INTERSECTIONAL COMPLICATIONS OF HEALTHISM

Jennifer Bennett Shinall*

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* Associate Professor of Law, Vanderbilt Law School, 131 21st Avenue South, Nashville, TN 37203. jennifer.shinall@vanderbilt.edu. (615) 343-9622. The author wishes to thank participants in the University of Houston Law Center's Health Law & Policy Institute 2016 Healthism Symposium for their helpful feedback on this article.

I. INTRODUCTION

In the United States, historically disadvantaged status often serves as a dividing line with respect to health outcomes. For instance, African Americans experience significantly higher rates of type 2 diabetes, heart disease, stroke, HIV, obesity, and many types of cancer than do their white counterparts.[1] Similarly, rates of obesity, diabetes, and periodontal disease are higher for Hispanics than for non-Hispanics.[2] These diseases, of course, can affect individuals of every background, yet frequently, mortality rates for these diseases remain higher for historically disadvantaged groups.[3] Indeed, these health disparities encountered by historically disadvantaged groups are so well known that the Centers for Disease Control and Prevention (CDC) have maintained a division dedicated to improving minority health for more than two decades.[4]

These well-documented disparities have also formed the basis of multiple scholarly arguments to expand legal protections for individuals encumbered by health conditions. Currently, the most extensive protections available to such individuals at the federal level derive from the Americans with Disabilities Act (ADA),[5] Rehabilitation Act,[6] and the Genetic Information Nondiscrimination Act (GINA).[7] Yet these laws do not completely prohibit discrimination against individuals afflicted by health conditions.[8] Indeed, an individual may find herself not

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1. *See* Ctr. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013* (2013), http://www.cdc.gov/mmwr/pdf/other/su6203.pdf [https://perma.cc/ZKS7-WAW5].

2. *Diabetes Among Hispanics: All Are Not Equal*, AM. DIABETES ASS'N (July 24, 2014), http://www.diabetes.org/newsroom/press-releases/2014/diabetes-among-hispanics-all-are-not-equal.html [https://perma.cc/8SFT-TDJJ].

3. *See* Ctr. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013* (2013), http://www.cdc.gov/mmwr/pdf/other/su6203.pdf [https://perma.cc/ZKS7-WAW5].

4. *See* Ctr. for Disease Control & Prevention, *About CDC's Office of Minority Health & Health Equity* (Nov. 14, 2016), http://www.cdc.gov/healthequity/about/index.html [https://perma.cc/DN4J-7SP5] ("Although CDC has had an Office of Minority Health in place for over 20 years (formerly the Office of Minority Health & Health Disparities or OMHD), in order to comply with *all* provisions of the new statute, CDC organizationally re-aligned and re-named its office: Office of Minority Health & Health Equity (OMHHE)").

5. *See* 42 U.S.C. § 12101 *et seq.* (2012).

6. *See* 29 U.S.C. § 793 *et seq.* (2012).

7. *See* 42 U.S.C. § 2000ff *et seq.* (2012).

8. *See, e.g.*, Sarah Zhang, *The Loopholes in the Law Prohibiting Genetic*

covered by these Acts, despite suffering from a debilitating health condition, because the condition does not fall within the statutory definition of disability,[9] the venue falls outside the reach of the statute,[10] or the condition cannot be accommodated without imposing an undue hardship.[11] To the extent that the law continues to permit discrimination on the basis of health conditions, historically disadvantaged groups bear the disproportionate onus due to their disproportionately high rates of affliction.

The resulting disparate impact of gaps in health-related antidiscrimination protections on historically disadvantaged populations has inspired a number of calls for reform. For example, Jessica Roberts has previously argued against employment policies that penalize health-related conduct because of their likelihood to "disparately impact historically disadvantaged groups, most notably racial and ethnic minorities, people with disabilities, and the poor."[12] Similarly, Stephen D. Sugarman has argued for the need for further legal protections

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Discrimination, THE ATLANTIC (Mar. 13, 2017), https://www.theatlantic.com/health/archive/2017/03/genetic-discrimination-law-gina/519216/ [https://perma.cc/3EGZ-RZ4K].

9. Under the ADA and the Rehabilitation Act, a disability is defined as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 42 U.S.C. § 12101(1) (2012). Although federal courts historically interpreted this definition in a narrow manner, the 2008 Americans with Disabilities Act Amendments Act (ADAAA) specifically instructed courts to interpret the term "disability . . . in favor of broad coverage of individuals . . . to the maximum extent permitted." 42 U.S.C. § 12102(4)(A) (2012); *see also* Jennifer Bennett Shinall, *What Happens When the Definition of Disability Changes? The Case of Obesity*, 5 IZA J. LAB. ECON. (2016), http://izajole.springeropen.com/articles/10.1186/s40172-016-0041-0 [https://perma.cc/TN7F-8XQ7].

10. For example, prohibitions on disability and genetic discrimination are more limited outside employment. *See, e.g.*, U.S. Equal Employment Opportunity Commission, *Americans with Disabilities Act Questions and Answers* (Oct. 9, 2008), https://www.ada.gov/qandaeng.htm [https://perma.cc/TE8P-7KC4] (noting that, outside employment, the ADA's guarantees of equal opportunity for disabled individuals are limited to "public accommodations, . . . transportation, State and local government services, and telecommunications").

11. *See* 42 U.S.C. §§ 12111(10), 12112(b)(5) (2012) (limiting employer's obligation to reasonably accommodate disabled employees in situations where the accommodation would create an "undue hardship," defined as "an action requiring significant
difficulty or expense").

12. Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. 571, 616 (2014).

against "lifestyle discrimination" in employment, in part by pointing to the way in which certain lifestyle choices (and the resulting negative consequences) are associated with race.[13] Most expansively, Jessica Roberts and Elizabeth Weeks Leonard have recently argued for sweeping antidiscrimination protections—both inside and outside the workplace—against healthism, which they define as "differentiat[ion] on the basis of health in such a way that leads to systematic disadvantage and is normatively wrong."[14] Like prior scholars, their argument rests in part on concerns surrounding the questionable voluntariness and mutability of health status, particularly for ethnic and racial minorities.[15] Indeed, even scholars who have taken the opposite view, and ultimately support employer imposition of health-related penalties, have recognized their potentially regressive nature and, in the absence of careful design choices, their likelihood of disparately impacting historically disadvantaged populations.[16]

These prior scholarly arguments have been based on the idea, grounded in empirical data, that historically disadvantaged groups are more likely to experience health-based discrimination because they are more likely to be afflicted by health conditions.[17] In other words, historically disadvantaged status is *correlated* with poor health status, and poor health status is often the target of discriminatory behavior in the form of penalties against certain lifestyle choices and health conditions that fall outside the ambit of current antidiscrimination

13. *See, e.g.*, Stephen D. Sugarman, *"Lifestyle" Discrimination in Employment*, 24 BERKELEY J. EMP. & LAB. L. 377, 410 (2003) (considering the correlation between race and life choices, which can lower life expectancy, and the temptation to disparately treat racial groups that may follow).

