force). Kansas’s statutory scheme created a task force to “submit a report, including proposed legislation ... to the governor, the speaker of the house of representatives an the president of the senate” by November 1, 2008. Id. at (d). However, the statute gives the task force little direction. Id. at (b) (providing the primary duties of the task force). The only tasks they were asked to complete prior to presenting this report consisted of talking to students about the health risks associated with obesity, and soliciting suggestions from parents about what the community could do “to have access to affordable effective prevention and management services.” Id. See also H.R. Res. 548, 2007 Reg. Sess. (Ala. 2007) (creating Alabama’s obesity task force). Alabama’s task force was established solely for the purpose of determining “the feasibility of [funding] bariatric surgery in the morbidly obese ” and whether bariatric surgery is a less expensive treatment than the traditional methods of treatment. Id. The task force was commissioned to present a report to the Governor and Legislature in 2008, at which time the task force automatically dissolved. Id.
79 See sources cited supra note 77.
80 See http://www.ubalt.edu/experts/obesity/initiative.html (last visited Feb. 15, 2008) (explaining the University’s research efforts).
Each state received two grades: one grade for that state’s “efforts to control obesity” and another grade for its “efforts to control childhood overweight prevalence.” The latest 2006 report card shows only three states received an “A” for efforts to control obesity, while six states received “A” grades for their efforts to control the prevalence of childhood overweight. The “A” grades are improvements from the

82 Id. The eight types of legislation are:
1. Nutrition standards—controlling the types of foods and beverages offered during school hours
2. Vending machine usage—prohibiting types of foods and beverages sold in school and prohibiting access to vending machines at certain times
3. Body mass index measured in school
4. Recess and physical education—state-mandated additional recess and physical education time
5. Obesity programs and education—programs established as part of curriculum
6. Obesity research—legislative support for other institutions or groups to study obesity
7. Obesity treatment in health insurance—expanding health insurance to cover obesity treatment where applicable
8. Obesity commissions—legislature-established commissions designed to study obesity.

Id. To receive an “A” grade for a given category of legislation, a state had to successfully pass a law related to obesity. Id. Points were awarded for at least introducing legislation in a given category, and the overall grade was the composite of the points awarded for introducing and enacting legislation within the eight categories. Id.

83 See Obesity Report Card, at http://www.ubalt.edu/experts/obesity/ (click on “Obesity Report Card” under the 2006 UB Obesity Report Card heading on the left) (last visited Feb. 16, 2008) (providing the grades relative to each state’s efforts to control obesity); see also Childhood Obesity Report Card, at http://www.ubalt.edu/experts/obesity/ (click on “Childhood Obesity Report Card” under the 2006 UB Obesity Report Card heading on the left) (last visited Feb. 16, 2008) (providing the grades relative to each state’s efforts to control the prevalence of childhood overweight).

84 Compare Obesity Report Card, supra note 83 (last visited Feb. 16, 2008) (showing 2006 grades relative to each state’s efforts to control obesity) and Childhood Obesity Report Card, supra note 83 (last visited Feb. 16, 2008) (showing 2006 grades relative to each state’s efforts to control the prevalence of childhood overweight) with 2005 Obesity Report Card http://www.ubalt.edu/experts/obesity/ (scroll to the bottom of the page and click on the 2005 UB Obesity Report Card) (last visited Feb. 16, 2008) (showing 2005 grades relative to each state's efforts to control obesity) and http://www.ubalt.edu/experts/obesity/ (scroll to the bottom of the page and click
grades received in 2005. Nevertheless, seventy percent of the states received B or C grades in 2006. Idaho, Nevada, Utah, and Wyoming all received failing grades in at least one category, which means these states took no action whatsoever regarding obesity.

a. Trust for America's Health

In August 2007, Trust for America's Health (TFAH) released its fourth annual report on obesity in America, "F as in Fat: How Obesity Policies are Failing in America" [hereinafter F as in Fat]. Two sections of the report and an accompanying supplement address legislative actions taken by both the states and the federal government to address the obesity epidemic.

i. Trust for America's Health: Analysis of State Action

Section two of F as in Fat highlights four major categories of state-based legislative action to combat obesity. The report first discusses community based efforts among the states, such as the National Governors Association's (NGA) "Healthy States Grant," and "Healthy Kids, Healthy America" programs. A separate section

---

on the 2005 UB Childhood Obesity Card) (last visited Feb.) (showing 2005 grades relative to each state's efforts to control the prevalence of childhood overweight).

85 See sources cited supra notes 83-84.
86 See sources cited supra notes 83-84. Over three fourths of the states received B or C grades for their efforts control the prevalence of childhood overweight in 2006. Id.
87 See sources cited supra note 84. Utah and Wyoming received Fs for both grades; Idaho received an F only for the "state efforts to control obesity," and Nevada received an F only for the "state efforts to control the prevalence of childhood obesity." Id. The other grades Idaho and Nevada were Ds. Id.
89 Id.; see also TRUST FOR AMERICA'S HEALTH, SUPPLEMENT TO "F AS IN FAT: HOW OBESITY POLICIES ARE FAILING IN AMERICA, 2007" OBESITY-RELATED LEGISLATION ACTION IN STATES, UPDATE , available at http://healthyamericans.org/reports/obesity2007/Supplement2007.pdf [hereinafter F AS IN FAT] (providing a detailed analysis of the legislative actions taken by each state to combat obesity).
90 See F AS IN FAT, supra note 88, at 17-39.
91 See F AS IN FAT, supra note 88, at 17-20; see also the National Governors Association (NGA), http://www.nga.org/portal/site/nga/menuitem.cdd492ad7dd9cf9e8ebb856a11010a0/ (last visited Feb. 20, 2008) (describing the NGA). According to its website, the NGA "provides
discusses “community-focused legislation and federal grants to states.” Also highlighted is the “school-focused obesity legislation.” Finally, the section discusses state based healthcare benefits related to obesity.

