Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers

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Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers

Stacey A. Tovino*

Gambling disorder is not a legally sympathetic health condition. Health insurance policies and plans have long excluded treatment for gambling disorder from health insurance coverage. Individuals with gambling disorder who seek disability income insurance benefits from public and private disability income insurers also tend not to be successful in their claims. In addition, federal and state antidiscrimination laws currently exclude individuals with gambling disorder from disability discrimination protections. This Article is the first law review article to challenge the legal treatment of individuals with gambling disorder by showing how health insurance and antidiscrimination laws hurt problem gamblers. Using neuroscience, economics, and principles of biomedical ethics to argue that individuals with gambling disorder should have the same legal protections as individuals with substance-related and other addictive disorders, this Article proposes important amendments to federal and state health insurance laws and antidiscrimination laws.

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I. INTRODUCTION

Imagine a thirty-five-year-old attorney named Gary. During the day, Gary practices intellectual property law at a prominent New Orleans law firm. At night, Gary plays poker at Harrah’s New Orleans Hotel and Casino, located just blocks away from the French Quarter and the New Orleans Riverfront.

Following a string of poker losses, Gary vows to stop gambling. Unfortunately, each attempt by Gary to stop gambling is unsuccessful. Regardless of how hard he tries to focus on his family and his law practice, Gary has persistent thoughts relating to his past poker wins and his future poker tournaments. Gary also has become preoccupied with finding creative ways to finance his gambling habit and has begun to lie to his wife, his law partners, and his clients regarding the extent of his gambling problem and the sources of funds he uses to finance his gambling. Recently, Gary’s gambling debts have grown so high that he borrowed money from his law firm clients’ trust accounts, in violation of Rule 1.15 of the Louisiana Rules of Professional Conduct.¹

After learning of the trust account improprieties, the managing partner of Gary’s law firm asks Gary to take a leave of absence from the partnership to obtain treatment for his problem gambling. Gary schedules an appointment with a mental health professional who subsequently diagnoses Gary with “gambling disorder” under the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association (APA) in May 2013.² The mental health professional recommends that Gary participate in a twenty-two-day residential treatment program for individuals with gambling disorder that is located near New Orleans, on the north shore of Lake Pontchartrain. Unfortunately, Gary’s health insurance excludes both inpatient and outpatient treatments for gambling disorder from coverage. Because he has spent his savings

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¹. LA. RULES OF PROF’L CONDUCT R. 1.15(a) (2011) (requiring attorneys who practice law in Louisiana to separate and properly safeguard client trust fund accounts).
². See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 585 (5th ed. 2013) [hereinafter DSM-5].
chasing gambling losses and has a heavily mortgaged house located in the affluent Garden District neighborhood, Gary cannot afford to pay for the residential treatment program. Gary’s gambling continues, and he now gambles more than ever before.

Shortly after learning that Gary has not followed through with treatment, Gary’s managing partner terminates Gary’s partnership with the law firm. Gary becomes anxious, wondering how he will support his family and pay for the treatment he finally admits he needs. With the hope of partially offsetting his lost law firm salary, Gary applies for disability income insurance benefits from the federal Social Security Administration and from his private disability income insurer. Unfortunately, both of Gary’s applications are declined after the insurers find that Gary’s loss of income results from his misappropriation of client trust fund accounts, not from an accident or injury. With dwindling savings and difficulty finding employment at a new law firm, Gary asks an attorney who specializes in employment discrimination whether he might have a case against his old law firm for disability discrimination. The attorney explains to Gary that federal and state antidiscrimination laws currently exclude gambling disorder from the definition of disability.

Gary begins to wonder: if he had cancer, quadriplegia, bipolar disorder, or Alzheimer’s disease, he would receive full protection under his health insurance policy, his disability income insurance policy, and federal and state antidiscrimination laws. The fact that Gary’s disease relates to gambling, however, makes him ineligible for coverage and protection under the most basic of health and disability laws. This Article questions the legal treatment of individuals with gambling disorder under health insurance, disability income insurance, and antidiscrimination law.

This Article proceeds as follows. Part II reviews the history of the APA’s understanding and diagnostic classification of gambling disorder. First identified as “pathological gambling” in 1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), the condition was grouped with kleptomania, pyromania, intermittent explosive disorder, and isolated explosive disorder in a section of the DSM-III relating to “Disorders of Impulse Control Not Elsewhere Classified.” As an impulse control disorder, pathological gambling was characterized with reference to an

individual’s “chronic and progressive failure to resist impulses to gamble [as well as] gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits.” With few changes, pathological gambling remained in the “Disorders of Impulse Control Not Elsewhere Classified” section of the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) (1987), the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (1994), and the text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (2000). In May 2013, the APA released the DSM-5, which renamed the condition “gambling disorder” and reclassified it under “Non-Substance-Related Disorders” within the “Substance-Related and Addictive Disorders” chapter. The APA explained that the condition’s new name and classification reflected clinical research findings suggesting “that gambling disorder is similar to [alcohol use disorder and other] substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment.”