14. Jessica L. Roberts & Elizabeth Weeks Leonard, *What is (and Isn't) Healthism*, 50 GA. L. REV. 833, 906 (2015).

15. *See id.* at 853-61 (discussing how some, but not all, policies that penalize poor health disparately impact historically disadvantaged populations).

16. *See, e.g.*, M. Todd Henderson, *The Nanny Corporation*, 76 U. CHI. L. REV. 1517, 1569-70 (2009) (recognizing that "[c]ompany-imposed 'taxes' on unhealthy or otherwise costly activities might be regressive" but ultimately arguing that employers could avoid their regressive nature by "easily tailor[ing the taxes] to the individuals' wealth").

17. David R. Williams & Selina A. Mohammed, *Discrimination and racial disparities in health: evidence and needed research*, 22 J. OF BEHAV. MED. 20 (2009), http://scholar.harvard.edu/files/davidrwilliams/files/2009-discrimination_and_racial-williams.pdf [https://perma.cc/2W5E-QUVB].

protections.[18] For such cases, the legislative solution proposed by Roberts and Leonard, which would prohibit healthist policies—that is, policies that both systematically disadvantage individuals with health conditions and produce a normative wrong—could be advantageous for historically disadvantaged populations.

For instance, imagine an employer wellness program that financially penalizes workers with risk factors for heart disease, such as high cholesterol and hypertension.[19] Given the current racial disparities in rates of heart disease and its risk factors,[20] such a policy is likely to disproportionately burden African American employees. Now suppose that, for the employer's part, the policy has purely good intentions—motivated by the idea that improving employees' health will both increase their productivity and reduce health-related costs (e.g., health insurance premiums and absenteeism) in the workplace—and the perverse effects of the policy are wholly unintentional and unexpected by the employer. Such a case may fall outside of the protections found within Title VII's prohibitions against disparate impact discrimination on the basis of race, given that the policy is arguably job-related (motivated by increasing

18. Often cited examples of such lifestyle choices and health conditions include tobacco usage, obesity, and life expectancy more generally. *See, e.g.*, Roberts, *supra* note 12, at 616; Sugarman, *supra* note 13, at 410. Note, however, that morbid obesity, clinically defined as a having a body mass index of 40 or higher (as distinguished from obesity, clinically defined as having a body mass index between 30 (inclusive) and 40), may be protected under the 2008 Americans with Disabilities Act Amendments Act (ADAAA). *See* Shinall, *supra* note 9.

19. Although the 2008 ADAAA broadened the definition of disability under the ADA, thus expanding the scope of the Act's coverage, discrimination on the basis of risk factors for heart disease like high cholesterol and hypertension, without more, arguably remains outside the scope of the ADA. A disability for ADA purposes must "substantially limit[] one or more major life activities" or cause an employer to "regard[the employee] as having such an impairment." 42 U.S.C. § 12102(1) (2012). (Given that high cholesterol and hypertension neither directly produce a substantial limitation (only their comorbidities and complications may eventually do so), nor are they readily apparent to an employer (although they may become increasingly apparent through the proliferation of employer wellness programs), these conditions will generally fall outside the scope of the ADA's protections).

20. *See, e.g.*, Garth N. Graham, et al. *Impact of Heart Disease and Quality of Care on Minority Populations in the United States*, 98 J. NAT. MED. ASS'N 1579, 1579 (2006) (noting the "widespread health disparities for heart disease and related risk factors among minorities in America"); George A. Mensah et al., *State of Disparities in Cardiovascular Health in the United States*, 111 CIRCULATION 1233, 1233-41 (2005) ("Hypertension prevalence was high among blacks (39.8%) regardless of sex or educational status").

employees' productivity) and consistent with business necessity (aimed at reducing costs imposed by employees' poor health that are borne by the employer).[21] In this case, legislation prohibiting healthism in employment could fill in the gaps left by current antidiscrimination protections, which—produce a normatively uncomfortable result.

The above example illustrates the more general proposition that, as long as historically disadvantaged status is merely correlated with poor health status, antihealthism legislation could provide a complete and satisfying solution to situations that are normatively troubling, yet presently lack a legal remedy. More generally, as long as discrimination on the basis of health status and historically disadvantaged status are additive in nature, novel legislation prohibiting discrimination on the basis of health, combined with existing legislation prohibiting discrimination on the basis of race, color, national origin, religion, sex, and age, would, in theory, sufficiently remedy individuals who both have a health condition and are a member of historically disadvantaged groups. The idea that discrimination is additive in nature simply means that the total amount of discrimination experienced by an individual who is a member of multiple protected groups is equal to the sum of its parts.[22] If true, then a sixty-year-old African American male with hypertension could be made completely whole by seeking remedies under Title VII for any race-based discrimination he experienced in the workplace, under the Age Discrimination in Employment Act (ADEA)[23] for any age-based discrimination he experienced in the workplace, and under antihealthism legislation for any health-based discrimination he experienced in the workplace.[24]

The antihealthism legislative solution proposed by Roberts

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21. *See* 42 U.S.C. § 2000e-2(k) (2012).

22. Bradley Areheart has previously characterized federal courts' current view of multiple discrimination claims as additive, as opposed to multiplicative. *See* Bradley Allen Areheart, *Intersectionality and Identity: Revisiting a Wrinkle in Title VII*, 17 GEO. MASON U. CIV. RTS. L.J. 199, 202 (2006).

23. *See* 29 U.S.C. § 621 *et seq.* (2012).