ii. Trust for America's Health: Analysis of Federal Action

Section three of the report highlights the federal legislative actions pursued in the last year to combat obesity. The report notes that federal actions include the reauthorizations of “The Farm Bill,” “No Child Left Behind [Act],” and “The State Children's Health Insurance Program Act.” Also addressed in section three are the governors and their senior staff members with services that range from representing states on Capitol Hill...to developing policy reports on innovative state programs...” Id. The Healthy States Grant Program provides thirteen states with $100,000 in funding for community based programs addressing weight issues; participating states include Colorado, Connecticut, Georgia, Iowa, Maine, Michigan, Minnesota, Nebraska, Oklahoma, South Dakota, Utah, Washington, and Wisconsin. F AS IN FAT, supra note 88, at 18-19. Only one out of the four states to receive an “F” grade by the University of Baltimore is on this list. See Obesity Report Card, supra note 83 (last visited Feb. 16, 2008) (providing grades for each state based on their efforts to control obesity); see also Childhood Obesity Report Card, supra note 83 (last visited Feb. 16, 2008) (providing grades for each state based on their efforts to control childhood overweight prevalence). As part of the Healthy Kids, Healthy America Program, the NGA is giving $110,000 to ten states “with programs focusing on preventing childhood obesity through policy and environmental change in the future.” F AS IN FAT, supra note 88, at 17. F AS IN FAT, supra note 88, at 34-36 (discussing the recent community and state based legislation). The community focused legislation discussed includes the states limits on litigation of obesity. Id. at 36. See also Cheeseburger Bill, supra note 67 (detailing the structure of states' restrictions on obesity related litigation). The CDC has also sponsored state implementation of efforts to reduce obesity with grants to states for nutrition and physical activity programs. F AS IN FAT, supra note 88, at 36 (discussing the state based legislation). However, only twenty eight states are receiving grants. Id. The states which received Fs from University of Baltimore were not among the twenty eight states. Id. See also supra note 87 (discussing which states received Fs from University of Baltimore).

F AS IN FAT, supra note 88, at 20-34 (discussing the recent school based legislation). The school focused legislation has been focused toward “improving the quality of food sold in schools, limiting sales of less nutritious foods, improving physical education and health education, and encouraging increased physical activity either within the school day or through extracurricular [activities].” Id. at 20. However, school districts generally have the authority to set school nutrition policies, so while a state legislation can set guidelines or create incentives, a school district can choose to ignore them. Id.

F AS IN FAT, supra note 88, at 37-39 (noting over “40 states offer Medicaid reimbursement for weigh-loss surgeries;” seventeen offer it for weight-loss drugs).

F AS IN FAT, supra note 88, at 41-49 (listing government agencies involved in the campaign against obesity, and specific legislative measures taken recently).

F AS IN FAT, supra note 88, at 44-47 (discussing the three acts). The Farm Bill proposes to
federal efforts toward “funding for CDC obesity grants,” and “accelerating research on effective obesity reduction and control.”

These two sections of the report indicate that a significant, multifaceted campaign has emerged to address the obesity epidemic. However, the report makes clear that, notwithstanding legislative action, obesity rates have continued to rise throughout the United States. This trend persists despite the increasing attempts at intervention by the governments at both the state and federal levels. Nevertheless, increased, synchronized and comprehensive government intervention may be a solution. In its report, by way of example, TFAH refers to the government-wide National Strategy for Pandemic Influenza Preparedness, praising the government’s “comprehensive approach” to and preparedness for a flu outbreak. With regard to

“...increase mandatory funding for the purchase of fruits and vegetables for nutrition programs...” the costs of which “have increased 40 percent since 1985.” Id. at 44. The No Child Left Behind Act, if reauthorized could “influence how physical education and physical activity are included within school. Id. at 47. The State Children’s Health Insurance Program (SCHIP) was up for reauthorization. Id. SCHIP “could take steps to further address the childhood obesity crisis by including a health insurance style benefit for obesity-related services to children enrolled in the program.” Id. But see abcnews.com, Kevin Freking, House Fails to Reverse Child Health Veto, http://www.abcnews.go.com/Politics/wireStory?id=3746450 (last visited Feb. 22, 2008) (reporting that the House failed to override the President’s vetoing the proposal to expand SCHIP).

97 See F AS IN FAT, supra note 88, at 48, 49 (discussing the current status on funding to CDC grants and research efforts to reduce obesity). The Bush Administration is cutting the budgets to the following CDC programs that address obesity in one way or another: Division of Nutrition, Physical Activity, and Obesity (DNPAO); Division of Adolescent School Health (DASH); and Steps to a Healthier U.S. Id. However, the Administration is funding the newly created Adolescent Health Promotion Initiative (AHPI) with $17.3 million in funding. Id. at 48. The report notes that while “there is a lot of scientific evidence about the benefits of nutrition and physical activity,” there is a need for research to help identify “long term, community-based strategies for obesity prevention.” Id. at 49.

98 See F AS IN FAT, supra note 88, at 17-50. For a thorough examination of each state’s approach to combating obesity, see generally F AS IN FAT SUPPLEMENT, supra note 89 (providing a state by state breakdown of legislation taken in response to the obesity epidemic).

99 F AS IN FAT, supra note 88, at 91 (proposing recommendations to combat the increase in the prevalence of obesity). The report advances the possibility that, despite the legislative measures taken, the obesity epidemic may be getting worse rather than better. Id.

100 See generally F AS IN FAT, supra note 88 (discussing the trends in obesity and the various legislative intervention on obesity).

101 F AS IN FAT, supra note 88, at 93 (providing a recommendation for improving governmental intervention on the obesity epidemic).

102 F AS IN FAT, supra note 88, at 41, 93. Government action regarding “The National Strategy for Pandemic Influenza” was marked with “comprehensive government-wide responsibilities,
the obesity problem, TFAH asserts that it is severe and warrants a government approach
to the Pandemic Influenza Preparedness strategy.103

The shortcomings that arise from the ad hoc patchwork of existing legislative
approaches, with states vying for places in federally funded programs, the federal
government regulating Medicaid and Medicare obesity treatments, and states regulating
restaurants through zoning ordinances, suggest that a cohesive approach under a
universal healthcare system might be more successful.104

b. The Obesity Epidemic: Analysis Under Canada’s Universal
Healthcare System

Many countries provide some form of a universal healthcare system.105 One
advantage to a universal healthcare system is that it usually reduces administration
costs.106 Physicians for a National Health Program (PNHP) is a nationwide network of
physicians who advocate for a single-payer system.107 PNHP contends that healthcare is
so expensive in America because it is a “patchwork system,” comprised of a multitude
of competing private insurers that end up spending an estimated thirty one percent of
health costs in administration fees.108 Centralized administration, a fundamental feature

clear timelines, and detailed action items.” Id. TFAH proposes that a similarly designed effort by
government, state and federal, against obesity would be successful. Id.