Part III of this Article examines the current scientific literature investigating gambling disorder. These studies reveal important information about the prevalence of gambling disorder, its comorbidities, its environmental and genetic factors, its neurobiological correlates, and its functional consequences. Functional neuroimaging studies, in particular, have begun to delineate the neural circuitry and neurochemistry involved in gambling disorder. These neuroimaging studies suggest multiple similarities between gambling disorder and other substance-related and addictive disorders. Part III reviews the current scientific understanding of gambling disorder and lays the foundation for the arguments and proposals set forth in Part VII of this Article.

Part IV of this Article examines the current status of gambling disorder under mental health insurance parity and essential health

4. Id.
9. See Substance-Related and Addictive Disorders, supra note 8, at 1.
benefits laws. Designed to reduce discrimination against individuals with mental health conditions in the context of health insurance, federal and state mental health parity laws require most, but not all, health plans to treat offered gambling disorder insurance benefits at parity with offered physical health insurance benefits. Designed to ensure that insureds are offered mental health insurance benefits, federal and state essential health benefits laws require many, but not all, health plans to include certain mental health benefits in their health insurance policies. Part IV of this Article identifies the protections and limitations of current federal and state mental health parity and essential health benefits laws, including the essential health benefits requirements that became effective on January 1, 2014, with respect to individuals who have gambling disorder. Part IV also examines the impact of the May 2013 publication of the DSM-5 on health insurance coverage of gambling disorder. Part IV shows how, even after the full implementation of the Affordable Care Act and the publication of the DSM-5, some insureds with gambling disorder still do not have equal access to gambling disorder insurance benefits.

Part V of this Article examines the status of gambling disorder under public and private disability income insurance benefits programs and plans. Although not specifically excluded from federal Social Security Disability Insurance (SSDI) benefits, individuals with gambling disorder face an uphill battle during the application process. That is, individuals with gambling disorder who apply for SSDI benefits must prove that their disorders are so severe that they can neither do their previous work nor any other kind of substantial gainful work that exists in the national economy. Although not usually excluded from private disability income insurance benefits, individuals with gambling disorder and other comorbid disorders may succeed in their applications for private disability benefits if they can prove that their disabilities caused their losses of income. On the other hand, individuals with gambling disorder may be denied disability insurance benefits if their losses of income are determined to result from a criminal or other illegal act instead of an "accident or injury" within the terms of their insurance policies. Unlike current health insurance exclusions of gambling disorder treatments, Part V of this Article approves of the individualized disability assessments that take place in the context of public and private disability income insurance and suggests this case-by-case approach as a model for use in the health insurance and antidiscrimination law contexts.
Part VI of this Article examines the status of gambling disorder under current federal and state antidiscrimination laws that prohibit discrimination based on disability. Although the Rehabilitation Act of 1973 did not specifically exclude individuals with gambling disorder from legal protection, the Americans with Disabilities Act of 1990 (ADA) as amended by the ADA Amendments Act of 2008 (ADAAA) as well as many state antidiscrimination laws that are modeled after the ADA expressly exclude individuals with gambling disorder from protection. Part VI uses *Rezza v. U.S. Department of Justice*, a case involving a Federal Bureau of Investigation (FBI) agent with gambling disorder that was litigated by this author's University of Nevada, Las Vegas (UNLV) colleague Professor Jean Sternlight, to illustrate how current antidiscrimination laws can hurt problem gamblers.

Part VII of this Article offers seven arguments against the disparate legal treatment of gambling disorder in the contexts of health insurance coverage and antidiscrimination law. Part VII concludes by proposing corrections to essential health benefits laws, state mental health parity laws, state benchmark health plans, and federal and state antidiscrimination laws that will place individuals with gambling disorder on equal footing with individuals with other substance-related and addictive conditions.

II. GAMBLING DISORDER: HISTORY AND DIAGNOSTIC CLASSIFICATION

Gambling disorder is a relatively new—or newly understood—disorder. Formally recognized by the APA in the DSM-III in 1980, the condition then-named "pathological gambling" was classified within the "Disorders of Impulse Control Not Elsewhere Classified."
Characterized with reference to an individual's "chronic and progressive failure to resist impulses to gamble and gambling behavior that compromises, disrupts, or damages personal, family, or vocational pursuits," pathological gambling was believed by the APA to have an adolescent age of onset and to be more common among males than females and more common in the fathers of males and in the mothers of females.14 Predisposing factors were thought to include "loss of parent by death, separation, divorce, or desertion before [the individual turns] 15 years of age; inappropriate parental discipline ...; exposure to gambling activities as an adolescent; a high family value on material and financial symbols; and lack of family emphasis on saving, planning, and budgeting."15