24. Employment discrimination victims are entitled both to be made whole and to be put in their rightful place under federal antidiscrimination statutes. *See* Albemarle Paper Co. v. Moody, 422 U.S. 405, 418 (1975) ("It is also the purpose of Title VII to make persons whole for injuries suffered on account of unlawful employment discrimination"); Franks v. Bowman Transportation Co., 424 U.S. 747, 748 (1976) (endorsing a discrimination victim's right to also "obtain his rightful place").

and Leonard is less complete, however, if historically protected status has a *causal* effect on health-based discrimination. Instead of being additive in nature, in such a case, multiple types of discrimination would be compounding or exacerbating in nature, so the total amount of discrimination experienced by an individual who is a member of multiple protected groups becomes *greater than* the sum of its parts.[25] This concept is often referred to as intersectionality.[26] Under the dominant analytical framework of employment discrimination laws, in which courts evaluate multiple claims of discrimination separately, intersectional discrimination claims are intrinsically unwieldy, and hence unlikely to produce a satisfactory remedy for plaintiffs.[27] If historically disadvantaged status actually increases the level of health-based discrimination, as opposed to coexisting with health-based discrimination, then our 60-year-old African-American male with hypertension would no longer be made whole by seeking a remedy under a combination of Title VII,[28] ADEA,[29] and antihealthism legislation.[30] In the best-case scenario, the separate remedies awarded under all three statutes would nonetheless fail to compensate him for the

25. Elaine W. Shoben, *Compound Discrimination: The Interaction of Race and Sex in Employment Discrimination*, 55 N.Y.U. L. REV. 793, 794 (1981).

26. The theory of intersectionality traces its roots to legal scholars Elaine Shoben and Kimberlé Crenshaw. *See* Shoben, *supra* note 25, at 798 (explaining her theory of compound discrimination, in which "members of two or more protected groups might be 'disproportionately exclude[d]' from employment"); Kimberlé Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics*, 1989 U. CHI. LEGAL F. 139, 139 (1989) (explaining the difficulty of attempting to fit the "multidimensionality" of African-American women's experience into the single-dimensional framework" of antidiscrimination law recognized by federal courts); *accord* Serena Mayeri, *Intersectionality and Title VII: A Brief (Pre-)History*, 95 B.U. L. REV. 713, 713, 727 (2015) (discussing Shoben's and Crenshaw's work); Rachel Kahn Best et al., *Multiple Disadvantages: An Empirical Test of Intersectionality Theory in EEO Litigation*, 45 LAW & SOC'Y REV. 991, 991-92 (2011) ("[Crenshaw's] work has inspired two decades of research on intersectionality in many fields, including critical race theory, stratification, social psychology, and women's studies").

27. *Accord* Areheart, *supra* note 22, at 202 (arguing that courts would not recognize intersectional discrimination claims on their own, in the absence of legislative action); Kathryn Abrams, *Title VII and the Complex Female Subject*, 92 MICH. L. REV. 2479, 2481 (1994) ("Many courts have been unwilling to accommodate these [intersectional discrimination] understandings within Title VII doctrine").

28. 42 U.S.C. § 2000ff-6 (2012).

29. 29 U.S.C. § 626(b) (2012).

30. Roberts & Leonard, *supra* note 14, at 841.

exacerbating effects that each form of discrimination had on the others. Even worse, the very nature of intersectional discrimination may leave him without sufficient evidence to prove one or more of his claims.[31] When analyzing this plaintiff's race, age, and health discrimination claims separately, a court may be unable to distinguish his employer's motivations from its suspicious actions (i.e., whether they were motivated by race, age, or health), and as a result, determine that there is insufficient evidence to support one or more of his discrimination claims.[32]

The proposition that health-based discrimination experienced by historically disadvantaged groups may be worse than the health-based discrimination experienced by non-historically disadvantaged groups is more than a hypothetical concern. Rather, prior scholarship suggests its reality. Based on this prior scholarship, this Article will argue that more is required than a simple legislative prohibition on healthism in order to protect historically disadvantaged groups adequately.[33] Instead, a complete solution to health-based discrimination requires recognition, either by legislatures or courts, that other types of legally prohibited discrimination may serve as aggravating factors.[34] In making this argument, this Article will first review prior scholarship that points towards an intersectional relationship between health and other types of discrimination. Although prior scholarship has heretofore focused on the exacerbating effects of sex discrimination on health discrimination, it nevertheless raises concerns that other historically disadvantaged groups, such as racial and ethnic minorities, may also fall victim to intersectional health-based discrimination.[35] The article will conclude by considering possible solutions for intersectional healthism.

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31. *See* Best, *supra* note 26, at 992 (finding that single-basis discrimination plaintiffs were two times more likely to prevail than intersectional discrimination plaintiffs).

32. *See id.* at 1018 (noting that "judges tend to believe that intersectional claims can be neatly separated" and the harm that causes plaintiffs whose claims could not be neatly separated).

33. *See infra* Section II.C.

34. *See infra* Section II.

35. *See infra* Section II.C.

II. NAVIGATING THE INTERSECTION OF HEALTH AND PROTECTED STATUS

The Introduction posed a hypothetical situation of intersectional healthism that could render a plaintiff without a complete remedy, or worse, without any remedy,—even under Roberts's and Leonard's proposal for novel antihealthism legislation. This Part moves beyond the hypothetical to document two widespread and systematic instances of intersectional health-based discrimination that presently occur in the workplace. As mentioned in the Introduction, the prior work examining intersectional healthism has been limited to the relationship between sex discrimination and specific types of health-based discrimination in the labor market. Still, this scholarship raises broader concerns about the potential for racism, colorism, ethnicism, religionism, and ageism to exacerbate health-based discrimination in the workplace and beyond.

A. At the Intersection of Sex and Weight Discrimination

Over the past three decades, an entire line of literature in economics has explored the role of weight in the workplace. These studies consistently find that a greater body mass index (BMI)—a simple ratio between weight and height squared[36]—is associated with lower employment rates and lower wages.[37] In fact, most of the recent literature has been devoted to

36. Throughout this article, weight categories are defined according to body mass index ("BMI"), which is calculated using the following equation: BMI = weight(lb) x 703 / (height(in)). Using BMI, individuals are then classified as underweight if their BMI is less than 18.5, normal weight if their BMI is greater than or equal to 18.5 but less than 25.0, overweight if their BMI is greater than or equal to 25.0 but less than 30.0, obese if their BMI is greater than or equal to 30.0 but less than 40.0, and morbidly obese if their BMI is greater than or equal to 40.0. *Obesity: Symptoms*, MAYO CLINIC ONLINE (2016), http://www.mayoclinic.org/diseases-conditions/obesity/basics/symptoms/con-20014834 [https://perma.cc/2KU7-H7HL].