103 See F AS IN FAT, supra note 88, at 93.
104 See supra notes 58-66 and accompanying text (discussing the legislative history regarding
obesity); see also Hillary Clinton’s website, supra note 5 (explaining how Senator Clinton’s
healthcare plan could reduce obesity levels to those of the 1980’s).
describing England’s publicly funded healthcare system, National Health Service (“NHS”);
Canada’s Health Care System, at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html (last
visited Oct. 15, 2008) (describing Canada’s healthcare system, referred to as “Medicare”);
(click on “Topics,” click “health,” and select “Health Insurance” then click on “Organization and
106 See Clinton, Health Plan, supra note 72, at 4 (detailing the advantages of Senator Clinton’s
particular universal healthcare plan). “In a reformed system where all Americans are covered and
risk is spread extensively, administrative costs could be dramatically reduced.” Id.
what PNHP is about); see also http://www.pnhp.org/facts/single_payer_resources.php
(summarizing PNHP’s definition of a “single-payer system”). “Single-payer national health
insurance is a system in which a single public or quasi-public agency organizes health financing,
but delivery of care remains largely private.” Id.
108 See http://www.pnhp.org/about/about_pnhp.php, supra note 107 (explaining the deficiencies
of the private healthcare system currently in place in the U.S.).
of a universal healthcare system, would arguably accomplish the same goals as the current ad-hoc approach to the obesity problem, but with significantly less spending.\textsuperscript{109} Canada, for example, provides its residents with a form of uniform healthcare through a system known as “Medicare.”\textsuperscript{110}

The trends in the prevalence of overweight and obesity in Canada, between 1996 and 2005 suggest the possibility that full government regulation of health via a publicly funded universal healthcare system effectuates lower prevalence of overweight and obesity among most age groups and in both genders.\textsuperscript{111} The National Population Health Survey (NPHS) conducted a ten-year longitudinal survey that commenced in 1994 and in which over 17,000 individuals from ten provinces were surveyed bi-annually with regards to their physical and mental health.\textsuperscript{112} According to the report, published in

\begin{footnotesize}
\begin{enumerate}
\item See generally Clinton, Health Plan, supra note 72 (detailing Senator Clinton’s particular universal healthcare plan); see also Stephanie Woolhandler & David U. Himmelstein, \textit{Liberal Benefits, Conservative Spending}, ONCOLOGY ISSUES, Nov. / Dec. 2002, at 20, 22, available at http://www.commondreams.org/views02/0525-06.htm (asserting the need for a national healthcare plan in America).
\item See http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index_e.html (last visited Feb. 17, 2008) (describing Canada’s healthcare system, referred to as “Medicare”). Medicare is not actually one, universal provider, but rather “a national program that is composed of [thirteen] interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage.” \textit{Id.} Medicare is the product of the “Canada Health Act” which established five basic principles to which each of the individual provinces must adhere, ensuring that coverage fits one national standard. \textit{See} http://www.hc-sc.gc.ca/hcs-sss/index_e.html (last visited Feb. 17, 2008) (describing “Medicare”). The publicly funded system actually consists of the federal government, ten provinces and three territories, and was product of the “Canada Health Act” (CHA). \textit{Id.} \textit{See also} http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/overviewapercu_e.html (last visited Feb. 17, 2008) (detailing the history of the Canada Health Act). Enacted around 1984, the purpose of the CHA was “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” \textit{Id.} \textit{See also} http://www.hc-sc.gc.ca/hcs-sss/pubs/system-regime/2005-hcs-sss/role_e.html (last visited Feb. 17, 2008) (discussing the five standards the individual provinces / territories must adhere to). Per the CHA, the healthcare plans in each of the provinces / territories must be:

\begin{quote}
\begin{enumerate}
\item available to all eligible residents of Canada;
\item comprehensive in coverage;
\item accessible without financial and other barriers;
\item portable within the country and during travel abroad; and
\item publicly administered.
\end{enumerate}
\end{quote}
\textit{Id.} The receipt by the provinces of federal funding is dependent upon adherence to these standards. \textit{Id.}

\item See generally \textit{ORPANA}, supra note 109 (giving an analysis on the trend in prevalence of overweight and obesity in Canada).
\item See \textit{ORPANA}, supra note 109, at 7 (discussing the survey conducted on a cross-section of
\end{enumerate}
\end{footnotesize}
2006, while both Canadian men and woman gained weight every two years, the rate of weight gain slowed as the survey progressed. In other words, “[o]verall, Canadian adults were still gaining weight,” but by the survey’s end, it was “significantly less than in the earlier periods [of the survey.]” Moreover, by the end of the survey period the percentage of both men and women who experienced weight loss had increased. One flaw in the survey, however, is that it does not indicate whether these statistics were attributable to Canada’s healthcare system.

The Canadian Community Health Survey conducted in 2004 reveals that twenty three percent of Canadian adults are obese. According to that survey, twenty one percent of Canadians between the ages of twenty five and thirty four and, twenty four percent of Canadians aged seventy five or older, are obese. While these percentages doubled from the previous survey conducted in 1978-1979, both percentages are dwarfed by the thirty-plus percent of American adults over the age of twenty estimated to be obese as of 2003-2004. Canadian adults). The survey started in 1994/1995, and weight changes were measured and recorded every two years. Id. Therefore, the first weight changes were recorded in 1996/1997. Id. A longitudinal survey features the repeated observation and notation of a variety of subjects and with multiple variables. Id. The NPHS was longitudinal because the subjects included both male and females and different age ranges for each sex, and were from a diverse geographical set; additionally, the subjects were observed biannually over the course of an eight year period. Id. at 7, 10. See http://www.merriam-webster.com/dictionary/longitudinal (last visited Feb. 17, 2008) (defining longitudinal).

ORPANA, supra note 109, at 8 (discussing survey results). At approximately half of the surveyed men and women, weight gain was the most prominent change in weight in any given two-year period. Id. Only twenty-two percent of those surveyed kept a stable weight. Id. ORPANA, supra note 109, at 10 (analyzing the survey results).

ORPANA, supra note 109, at 17.