37. *See, e.g.*, Steven L. Gortmaker et al., *Social and Economic Consequences of Overweight in Adolescence and Young Adulthood*, 329 NEW ENG. J. MED. 1008, 1011 (1993); Susan Averett & Sanders Korenman, *The Economic Reality of the Beauty Myth*, 31 J. HUM. RESOURCES 304, 306-09 (1996); Jose A. Pagán & Alberto Dávila, *Obesity, Occupational Attainment, and Earnings*, 8 SOC. SCI. Q. 756, 757-58 (1997); John Cawley, *The Impact of Obesity on Wages*, 39 J. HUM. RESOURCES 451, 468 (2004).

questioning the mechanisms behind the negative effects of BMI on labor market outcomes, which has been documented across multiple large observational datasets.[38] Specifically, economists have proposed three hypotheses for these negative effects. First, an employee with a greater BMI may be rendered less productive than an employee with a lower BMI because of the physiological effects of weight on the body.[39] This would, in turn, make the employee with a lower BMI more ideal for employers. Second, a greater BMI may raise employers' costs, such as raising the price of health insurance premiums (since greater BMI is associated with a long list of comorbidities) or introducing accommodation costs (for example, necessitating that an employer buy a worker a larger chair).[40] Third, the negative relationship between BMI, wages, and employment may result from taste-based animus;[41] such animus could take a variety of forms, including employers not liking heavier workers or employers perceiving that either their customers or their other employees prefer to deal with thinner workers.[42]

The negative relationship between BMI and labor market outcomes may result from one or more of the above hypotheses, but recent evidence suggests that at least some of the penalty derives from the third hypothesis, taste-based animus.[43] Although often referred to as "the obesity penalty,"[44] the data reveals that this negative relationship impacts the labor market outcomes of overweight individuals (who have a BMI greater than or equal to 25 but less than 30), obese individuals (who have a BMI greater than or equal to 30 but less than 40), and morbidly obese individuals (who have a BMI greater than or

38. *See* Jennifer Bennett Shinall, *Distaste or Disability: Evaluating the Legal Framework for Protecting Obese Workers*, 37 BERKELEY J. EMP. & LAB. L. 101 (2016). These prior authors have documented a negative relationship between weight and labor market outcomes in all the major publicly available datasets that include observations on weight and wages, including the National Longitudinal Survey of Youth (NLSY), the Behavioral Risk Factor Surveillance System (BRFSS), and the Current Population Survey (CPS) combined with the American Time Use Survey (ATUS).

39. *See id.* at 124.

40. *Id.*

41. *Id.* at 115.

42. For a more detailed discussion of these theories, see *id.* at 107-22.

43. *See id.* at 122-34 (arguing that the productivity and costs hypotheses are undercut after examining the types of occupations in which overweight and obese workers are employed).

44. Shinall, *supra* note 38, at 106.

equal to 40), with the penalty increasing as BMI classification increases.[45] Juxtaposed with this well-documented penalty is the fact that overweight and obesity rates are high and rapidly increasing in the U.S. population. In 1994, only one in five adults were obese or morbidly obese (22.9 percent of the population) and one in three (33.1 percent of the population) were overweight.[46] By 2014, 37.7 percent of adults were obese or morbidly obese, and an additional 32.8 percent of adults were overweight.[47] In only three decades, obesity rates increased by almost two-thirds, so that today, nearly 70 percent of adults are overweight, obese, or morbidly obese.[48]

Despite the fact that such a large portion of the population endures the obesity penalty in the labor market, legal protections at the federal level are limited.[49] Early in the ADA's history, multiple plaintiffs filed lawsuits against their employers, claiming that obesity was a disability for the purposes of the Act.[50] This litigation was successful in only one instance: in 1993, the First Circuit upheld a $100,000 jury verdict awarded to a morbidly obese job applicant in the refusal-to-hire case entitled *Cook v. Department of Mental Health, Retardation, & Hospital.*[51] Other federal courts that heard

45. *See, e.g.*, *id.* at 140-42; Shinall, *supra* note 9, at 12.

46. Estimates are derived from the National Health Examination Survey for adults ages 20 and over from 1988 to 1994. *See* National Ctr. for Health Statistics, Ctr. for Disease Control & Prevention, *Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults Aged 20 and Over: United States, 1960–1962 Through 2013–2014* (July 18, 2016), https://www.cdc.gov/nchs/data/hestat/obesity_adult_13_14/obesity_adult_ 13_14.htm [https://perma.cc/U76H-UJMG].

47. Estimates are derived from the National Health Examination Survey for adults ages 20 and over from 2013 to 2014. *See id.*

48. National Institute of Diabetes and Digestive and Kidney Diseases, *Overweight & Obesity Statistics*, https://www.niddk.nih.gov/health-information/health-statistics/overweight-obesity [https://perma.cc/YN2V-D67T] (last visited Aug. 4, 2017).

49. Note that ten state and local jurisdictions specifically prohibit discrimination on the basis of weight and/or personal appearance. *See* Jennifer Bennett Shinall, *Less Is More: Procedural Efficacy in Vindicating Civil Rights*, 68 ALA. L. REV. 49, 67-72, 99-118 (2016).

50. *See, e.g.*, Francis v. City of Meriden, 129 F.3d 281, 282-83 (2d Cir. 1997).

51. 10 F.3d 17, 20-21 (1st Cir. 1993). Note that Cook is a Rehabilitation Act case since Cook's employer was a public, not a private, employer, but ADA and Rehabilitation Act case law is interchangeable for the purposes of determining the existence of a disability. *See* 29 U.S.C. § 794(d) (2012) ("The standards used to determine whether [the Rehabilitation Act] has been violated in a complaint alleging employment discrimination under this section shall be the standards applied under

obesity cases prior to 2008 denied relief under the ADA, either distinguishing or expressly rejecting the *Cook*, in finding that the obese plaintiff was not disabled for purposes of the Act.[52] With the passage of the Americans with Disabilities Act Amendments Act (ADAAA) in 2008, the obesity jurisprudence under the ADA appeared to reverse course due to the more inclusive definition of disability (and hence, the more expansive coverage) under the Amendments Act.[53] Between 2008 and 2016, multiple district courts concluded that at least morbid obesity could qualify as a disability under the amended ADA,[54] and the EEOC successfully litigated two disability cases arising out of discriminatory practices against morbidly obese employees.[55] This uniform stance taken by the federal courts with respect to morbid obesity in the years since the ADAAA has been recently jeopardized by the Eighth Circuit's decision in *Morriss v. BNSF Railway Company*,[56] which largely relied on pre-ADAAA case law to decide that a morbidly obese plaintiff was not disabled for the purposes of the ADA.[57]

Even if the Eighth Circuit decision turns out to be an outlier, and other federal courts continue to recognize morbid obesity as a disability under the ADA, the fact remains that neither regular obesity nor overweight have ever been

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title I of the Americans with Disabilities Act of 1990").

52. *See, e.g.*, Greenberg v. Bellsouth Telecommunications, Inc., 498 F.3d 1258, 1264 (11th Cir. 2007); E.E.O.C. v. Watkins Motor Lines, 463 F.3d 436, 441, 443 (6th Cir. 2006); Francis v. City of Meriden, 129 F.3d 281, 287 (2d Cir. 1997); Andrews v. State of Ohio, 104 F.3d 803, 810 (6th Cir. 1997); *see also* Shinall, *supra* note 9, at 5-6.

53. 42 U.S.C. § 12102 (2012).

54. *See, e.g.*, Whittaker v. America's Car-Mart, Inc. Case No. 1:13 CV 108 SNLJ (E.D. Mo., April 24, 2014); Lowe v. American Eurocopter, LLC, No. 1:10 CV 24-A-D, at 14 (N.D. Miss., Dec. 16, 2010); Melson v. Chetofield, No. 08-3683 Section:(R(3)), at 3-4 (E.D. La. Mar. 4, 2009); *see also* Jennifer Bennett Shinall, *Unfulfilled Promises: Discrimination and the Denial of Essential Health Benefits Under the Affordable Care Act*, 65 DEPAUL L. REV. 1235, 1267-69 (2017).

55. *See* E.E.O.C. v. Res. for Human Dev., Inc., 827 F. Supp. 2d 688, 695 (E.D. La. 2011); Press Release, Equal Employment Opportunity Commission, Res. for Human Dev. Settles EEOC Disability Suit for $125,000 (Apr. 10, 2012), http://www.eeoc.gov/eeoc/newsroom/release/4-10-12a.cfm [https://perma.cc/JF8Q-MUP2]; L.M. Sixel, *Feds Sue Company for Firing 600 Pound Worker*, HOUSTON CHRON. (Sep. 27, 2011), http://www.chron.com/default/article/Feds-sue-company-for-firing-600-pound-worker-2191655.php [https://perma.cc/PA89-EMG3]; L.M. Sixel, *Fired Obese Worker Will Get $55,000*, HOUSTON CHRON. (July 24, 2012), http://www.chron.com/default/article/Fired-obese-worker-will-get-55-000-3732044.php [https://perma.cc/Q85J-8GGL]; *see also* Shinall, *supra* note 38, at 111-12.

56. 817 F.3d 1104 (8th Cir. 2016).

57. *Id.* at 1112-13.

recognized as a disability by federal courts. Yet, as described above, the raw data makes clear that these conditions are associated with wage and employment penalties (although admittedly, the penalties for overweight and obese individuals are less severe than for morbidly obese individuals).[58] The dearth of federal remedies available to the millions of individuals whose labor market fortunes are diminished as a result of their weight appears ripe for novel gap-filling legislation, and the antihealthism legislation proposed by Roberts and Leonard initially seems like a viable solution.[59] Ideally, such legislation would provide a remedy for individuals whose health condition has heretofore fallen outside the scope of federal antidiscrimination protections—like overweight and obese individuals—and if future federal courts follow the Eighth Circuit, which would also serve as a remedy for morbidly obese individuals.[60]

Although Roberts's and Leonard's proposal might be helpful in ameliorating the weight-related penalties in the labor market, a closer examination of the data on overweight and obese workers questions whether it would serve as a complete remedy. Table 1, which presents wage penalty estimates by sex and BMI classification, reveals the intersectional nature of weight discrimination.[61] The top two columns present the raw wage penalties for overweight, obese, and morbidly obese men and women—that is, the penalties that do not adjust for the underlying differences in education, demographics, and job characteristics between these groups.[62] The bottom two columns present the adjusted wage penalties that do take these underlying differences into account.

58. Jose A. Pagan & Alberto Davila, *Obesity, Occupational Attainment, and Earnings*, 78 SOC. SCI. Q. 756-67 (1997).

59. Roberts & Leonard, *supra* note 14, at 906-07 (2015).

60. *Id.* at 841-43.

61. The estimates presented in Table 1 are derived from estimates first presented in Shinall, *supra* note 38, at 142. That article used matched data from the 2006 through 2008 Current Population Survey, American Time Use Survey, Eating and Health Module, and Occupational Information Network.

62. *Id.*

Table 1. Wage Penalties for Overweight, Obese, and Morbidly Obese Individuals in the Workplace, by Sex

Raw Wage Penalties		
	Men	Women
Overweight	0.6%	-14.6%*
Obese	-8.7%*	-22.3%*
Morbidly Obese	-12.4%	-34.5%*
Adjusted Wage Penalties		
	Men	Women
Overweight	3.0%*	-4.0%*
Obese	0.0%	-7.4%
Morbidly Obese	-9.1%*	-18.4%*

Notes: Wage penalty estimates are derived from respondents ages 18 to 65 from the combined 2006-2008 Current Population Survey, American Time Use Survey, Eating and Health Module, and Occupational Information Network data. Raw estimates report the summary statistics by BMI classification. Adjusted estimates are from OLS regressions that include controls for underweight, government sector, union status, married, presence of a child, black, Hispanic, geographic region (South, Midwest, and West), urban area, years of education, age, and age squared. An * indicates a significant difference at the 10 percent level between the normal-weight group and the BMI classification group of interest.[63]

Turning first to individuals classified as overweight, men appear to receive an overweight *premium*, which actually increases in the adjusted estimates. In contrast, overweight women unambiguously encounter a wage penalty in the labor market of at least 4.0 percent, when compared to their normal-weight counterparts. These wage penalties exponentially increase as a woman moves up in BMI classification. As a result, morbidly obese women endure an 18.4 percent wage penalty compared to normal-weight women, even after adjusting for underlying differences in education, demographics, and job characteristics. Compare these results to the results for morbidly obese men, who encounter only a 9.1 percent wage penalty (after adjustment) compared to normal weight men—less than half of the penalty encountered by morbidly obese women in the labor market. Moreover, in the adjusted wage figures, the penalty completely disappears for obese men. Meanwhile, obese women confront a 7.4 percent wage penalty, even after adjusting for underlying differences.

63. For more details on these estimates, see Shinall, *supra* note 38, at 140-42.

The numbers in Table 1 indicate that the realities of weight discrimination are far more complex than an obesity penalty that uniformly applies to all workers. The data make clear weight gain alone does not automatically harm labor market outcomes. Rather, weight gain plus sex harms labor market outcomes. Instead of being a straightforward example of healthism, overweight and obesity are more complicated examples of intersectional healthism. That is, in the context of weight, it is not "differentiat[ion] on the basis of health . . . that leads to systematic disadvantage and is normatively wrong[;]"[64] it is differentiation on the *combined* basis of health and sex that leads to systematic disadvantages and is normatively wrong.