ORPANA, supra note 109, at 11 (noting a deficiency within the survey). While the survey data “describe the pattern of weight change among Canadian adults from 1996/1997 to 2004/2005, [it does] not explain it” (emphasis in original). Id.


Id. Additionally, 9 percent of Canadian adolescents aged twelve to seventeen were obese, and another 20 percent were overweight. Id.

The Canadian government has taken additional action in response to its concern for the prevalence of childhood obesity. The "Children's Fitness Tax Credit" (CFTC) was introduced and was effective as of the 2007 tax year. While these percentages doubled from the previous survey conducted in 1978-1979, both percentages are dwarfed by the thirty-plus percent of American adults over the age of twenty estimated to be obese as of 2003-2004.

The Canadian government has taken additional action in response to its concern for the prevalence of childhood obesity. The "Children's Fitness Tax Credit" (CFTC) was introduced and was effective as of the 2007 tax year. The CFTC allows Canadian families to claim a $500 tax credit in "eligible fitness expenses" for each child under the age of eighteen.

every three adults in Canada are overweight or obese." Id. This would imply that more than 66 percent of Canadian adults are overweight or obese, whereas only 60 percent of American adults are overweight or obese. See supra note 13 (indicating 65.2 percent of Americans are overweight).


See supra note 39 and accompanying text (discussing U.S. obesity prevalence). See C. Laird Birmingham et al., The Cost of Obesity in Canada, 160 CAN MED. ASS'N J. 483, 484 (Feb. 23, 1999) (defining obesity). As late as 1999, the National Population Health Survey defined "obesity" as a BMI of 27 or greater, rather than 30 or greater. Id. The lower number would obviously result in higher rates of obesity prevalence than the modern method of calculating obesity prevalence. Id. See also Obesity, IT'S YOUR HEALTH (Health Can. & Pub. Health Agency, Can.), Oct. 2006, at 1, available at http://www.hc-sc.gc.ca/hl-vs/alt_formats/pacrbdgaptc/pdf/iyh-vs/vie/life-vie/obes-eng.pdf. (providing obesity statistics for Canada). "Statistics Canada reports that two out of every three adults in Canada are overweight or obese." Id. This would imply that more than 66 percent of Canadian adults are overweight or obese, whereas only 60 percent of American adults are overweight or obese. See supra note 13 (indicating 65.2 percent of Americans are overweight).


See http://www.cra-arc.gc.ca/whtsnw/fitness-eng.html (last visited Sept. 28, 2008) (describing for parents how CFTC works). Parents may be eligible to claim an additional $500 for children who also qualify for Canada's disability tax benefit program. Id. "Eligible fitness expenses" is defined by Canada's Revenue Agency as:

[T]he cost of registration or membership of an eligible child in a prescribed program of physical activity. Generally, such a program must:
In its 2006 report, the Expert Panel for Children's Fitness Tax Credit acknowledged that the prevalence of childhood obesity in Canada was among the highest of developed countries.\(^{126}\) Despite its Medicare system, Canada considers obesity to be an increasing problem of national scale which requires legislative attention.\(^{127}\) This brief study of Canadian data does not definitively support, nor does it undermine the theory that a universal health care plan more efficiently or adequately addresses an obesity epidemic; however, there is still evidence that a universal system like Medicare is generally more efficient.\(^{128}\)

c. The Obesity Epidemic: Possible Outlook for America without Universal Healthcare

If the U.S. continues to operate on a form of the current privatized healthcare system, certain trends are likely to result.\(^{129}\) One of the dramatic changes which might occur is the overwhelming shift by corporations from utilizing third party insurances companies to self-insuring.\(^{130}\) Self-insuring, particularly for larger corporations, saves

---

[1] be ongoing (either a minimum of eight consecutive weeks long or, for children’s camps, five consecutive days long);

[2] be suitable for children; and

[3] include a significant amount of physical activity that contributes to cardiorespiratory endurance, plus one or more of: muscular strength, muscular endurance, flexibility, or balance.

Id.

\(^{126}\) See DEPT. OF FINANCE CANADA, REPORT, supra note 123 (explaining the rationale behind CFTC).

\(^{127}\) See generally DEPT. OF FINANCE CANADA, REPORT, supra note 123 (explaining the obesity epidemic in Canada); Healthy Canadians, Your Source for a Healthier Lifestyle, http://www.healthycanadians.gc.ca/index_e.html (last visited Sept. 28, 2008) (providing access to all health related links for Canadians). The site is sponsored by the Canadian government. Id. See also Healthy Canadians: Our Campaigns, http://www.healthycanadians.gc.ca/camp_e.html (last visited Sept. 28, 2008) (listing Canada’s current health campaigns). Two of the three current campaigns are directly related to obesity. Id.

\(^{128}\) See supra notes 105-126 and accompanying text (analyzing potential benefits of universal healthcare system and acknowledging limitations of the Canadian study).

\(^{129}\) See infra notes 129-136 and accompanying text (introducing likely trends if privatized healthcare continues).

money and allows the corporations to avoid state regulation of the health benefits package.131 Self-insuring allows a corporation to “design [its] own uniform health plan.”132 However, as the costs associated with obesity rise, employers could end up allocating the burden to employees covered under the custom-made health plan.133 Alternatively, one theory suggests that those costs will not be allocated to workers because while obese workers cost employers more, the employers pass the losses onto the government.134 In fact, there is reason to believe that encouraging employees to seek certain treatments for obesity may cost the employer more than if the employee

---

employer puts money directly into a plan, which then pays for the covered benefits when claims are incurred rather than paying premiums to insurance companies.” Id. See also Alain Enthoven, Connecting Consumer Choice to the Health Care System, 39 J. HEALTH L. 289, 304 (Summer 2006) (demonstrating rate at which employers are self-insuring). “From 2000 to 2004, as premiums rose 59%, the number of individuals with employment-based coverage fell by 3.6 million and Medicaid/SCHIP enrollment rose by 8 million.” Id.

131 See Park, supra note 130, at 340. “The Employer Retirement Income Security Act (ERISA) . . . regulates employer-based . . . health plans.” Id. at 341. ERISA supersedes state law, and “exempts self-insured plans from providing state-mandated benefits and from paying state premium taxes. . . .” Id.

132 See Park, supra note 130 at 341.

133 See Enthoven, supra note 130 at 290 (alluding to higher insurance costs associated with an increase in National Health Expenditures).