At first, this distinction may seem like mere semantics. Yet from an enforcement standpoint, the realities of weight discrimination pose significant problems for antihealthism legislation, such as the legislation proposed by Roberts and Leonard, that does not take intersectional discrimination into account. Even if such legislation made health a protected class—in the same manner that race, color, national origin, sex, religion, age, and disability are protected classes—female workers penalized for their weight may nonetheless find themselves without a remedy. Because most employment discrimination plaintiffs lack so-called "direct evidence of discrimination" (smoking-gun statements by the employer are the paramount example of direct evidence),[65] the vast majority of cases rely on the indirect method of proof, as formulated by *McDonnell Douglas v. Green*[66] and its lineage of successor cases.[67] Under this proof framework, courts' traditionally

64. *See* Roberts & Leonard, *supra* note 14, at 906.

65. Charles A. Sullivan, *Accounting for Price Waterhouse: Proving Disparate Treatment under Title VII*, 56 BROOK. L. REV. 1107, 1118-19 (1991) ("[T]he phrase 'direct evidence' is a misnomer. If direct evidence means anything, it refers to evidence that, if believed, would establish a fact at issue. In disparate treatment cases, the fact at issue is discriminatory *intent*. Even believing that . . . [a supervisor] uttered [a smoking-gun statement] . . . would not establish that he (much less the company) had such intent . . . . [He] may have said the words jokingly, ironically, or mistakenly").

66. 411 U.S. 792 (1973).

67. *See* Furnco Constr. Corp. v. Waters, 438 U.S. 567, 577-78 (1978) (holding that a plaintiff's prima facie case establishes an inference of discrimination); Texas Dept. of Commun. Affairs v. Burdine, 450 U.S. 248, 252-53 (1981) (holding that the defendant merely has the burden of producing a legitimate, nondiscriminatory reason); St. Mary's Honor Ctr. v. Hicks, 530 U.S. 502, 506-07 (1993) (holding that plaintiff's disproving the veracity of the employer's legitimate nondiscriminatory

favored method to raise an inference of discrimination is by way of the similarly situated comparator,—an individual who is similarly situated to the plaintiff in all material respects, except protected class status, and has been treated better by the employer.[68] Although this method has been criticized by scholars for multiple reasons,[69] the example below will clarify why it becomes particularly problematic in the context of overweight and obesity.

Suppose an overweight female worker is demoted, and she suspects that the demotion results from her employer's discriminatory animus towards her weight. Further suppose that antihealthism legislation becomes a reality, and health is a protected class. Even with this additional legal protection, in the absence of explicitly derogatory statements by the employer (such as, "fat people are all lazy"), the female worker would have to rely on circumstantial evidence of her supervisor's animus towards her health condition. She could attempt to prove weight discrimination by comparator, but this strategy could be difficult. According to Table 1, being overweight is associated with a wage premium for overweight men. If this female worker's employer was similar to most employers in the labor market, then any animus towards being overweight would be limited to women; even more problematic, being overweight might be a positive attribute for men who work for the same employer. Accordingly, any similarly situated overweight male employees working at the same company would be at least as well off (and perhaps even better off) than normal-weight male employees. In other words, the employer would have a built-in defense to claims of weight discrimination brought by female

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reason is not necessarily sufficient to prove discrimination); Reeves v. Sanderson Plumbing Products, Inc., 530 U.S. 133, 146-47 (2000) (clarifying that plaintiff's disproving the veracity of the employer's legitimate nondiscriminatory reason may be sufficient to prove discrimination).

68. *Accord* Minna J. Kotkin, *Diversity and Discrimination: A Look at Complex Bias*, 50 WM. & MARY L. REV. 1439, 1491 (2009) ("The most common method is to show that similarly situated employees of a different race or sex received more favorable treatment").

69. *See, e.g.*, Ernest F. Lidge III, *The Courts' Misuse of the Similarly Situated Concept in Employment Discrimination Law*, 67 MO. L. REV. 831, 849-62 (2002); Charles A. Sullivan, *The Phoenix from the Ash: Proving Discrimination by Comparators*, 60 ALA. L. REV. 191, 206-07 (2009); Suzanne B. Goldberg, *Discrimination by Comparison*, 120 YALE L. J. 728, 748 (2011); Jennifer Bennett Shinall, *The Substantially Impaired Sex: Uncovering the Gendered Nature of Disability Discrimination*, 101 MINN. L. REV. 1099, 1155 n. 169 (2017).

employees relying on circumstantial evidence: "I do not discriminate against overweight employees; here are examples of all the overweight male workers who are highly successful in this company."

The employer's built-in defense would disappear, of course, if the female worker were allowed to bring an intersectional healthism claim—that is, a claim that she was discriminated against neither on the basis of weight alone, nor sex alone, but the combination of weight and sex together. Thus, in the case of weight discrimination, legal protections against simple healthism[70]—without further legal protections against more complex, intersectional healthism—will leave continue to leave many victims without a remedy. Moreover, as the next section will explain, the concerns raised here about intersectional healthism extend beyond the isolated example of weight discrimination.

B. At the Intersection of Sex and Disability Discrimination

The exacerbating effect of sex discrimination is not necessarily limited to weight-related animus. The concerns raised in the previous sections regarding intersectional weight discrimination may extend to health discrimination more broadly. Specifically, prior empirical evidence suggests that sex discrimination may also have a compounding effect on disability discrimination.[71] In fact, a review of all disability discrimination charges filed with the Equal Employment Opportunity Commission (EEOC) between 2000 and 2006 reveals just how closely sex and disability discrimination are intertwined.[72] Women file disability discrimination charges with the agency more often than men,[73] even though they are less likely to work in risky jobs.[74] In industries that are male-dominated, such as

70. By "simple healthism," I mean discriminatory animus that is solely based on health status. Simple healthism lacks any confounding discriminatory animus based on other historically disadvantaged statuses, such as animus based on race, color, national origin, religion, age, disability, or sex.

71. *See* Shinall, *supra* note 68, at 1102, 1113.

72. Americans with Disabilities Act of 1990 (ADA) Charges FY 1997 – FY 2016 (2016), https://www.eeoc.gov/eeoc/statistics/enforcement/ada-charges.cfm [https://perma.cc/PA79-NEX7].

73. *See id.* at 1118-20.