134 See Herper, supra note 6 (qualifying the financial burden obese employees have on employers). The average employee only works at a given company for an average of 4.5 years, which is not necessarily sufficient time for health problems and financial consequences associated with obesity to develop. Id. While obese people generally cost more money, with regard to young obese people in particular “[they] really don't cost much at all. Why should an employer invest in obesity prevention to save Medicare money?” Id. See also Eric A. Finkelstein & Derek S. Brown, Why Does the Private Sector Underinvest in Obesity Prevention and Treatment?, 67 N.C. MED. J. 310, 311 (July/Aug. 2006), available at http://www.ncmedicaljournal.com/jul-aug-06/Finkelstein.pdf. Finkelstein & Brown give three reasons why corporations have not taken steps to combat obesity in employees:

Employers do not have incentive to indulge in the expenditure of funds for three reasons: 1) younger obese employees have not yet developed the “costly complications” associated with being obese; 2) the existence of a tendency for employees to stay employed with a company for only 4-5 years, meaning the employee will probably leave the employer before it incurs expenses from the “costly complications” associated with obesity are incurred; and 3) the existence of Medicare, which “assumes responsibility for primary health insurance coverage for most Americans once they reach age 65,” again, before the employer has incurred the “costly complications” associated with obesity.

Id. at 311.
remained obese. On the other hand, if the costs are allocated to the employees, the costs would presumably be allocated among all employees, not just obese ones. This scenario presumes that health insurance coverage is issued on an equality basis; however, it raises a frightening corollary: where coverage is uniform regardless of weight, employees have little incentive to lose weight or to keep from becoming obese. Still, a more drastic measure employers may take is to avoid hiring obese or overweight people altogether.

To deter the possibility of these corporate actions, the government would likely need to respond legislatively. To this point, legislative responses to the problem of obesity range from what some critics consider the unnecessary, such as attempting to ban Fluffernutter® sandwiches at school, to the controversial, for example, levying a tax specifically on “junk foods.” Much of this current reactive legislation focuses on

135 See Finkelstein, supra note 134 at 311. For example, because young obese employees do not really cost employers any additional amount, an employer would only lose money by paying for health benefits that cover a procedure such as bariatric surgery. Id.

136 See Douglass Farnsworth, Final Wellness Program Regulations Offer One Piece in the Health Care Cost Puzzle, 3 ABA HEALTH ESOURCE, June 2007, http://www.abanet.org/health/esource/Volume3/10/farnsworth.html (discussing HIPAA rights). Because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), an employer cannot engage in the discrimination of employees on the basis of “certain health factors.” Id. For example, a company plan cannot “require employees to stop smoking or face exclusion from the plan, or charge greater premiums to employees with a body mass index over 25.” Id. Therefore, in the event that an employer does shift the financial burden of obesity onto the employees, all employees, whether they are obese or not, would appear to share the burden equally in terms of cost of coverage. Id.

137 See id.

138 See Carmichael, supra note 7 (reporting on the discrimination of obese employees). “In one study, 26 percent of the overweight [and 85 percent of the very obese] reported being stigmatized and say there were passed over for promotions solely because of their size.” Id. People from “factory workers to mail carriers [have been] refused jobs because of their weight.” Id. “Some bosses pressure their workers to lose weight, then dismiss them when they fail.” Id.

139 See id. (discussing Massachusetts bill under consideration wherein weight discrimination would be banned).

140 See McKenna, supra note 4 (discussing one Senator’s attempt to ban Fluff®; see also F AS IN FAT, supra note 88, at 35 (discussing the “Snack Taxes”):

Seventeen states and D.C. currently have laws that tax foods of low nutritional value: Arkansas, California, D.C., Illinois, Indiana, Kentucky, Maine, Minnesota, Missouri, New Jersey, New York, North Dakota, Rhode Island, Tennessee, Texas, Virginia, Washington, and West Virginia. These taxes are very controversial. Proponents . . . argue that a tax on junk food could be used to fund a healthy eating and nutritional information campaign. Opponents argue
reducing childhood obesity and overweight.\textsuperscript{141} The rationale for directing legislation at childhood overweight and obesity is that this will trigger a trend where healthy lifestyles become habit at an early age, and carry over into adulthood.\textsuperscript{142} However, such legislation insufficiently addresses the obesity epidemic one third of American adults currently face, and does not accommodate those children who, despite such early intervention, become obese from physiological causes or medical conditions.\textsuperscript{143} This raises the question of what the most effective method for addressing the obesity epidemic occurring within American adults is, and whether it is being utilized efficiently.\textsuperscript{144}

V. Legislative Response: How the U.S. Government Should Address Adult Obesity

There is no known “cure all” approach that would effectively eliminate obesity.\textsuperscript{145} With the availability of inexpensive, calorie-dense foods increasing and that junk food taxes are . . . unlikely to encourage people to substitute healthier foods for junk food.

\textit{Id.}

\textsuperscript{141} See \textit{HANDBOOK, supra} note 1, at 37 (noting importance of early education in battle against obesity). “Educating youth about overweight at an early age, before they reach adulthood, will ultimately aid in the fight against obesity.” \textit{Id.} See also \textit{F AS IN FAT, supra} note 88, at 20 (noting benefit of state legislation in the form of school-based programs).

\textsuperscript{142} See Paul J. Veugelers & Angela L. Fitzgerald, \textit{Effectiveness of School Programs in Preventing Childhood Obesity: A Multilevel Comparison}, 95 AM. J. PUB. HEALTH 432, 434 (2005), available at http://www.ajph.org/cgi/reprint/95/3/432 (discussing the benefits of school programs focused on health education). “School-based healthy eating and physical activity programs provide a great opportunity to enhance the future health and well-being of children because they can reach almost all children and . . . help to establish healthy behaviors at an early age that will lead to lifelong healthy habits.” \textit{Id.}

\textsuperscript{143} See generally \textit{F AS IN FAT, supra} note 88, at 20-36 (summarizing vast legislation that addresses obesity epidemic within younger generations). Legislation managing the standards of school lunches, vending machine options for both snacks and drinks, and the level and amount of education to be taught in schools will not affect the prevalence of obesity of those who are already adults \textit{Id.}

\textsuperscript{144} See \textit{F AS IN FAT, supra} note 88, at 91 (making a claim as to the proper way to address obesity epidemic). The report calls for an approach that moves away from “dieting” and argues that there must be a “cultural emphasis…toward promoting healthy eating and physical activity.” \textit{Id.} See also Veugelers & Fitzgerald, \textit{supra} note 142, at 434 (discussing limits of studies showing school programs positively affecting childhood obesity). “[B]ecause only a limited number of studies have been conducted, and results have varied, the effectiveness of [school] programs is not well established.” \textit{Id.}

\textsuperscript{145} See \textit{supra} notes 101-102 (examining the proposal that government should treat obesity like an
technological advances allowing Americans to accomplish an ever increasing number of
tasks while exerting less energy, totally eliminating obesity is not a feasible

1 goal. To adequately manage the prevalence of obesity and overweight within the American adult
contingent, given the number of hours the average American works the manner in
which obesity and overweight are addressed in the employment setting will need to
change through improvements of employer “wellness programs,” and legislation.147

a. Workplace Wellness Programs:148 A Method to Combat Obesity

A Workplace Wellness Program (WWP) is the collective of programs, events,
benefits and promotions an employer offers its employees to promote health.149 A
comp any's WWP usually extends beyond basic health insurance to include such benefits

a. Workplace Wellness Programs:148 A Method to Combat Obesity

A Workplace Wellness Program (WWP) is the collective of programs, events,
benefits and promotions an employer offers its employees to promote health.149 A
comp any's WWP usually extends beyond basic health insurance to include such benefits

146 See Finkelstein & Brown, supra note 134, at 312 (explaining difficulty for the modern American
in keeping a healthy weight).

147 See F AS IN FAT, supra note 88, at 94 (explaining that employers need to team with government
entities to fight obesity). “Federal, state, and local governments need to work with private
employers and insurers to ensure that every working American has access to a workplace wellness
program.” Id.

148 Workplace Wellness Programs (WWPs) are employer based programs that “consist of a
combination of activities designed to increase awareness, assess risks, educate and promote
voluntary behavior change to improve the health of a group, modify their consumer health
behavior, enhance their personal well-being and productivity, and prevent illness and injury.” See
WASH. STATE DEPT. OF HEALTH, WASHINGTON STATE WELLNESS GUIDELINES FOR
here/howto/images/wellnessguidelines.pdf (defining a “wellness program”).

149 Id.
as gym membership discounts, on-site yoga classes and smoking cessation courses. Some companies utilize more unique incentives to promote employee health, such as creating walking paths around work campuses, building on-site gym facilities, and affixing signs throughout the building advising employees to use stairs instead of elevators when possible.

According to the U.S. Department of Health and Human Services’ program Healthy People 2010, companies are motivated to provide WWPs in order to improve or maintain employee morale, and ultimately, increase productivity.

b. Work Wellness Programs: Improvement and Expansion through Legislation

Data compiled in Healthy People 2010’s workforce companion, Healthy

---

150 See Farnsworth, supra note 136 (describing wellness programs and legislation associated with them). “The most successful wellness plans integrate a variety of elements, including nutritional counseling, [health] screenings, use of health data to target high-cost diseases, and incentives to motivate physical activity.” Id. See also Krisi Ceccarossi, Stretching Benefits: Companies Offer Yoga as Perk, Carb on Health Costs, THE BOSTON GLOBE, Jan. 26, 2008, at E10, 11, available at http://www.boston.com/business/articles/2008/01/26/stretching_benefits/ (explaining some historical elements of WWPs). “Generally they included discounted gym memberships, diet groups, or smoking-cessation courses.” Id. “[I]n recent years, many Massachusetts companies . . . have incorporated yoga into the workweek.” Id. at E11 (reporting on the inclusion of lunch-hour yoga sessions in Abt Associates’ program).

151 See F AS IN FAT, supra note 88, at 77 (describing health promotion tactics utilized by Dow Chemical and Nordam Group); see also Nike: Other Benefits, http://www.nikebiz.com/careers/benefits/other/work_life_balance.html (last visited Sept. 28, 2008) (explaining Nike’s dedication to employee fitness by offering on-site gyms).


Healthy People 2010 is a set of national health objectives, with 10-year targets. The overall goals of Healthy People 2010 are to: 1) increase quality and years of healthy life and 2) eliminate health disparities. The [Healthy People 2010 report] contains 467 objectives organized into 28 focus areas. In addition, 10 Leading Health Indicators have been identified—including physical activity, tobacco use, and overweight and obesity—to help motivate national action around major public health concerns.

See HEALTHY WORKFORCE 2010 (explaining what Healthy People 2010 is).
Workforce 2010, reveal distinct benefits of wellness programs to employers, including the improvement of productivity of their workforce, lowering the employer’s healthcare costs, and enhancing the employer’s corporate image within the public. WWPs are particularly important because most American adults spend at least half of their waking hours at worksites, which in turn “have a powerful impact on individuals’ health.”

Despite implementation of WWPs by some corporations, the prevalence of obesity has increased steadily through 2004 and may still continue to increase, even if at a reduced rate. Lack of motivation on the part of employers to establish or maintain WWPs could account for continued increase in the prevalence of obesity in adults. Additionally, smaller companies may be under the impression that only large corporations would see financial savings by maintaining WWPs. In point of fact, most of the evidence showing the financial benefit to employers of implementing WWPs has come from the study of larger corporations. However, according to Healthy Workforce 2010, it is not only large companies that could benefit from

153 See HEALTHY WORKFORCE 2010, supra note 152, at 3-9 (explaining benefits to employers who institute WWPs). Increased productivity is achieved through the “reduction of employee health risks,” “reduced absenteeism,” and “job satisfaction and employee morale,” all of which positively affect employer bottom line. Id. at 5. See also F AS IN FAT, supra note 88, at 76 (explaining how employers benefit from WWPs). The “Return on Investment (ROI) for large corporate health management programs . . . range[s] from $1.49 to $4.91 per dollar spent, with a median of $3.14).” Id.