74. *See* Joni Hersch, *Compensating Differentials for Gender-Specific Job Injury*

agriculture, mining, and construction, female workers file disability charges at far greater rates than male workers.[75] Male employees, conversely, file disability charges at greater rates than female workers in the health care and education industries,[76] which are female-dominated.[77] Moreover, disability charges filed by a minority sex within an industry are far more likely to be accompanied by a simultaneous Title VII sex discrimination charge.[78] This apparent relationship between sex discrimination charges and disability discrimination charges leads to greater overall disability charge filing rates for women,[79] as the majority of industries in the labor market are male-dominated.[80]

Of course, greater charge-filing rates do not necessarily indicate greater rates of discrimination. Yet a more comprehensive review of the EEOC disability discrimination charge universe reveals that men's charges are no more likely to be meritorious than women's charges, at least from the agency's perspective.[81] That fact alone implies that women file *meritorious* disability discrimination charges at greater rates than do men.[82] In addition, data from the Current Population Survey—a large, observational data set administered by the Bureau of Labor Statistics that contains information on labor market outcomes and disability—indicate that while sex differentials exist in the types of disabling conditions, overall disability rates do not vary meaningfully by sex.[83] That is to

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Risks, 80 AM. ECON. REV. 598, 598 (1998) (finding that women's job-injury risk is 71% of men's job-injury risk).

75. *See* Shinall, *supra* note 68, at 1132 (displaying ADA charge-filing rates per worker graphically, by industry and sex). In the mining industry, for example, women file ADA charges at rates that are more than double the rate at which men file ADA charges.

76. *Id.*

77. *See id.* at 1130-32.

78. This statement holds true for both men and women when they are the minority sex within their industry. *See id.* at 1134 (displaying Title VII sex discrimination charge-filing rates per worker graphically, by industry and sex, within the universe of disability charge filers).

79. *Id.* at 1129.

80. *Id.* at 1131.

81. Shinall, *supra* note 68, at 1128-29 (showing that men's claims are no more likely to be rated as meritorious at intake, nor are they more likely to result in a finding of reasonable cause).

82. *Id.* at 1127.

83. *Id.* at 1124.

say, women are no more likely to be disabled than are men.[84] The fact that rates of disability are not higher among women—taken together with the fact that rates of meritorious disability discrimination charge filings are higher among women—forms a compelling argument that rates of disability discrimination are indeed higher among women, particularly women in male-dominated fields.[85] Weight discrimination, it seems, is not unique in its intersectionality with sex discrimination; rather, sex discrimination's exacerbation of discrimination based on health conditions appears to be much broader in scope.

C. At the Intersection of Historically Disadvantaged Status and Healthism

Taken together, the evidence regarding the intersectionality of sex discrimination with both weight discrimination and disability discrimination raises two larger concerns for future antihealthism legislation, including the legislation proposed by Roberts and Leonard. First, and most obviously, it raises concerns that sex discrimination's exacerbating effects extend beyond weight discrimination and disability discrimination to health-based discrimination more generally.[86] If sex discrimination's intersectional effects extend to discrimination based on all health conditions—even those health conditions that do not qualify as a disability—then a simple legislative prohibition on health discrimination that fails to account for such intersectionalities will arguably be less effective for the female half of the U.S. population.[87] Indeed, a great deal of empirical evidence already exists to suggest that disability discrimination laws have been more effective for disabled men than for disabled women.[88] Without accounting for sex-health

84. *Id.* at 1121, 1125.

85. *Accord id.*

86. *See* Roberts & Leonard, *supra* note 14, at 895-96.

87. In 2015, Women comprised 50.8% of the total U.S. population. United States Census Bureau, *QuickFacts, 2016*, https://www.census.gov/quickfacts/table/PST045216/00 [https://perma.cc/C3PF-9AEN]. In the same year, women comprised 46.8% of the employed population in the United States. Bureau of Labor Statistics, *2015 Current Population Survey Household Data: Annual Averages, Employed Persons by Detailed Occupation, Sex, Race, and Hispanic or Latino Ethnicity* (2016), https://www.bls.gov/cps/cpsaat11.pdf [https://perma.cc/XB29-3988] [hereinafter Labor Statistics].

88. *See, e.g.*, Daron Acemoglu & Joshua D. Angrist, *Consequences of Employment Protection? The Case of the Americans with Disabilities Act*, 109 J. POL.

intersectionalities, more general health discrimination laws will suffer the same fate.

Second, and more broadly, the prior research on sex-weight and sex-disability intersectionality raises concerns that other types of discrimination besides sex that are already prohibited by law—including racism, colorism, ethnicism, religionism, and ageism—may also have intersectional, exacerbating effects on healthism.[89] To the extent that they do have such effects, a simple legislative prohibition against healthism may prove to be an ineffective remedy for individuals whose historical disadvantage stems from more than just health. For individuals whose disadvantaged status *is* solely based on health, then a simple legislative prohibition on health discrimination would be sufficient. But for individuals whose disadvantaged status is based on health plus another protected characteristic, proving such an intersectional health discrimination claim may turn out to be very difficult, if not impossible, under a simple legislative prohibition against healthism. For all the same reasons any intersectional discrimination claim is difficult to pursue under current antidiscrimination proof structures, as discussed at the end of Part II.A, an intersectional health discrimination claim is unlikely to fare much better.

If race, color, national origin, religion, and/or age discrimination have intersectional effects with health discrimination—in the same way that sex discrimination arguably does—it further narrows the percent of the population for whom simple antihealthism legislation would ultimately prove beneficial. Currently, 38.4 percent of the total U.S. population identifies as a racial and/or ethnic minority,[90] and

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ECON. 915, 949 (2001) (demonstrating empirically that young disabled women worked between 2.37 and 4.57 fewer weeks in the years following the ADA, but young disabled men worked between 0 and 3.11 fewer weeks); Kathleen Beegle & Wendy A. Stock, *The Labor Market Effects of Disability Discrimination Laws*, 38 J. HUM. RESOURCES 806, 853 (2003) (demonstrating empirically that disabled women's earnings declined by 4.9% after passage of a state disability law, but disabled men's earnings declined by only 1.5%).

89. *See* Roberts & Leonard, *supra* note 14.

90. This figure comes from the 2015 Census estimate. United States Census Bureau, *QuickFacts* (2016), https://www.census.gov/quickfacts/table/RHI125215/00 [https://perma.cc/LR8Z-8HKA]. Racial and ethnic minorities are, on the whole, underrepresented in the employed population within the United States. *See, e.g.*, Bureau of Labor Statistics, *2014-2015 Current Population Survey Household Data: Annual Averages, Employed Persons by Occupation, Race, Hispanic or Latino Ethnicity, and Sex* (2016), https://www.bls.gov/cps/cpsaat10.pdf [https://perma.cc/

close to half of the population is over forty.[91] Given the well-documented correlations between racial and ethnic minority status and poor health[92]—not to mention the well-documented correlations between age and poor health[93]—intersectional healthism could theoretically reach a great deal of individuals afflicted with health conditions. Certainly, further research is needed to determine whether intersectional healthism actually extends beyond sex to other protected characteristics, but to the extent that it does, any new legislation prohibiting health discrimination must take such intersectionalities into account.