154 See HEALTHY WORKFORCE 2010, supra note 152, at 2.

155 See supra notes 39-40 and accompanying text (explaining the rise in obesity through the year 2006).

156 See supra notes 134-135 and accompanying text (explaining why companies would not be motivated to address obesity in the workplace). The costs associated with obese employees commence when the employee is older. Id. If an employer does have an older, obese employee, studies indicate that the employee will be leaving his or her job in 4-5 years anyway. Id. Finally, if an older, obese employee does not leave the job, this “financial worst case scenario for the employer” is further mitigated by Medicare covering health benefits once employees reach age 65. Id. There do not appear to be sufficient circumstances where an obese employee would be costing an employer so much more that the employer is motivated to address the obesity. Id.

157 See HEALTHY WORKFORCE 2010, supra note 152, at 1 (explaining that smaller companies do not feel that they can afford sufficient “health promotion activities”). But see F AS IN FAT, supra note 88, at 76 (noting studies that suggest benefits occur over long periods and in companies with low turnover). This begs the question, however; where employee morale is increased by dint of employer investment in employee wellness, turnover of employees may well decrease. See supra note 148-152 and accompanying text (outlining the benefits WWPs create).

158 HEALTHY WORKFORCE 2010, supra note 152, at 5 (indicating that the evidence that WWP’s benefit corporations was gleaned from study of larger corporations).
implementing WWPs.159

Existing Work Wellness Programs have not adequately reduced the prevalence of obesity in employees because they are missing a critical element: an employee right to participate in wellness programs during the workday.160 The results of a groundbreaking survey conducted on behalf of Steelcase Inc. reveal that employees do not feel able to participate in WWPs, such as engaging in physical activity, during the work day.161 The lack of the opportunity to exercise during the workday is the major vulnerability of WWPs, and has hampered their effectiveness in reducing the prevalence of obesity among working adults.162 The average employed American works approximately 9.3 hours per-day-worked (about thirty-eight percent of the day), including time for commuting.163 Another 7.6 (about thirty-one percent) hours are spent sleeping.164 Over two-thirds of the average working American’s day is accounted for without taking into consideration time needed to raise children, prepare and eat meals, and address personal needs.165 The average American is left with just over seven hours to attend to all of

159 See HEALTHY WORKFORCE 2010, supra note 152, at 5.
160 See Kiplinger.com: PR Newswire News Releases: Exercise and Work Productivity Go Hand-in-Hand According to Steelcase Workplace Index Survey, Oct. 15, 2007, http://markets.kiplinger.com/kiplinger?GUID=3592651&Page=MEDIAVIEWER [hereinafter Steelcase Survey] (last visited Oct. 13, 2008) (reporting results of a survey conducted on 700 American workers). The survey was conducted of workers in the U.S., though not necessarily Steelcase Inc. employees. Id. The survey “examined the importance of fitness in the workplace, the role companies play in encouraging employee fitness, and the impact that fitness has on productivity levels overall.” Id. Steelcase Inc. provides work environments (i.e., office cubes, etc.) for other companies, and employs nearly 14,000 people. Id. See HEALTHY WORKFORCE 2010, supra note 152, at 5 (mentioning Steelcase Inc.). Steelcase is “considered one of the 100 best places to work by Fortune Magazine.” Id.
161 See Steelcase Survey, supra note 160. For the purposes of this section, physical activity (“exercise”) will be the only wellness program addressed. Sixty nine percent of the surveyed workers acknowledged they do not exercise during the work day. Id. Of that 69 percent, 62 percent cited lack of an “appropriate place to do so,” and another 19 percent explained that “it is frowned upon in the workplace.” Id. Another 14 percent said that they did not have enough energy to exercise during the day, but, 85 percent of respondents indicated that exercise actually gives them energy to stay awake during the day. Id. In other words, if the fourteen percent of people actually exercised during the workday, they probably would not lack the energy to exercise. Id.
162 See Steelcase Survey, supra note 160.
164 Id.
165 See generally id. Personal activities include cleaning, mowing the lawn, paying bills, going to the bathroom. Id.
these needs and, if desired, exercise. However he or she must also negotiate the restrictions on when everything else can be executed during the day; for example, he or she would logically prepare dinner after 5:00 p.m., and he or she can only go to a gym during its business hours. According to the Steelcase Inc. study, "[seventy-eight] percent of workers say that exercise . . . would have a positive impact on their overall productivity at work." However with more than eighty percent indicating that such exercise cannot be done during work hours, the difficulty of scheduling exercise within the rest of a working adult’s schedule becomes a graver issue.

Both the Healthy Workforce 2010 and F as in Fat reports are calls to action to employers both large and small, nationwide, to participate in the campaign against the prevalence of adult overweight and obesity. F as in Fat does acknowledge that government intervention is needed to accomplish this goal. Tax credits can be issued to companies that establish eligible WWPs. Laws can be passed making job

---

166 Id.
168 See Steelcase Survey, supra note 160 (reporting the results of a survey conducted on 700 American workers).
169 See Steelcase Survey, supra note 160. Sixty two percent of workers indicated exercise was not possible during working hours because there were not adequate facilities; another nineteen percent replied that exercise during work hours is actually frowned upon. Id. See also Finkelstein & Brown, supra note 134 (giving three reasons why corporations might not invest in WWPs). The problem of employees finding time to schedule exercise becomes graver because, unmotivated, employers do not invest in WWPs causing a standstill in the level of employee exercise. Id.
170 See generally HEALTHY WORKFORCE 2010, supra note 152; see also F AS IN FAT, supra note 88, at 94 (explaining how employers benefit from WWPs). The TFAH sums up the issue succinctly:

The negative health consequences of inactivity and poor nutrition are leading to a less productive U.S. workforce and exponentially driving up health care costs. It is in the economic interest of every employer and the nation as a whole to put a greater emphasis on keeping the workforce healthy and providing preventative health care.

Id.
171 See F AS IN FAT, supra note 88, at 94 (examining the strategy to accomplish the goal of reducing prevalence of obesity in the workplace). Federal and state governments must lead by example by instituting WWPs for state and federal employees; additionally, governments may need to provide incentives to employers. Id. For example, U.S. Senators Tom Harkin and Gordon Smith “have introduced the Healthy Workforce Act of 2007 . . . [which] would provide tax credits to businesses that offer comprehensive wellness programs to their employees.” Id. at 76.
172 F AS IN FAT, supra note 88, at 76.
discrimination on the basis of weight illegal, forcing companies to address the obesity issue when it affects a greater number of their employees. However, until employees are reasonably able to participate in WWPs during work hours without risking negative consequences to their employment, the benefits of WWPs on the prevalence of adult overweight and obesity will not be fully realized.