III. REMEDYING INTERSECTIONAL HEALTHISM

For Americans in the labor market with health conditions that fall outside the scope of the ADA, the Rehabilitation Act, and GINA, antihealthism legislation, like the kind proposed by Roberts and Leonard,[94] would unquestionably serve as a critical first step in increasing their legal protections in the workplace. Moreover, to the extent that such legislation would also operate outside the workplace, it could expand legal protections even for individuals who presently enjoy coverage by disability and genetic discrimination laws solely inside the workplace. Yet, as this article has argued, simple healthism—discriminatory animus based solely on health—may be surprisingly rare. Existing empirical evidence already suggests the frequency and severity with which sexism exacerbates healthism in the workplace (and presumably, outside the workplace as well). Considering courts' historic inability to recognize intersectional claims in the absence of express statutory recognition—and

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CR3U-M9S3] (finding that 20.8% of the U.S. employed population identifies as nonwhite).

91. According to 2010 Census estimates, 39.4% of the total U.S. population is 45 or older. U.S. Census Bureau, *Age and Sex Composition: 2010* (May 2011), http://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf [https://perma.cc/5YS5-PZYM]. Bureau of Labor Statistics estimates from last year suggest that older individuals are slightly overrepresented in U.S. workplaces, comprising 44.4% of the U.S. employed population. *See* Labor Statistics, *supra* note 87.

92. *See, e.g.*, Ctr. for Disease Control & Prevention, *CDC Health Disparities and Inequalities Report—United States, 2013* (Nov. 22, 2013), http://www.cdc.gov/mmwr/pdf/other/su6203.pdf [https://perma.cc/94EJ-QBTJ].

93. *See, e.g.*, Anne Case & Angus S. Deaton, *Broken Down by Work and Sex: How Our Health Declines*, *in* DAVID A. WISE, ED., ANALYSES OF THE ECONOMICS OF AGING 185-86 (2005).

94. *See* Roberts & Leonard, *supra* note 14, at 895-96, 906.

appreciate the exacerbating effects of multiple types of discrimination,—the existing evidence both highlights the importance of explicitly incorporating protections for sex-health intersectionality into antihealthism legislation, and contemplates proactive protections against other types of intersectional healthism that may already exist, but are less well understood.

Still, given the current political climate, the argument presented here regarding new antihealthism legislation may seem to be a mere thought experiment in a pure hypothetical. The new Republican presidential administration—along with the newly installed One Hundred and Fifteenth Congress with Republican majorities in both houses—have repeatedly signaled their hostilities towards existing civil rights protections, let alone new civil rights protections.[95] Yet new antihealthism legislation may not be completely out of the question in the coming years. Whether or not Democrats like to admit it, all existing federal protections against health-related discrimination in the workplace have passed during Republican presidential administrations: the Rehabilitation Act passed in 1973 under President Richard Nixon's administration, the ADA passed in 1990 under President George H. W. Bush's administration, and both the ADAAA and GINA passed in 2008 under President George W. Bush's administration.[96] Indeed,

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95. *See, e.g.*, Janell Ross, *What the Trump Administration Wants You to Know about Civil Rights and Policing*, WASH. POST, (Jan. 23, 2017), https://www.washingtonpost.com/national/what-does-the-trump-administration-have-to-say-about-civil-rights-and-policing/2017/01/23/edf29d4c-e17a-11e6-879b-356663383f1b_story.html?utm_term=.1ed3e0b4260c [https://perma.cc/6QCT-N88U] (arguing that "[s]ince Trump's election victory, his decision to nominate Sen. Jeff Sessions (R-Ala.) as the nation's next attorney general has intensified this perception" that the new administration "would not be particularly attentive to civil rights"); Justin Miller, *Trump's WhiteHouse.Gov Disappears Civil Rights, Climate Change, LGBT Rights*, DAILY BEAST (Jan. 20, 2017), http://www.thedailybeast.com/articles/2017/01/20/trump-s-whitehouse-gov-disappears-civil-rights-climate-change-lgbt-rights.html [https://perma.cc/QZN3-S2GE] (describing the immediate disappearance of civil rights webpages from the White House website upon President Trump's inauguration).

96. One arguable exception to this statement is the Patient Protection and Affordable Care Act (ACA), passed under President Barack Obama's administration (and perhaps soon to be repealed), which—among other things—mandated that health insurance plans end discrimination based on preexisting conditions. *See* U.S.C. § 1181 *et seq.* (2012). Since this mandate affected both non-employer-provided and employer-provided insurance, the ACA indirectly reduced health-related discrimination in the workplace. For a critique of the ACA's approach to antidiscriminatory reform in health care, see Jessica L. Roberts, *Healthism: A*

President George H. W. Bush recently recalled the ADA as one of his "proudest achievements."[97]

If this suggestion proves overly optimistic, however, and antihealthism legislation like the kind proposed by Roberts and Leonard remains unrealized in the coming years, they have nonetheless presented a compelling argument for courts to intervene and interpret existing health-related protections more broadly. This is especially true with regards to the ADA, which holds the potential to have the broadest reach.[98] Along these lines, the evidence reviewed in this article at the very least presents additional grounds for courts to resist their historical urges to parse a multifaceted claim brought under existing antidiscrimination statutes into multiple, individual claims. Instead, courts must recognize that discriminatory animus can compound—particularly when health is involved—and open the door to consideration of these multifaceted, intersectional claims under existing antidiscrimination laws.[99]

Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform, U. ILL. L. REV. 1159, 1159 (2012).

97. David Crary, *25 Years On, Disabilities Act Has Changed Lives of Millions*, SAN DIEGO UNION-TRIB. (July 25, 2015), http://www.sandiegouniontribune.com/sdut-25-years-on-disabilities-act-has-changed-lives-of-2015jul25-story.html [https://perma.cc/4HLM-K84Y].

98. The definition of disability under the ADA, which protects employees who work for an employer with fifteen or more employees in the private sector, could be interpreted quite expansively. *See* 42 U.S.C. § 12101(1) (2012). Moreover, in the 2008 Amendments, Congress admonished courts to read the definition "to the maximum extent permitted." 42 U.S.C. § 12102(4)(A) (2012).

99. Indeed, existing antidiscrimination statutes do not prohibit courts from considering intersectional claims together, and the Title VII's "plus" line of cases provide an explicit framework for considering sex-plus-health or race-plus-health discrimination claims. For a discussion of how courts can better use the plus framework to consider health-based intersectional discrimination claims. *See* Shinall, *supra* note 68, at1149-50.