The federal and state governments should create new legislation that prohibits employers from retaliating against employees who voluntarily engage in physical exercise during the workday. Forcing companies to allow employees to use company time in order to stay fit may seem somewhat dramatic; however, obesity has reached epidemic proportions. Additionally, research has indicated that such a mandate will ultimately benefit the companies financially. Research also indicates that allowing employees to exercise during the workday results in heightened employee productivity throughout the rest of the workday. Such a mandate could also allow companies to fulfill its obligations to employees through a flex program. In fact, statistically, employees are

173 See Carmichael, supra note 7 (reporting on possibility of a law addressing weight discrimination in work place). Michigan already has such a law in place. Id.

174 See Steelcase Survey, supra note 160 (explaining reasons why workers do not exercise during work hours). Nineteen percent of surveyed workers do not exercise during work hours because they feel it is frowned upon by employers. Id.

175 See generally F AS IN FAT, supra note 88, at 51-80. A physical exercise allowance is the WWP component which is most likely to benefit from legislation. Id. This is because it is not only a highly effective method for weight loss and increasing life expectancy through strengthening the heart and reducing cholesterol, it also requires constant, continual participation to be effective. Id. A yoga or meditation session, on the other hand, can more likely be conducted in or very near the worksite, and a smoking cessation program, if successful, would by its nature only take a limited amount of workday time. See Ceccarossi, supra note 150 (discussing WWPs).

176 See HANDBOOK, supra note 1; see also supra notes 147-148 and accompanying text (providing recommendations for the government to address obesity). “Obesity is as much of a threat to the public’s health as the looming possibility of a flu pandemic, and the nation must make a similar level of commitment by creating a government-wide plan for addressing the problem and providing the funding needed to carry out the plan.” F AS IN FAT, supra note 88, at 93.

177 See supra notes 153-154 and accompanying text (explaining benefits companies will enjoy by offering WWPs). Not mentioned earlier are the additional savings to companies through decreases in the number and amount of workers’ compensation claims. See F AS IN FAT, supra note 88, at 59.

178 See Steelcase Survey, supra note 160 (reporting on research that shows increased productivity in workers who exercise during the workday).

179 See Nike: Other Benefits, supra note 151 (detailing some of Nike’s employee benefits). Nike, like so many companies, offers “flex time” programs wherein employees can manage their own schedules to, for example, take Fridays during the summer off. Id. This type of policy could easily be adapted to an exercise routine, wherein an employee agrees to stay at work later every day and/or shorten the number of breaks throughout the work day, in exchange for a fixed
generally more productive at work when they are allowed to exercise during the workday, so they may not even need to work longer hours to accommodate any lost production due to an exercise break. Finally, a mandate could be further justified as a modern employment right created by the government in response to a deadly epidemic and bestowed to the American worker, and entitling him or her to reasonable flexibility in pursuing physical exercise, in order to enhance overall health and wellness.

VI. Conclusion: Worker’s Right to Physical Exercise

The prevalence of both overweight and obesity among Americans has dramatically increased over the last five decades. While the rate of the increase in the number of obese or overweight American adults has slowed down within the last three years, the prevalence of obesity is still an epidemic. The prevalence of overweight is also a serious problem since the condition of overweight not only causes significant health conditions, but often leads to obesity. Failure to adequately address these problems and the serious health risks that accompany them will most likely lead to the first ever decrease in life expectancy for subsequent generations.

While America’s healthcare system may be on the verge of a format alteration, it is not clear whether a privatized or a government-funded universal healthcare system will address the problems of overweight and obesity more efficiently, or whether either system could effectively manage these problems. Meanwhile, legislative actions, mostly at the state level have been taken to motivate healthier lifestyles among America’s youth in an effort to jumpstart a downward trend in the prevalence of overweight and obesity.

---

180 See Steelcase Survey, supra note 160 (reporting on research that shows increased productivity in workers who exercise during the workday).

181 See Family and Medical Leave Act, 29 U.S.C.A. §§ 2601-2654. The Family and Medical Leave Act (FMLA) gives eligible employees the right to take leave from work for the birth of a child, serious health condition of the employee or family member, and other circumstances for up to twelve weeks. Id. The employer does not have to pay the employee for the period during which the employee is on leave, however, the employer must give the employee the job back providing that the employee return at the end of the twelve week period. Id. The FMLA was enacted in 1993, in response to the increasing number of one-parent families, and the increase in the number of families in which both spouses work. Id. Congress found specifically, “that the lack of employment policies to accommodate working parents can force individuals to choose between job security and parenting.” Id. The phenomenon was adversely affecting the new family models, and Congress responded to alleviate the situation. Id. The analogy can be made to the epidemic of obesity, which not only affects an individual's career, but also his or her health. Id. As such, legislative response expanding the penumbra of an employee’s right to job security while addressing his or her personal health is justified. Id.
These actions are centered on improving the nutritional value of the meals and snacks available to students at schools, and on educating students how to live healthier lives. Some legislative actions are designed to also affect the adult population, including city-wide bans on trans fats, and zoning regulations that manipulate the number of fast food restaurants allowed in a given neighborhood.

However, not enough is being done legislatively to address the prevalence of overweight and obesity in adults. The critical health and financial effects caused by obesity and overweight cannot be wholly improved unless adults have adequate measures to combat weight gain. To accomplish this, the federal and state governments must work concomitantly to fortify the Workplace Wellness Program format by legislating employees the right to reasonable access to physical exercise during the workday. Without such legislation, WWPs are ineffective since employees must still fear professional consequences of partaking in physical exercise during work hours. The alternative, participating in a WWP or any physical activity during private time has become untenable. On average, adults spend over nine hours working and almost eight sleeping, leaving only seven hours to do everything else.

The right to reasonable access to physical exercise during the workday has become as necessary to a working adult’s health as the right to take a twelve week leave from work for a health-related condition, without the fear of professional consequence. Legislating this right will incentivize employees who would otherwise not have time to fulfill a desire to exercise. Furthermore, employers have been shortsighted by resisting employee access to workday exercise, considering only the immediate decrease in number of hours worked per day. However, such legislation will ultimately pay dividends to reluctant employers in the form of increased productivity and improved employee morale while decreasing both their own and the governments overall healthcare costs.