The DSM-III established three main diagnostic criteria for pathological gambling: (1) "[t]he individual [must be] chronically and progressively unable to resist impulses to gamble"; (2) the individual's "[g]ambling [must] compromise[, disrupt[, or damage[,] family, personal, and vocational pursuits, as indicated by at least three of [seven subcriteria]]"; and (3) the individual's gambling must not be due to antisocial personality disorder.16 The seven subcriteria within the second criterion included:

1. arrest for forgery, fraud, embezzlement, or income tax evasion due to attempts to obtain money for gambling
2. default on debts or other financial responsibilities
3. disrupted family or spouse relationship due to gambling
4. borrowing of money from illegal sources (loan sharks)
5. inability to account for loss of money or to produce evidence of winning money, if this is claimed
6. loss of work due to absenteeism in order to pursue gambling activity
7. necessity for another person to provide money to relieve a desperate financial situation.17

The DSM-III distinguished pathological gambling from social gambling, defined as gambling with friends "on special occasions and with predetermined acceptable losses."18

Pathological gambling reportedly made its way into the DSM-III due to the efforts of Dr. Robert Custer, a psychiatrist who had treated

15. Id. at 292.
16. Id. at 292-93.
17. Id. at 293.
18. Id. at 292.
pathological gamblers and had written about their conditions.\textsuperscript{9} The DSM-III diagnostic criteria were not tested beforehand; instead, the criteria were based on the clinical experience of Dr. Custer and other mental health professionals.\textsuperscript{20}

Seven years later, in the DSM-III-R (1987), the APA tinkered with the diagnostic criteria for pathological gambling. That is, the APA recharacterized pathological gambling as:

Maladaptive gambling behavior, as indicated by at least four of [nine criteria]:

(1) frequent preoccupation with gambling or with obtaining money to gamble
(2) frequent gambling of larger amounts of money or over a longer period of time than intended
(3) a need to increase the size or frequency of bets to achieve the desired excitement
(4) restlessness or irritability if unable to gamble
(5) repeated loss of money by gambling and returning another day to win back losses ("chasing")
(6) repeated efforts to reduce or stop gambling
(7) frequent gambling when expected to meet social or occupational obligations
(8) sacrifice of some important social, occupational, or recreational activity in order to gamble
(9) continuation of gambling despite inability to pay mounting debts, or despite other significant social, occupational, or legal problems that the person knows to be exacerbated by gambling[.]\textsuperscript{21}

Seven years later, in the DSM-IV (1994), the APA continued to tinker with the diagnostic criteria for pathological gambling.\textsuperscript{22} Under the DSM-IV, pathological gambling was characterized with reference to "persistent and recurrent maladaptive gambling behavior . . . that disrupts personal, family, or vocational pursuits."\textsuperscript{23} Although the DSM-III and the DSM-III-R distinguished pathological gambling from social gambling,\textsuperscript{24} they did not distinguish pathological gambling from professional gambling. According to the DSM-IV, pathological gambling and had written about their conditions. The DSM-III diagnostic criteria were not tested beforehand; instead, the criteria were based on the clinical experience of Dr. Custer and other mental health professionals.

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(6) repeated efforts to reduce or stop gambling
(7) frequent gambling when expected to meet social or occupational obligations
(8) sacrifice of some important social, occupational, or recreational activity in order to gamble
(9) continuation of gambling despite inability to pay mounting debts, or despite other significant social, occupational, or legal problems that the person knows to be exacerbated by gambling[.]\textsuperscript{21}

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gambling is different from professional gambling, which involves limited risks and significant discipline.25

Building on the DSM-III-R, which required at least four of nine criteria to be present for a diagnosis of pathological gambling, the DSM-IV required the presence of at least five of ten criteria; that is, the individual:

1. is preoccupied with gambling (e.g., preoccupied with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
2. needs to gamble with increasing amounts of money in order to achieve the desired excitement
3. has repeated unsuccessful efforts to control, cut back, or stop gambling
4. is restless or irritable when attempting to cut down or stop gambling
5. gambles as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression)
6. after losing money gambling, often returns another day to get even ("chasing" one's losses)
7. lies to family members, therapist, or others to conceal the extent of involvement with gambling
8. has committed illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
9. has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
10. relies on others to provide money to relieve a desperate financial situation caused by gambling.26

(The DSM-IV-TR, published in 2000, also required the presence of at least five of the same ten criteria listed in the DSM-IV.27)

Following the publication of the DSM-IV, some critics voiced concern regarding the manual's clinical description of pathological gambling.28 For example, some critics noted the lack of empirical (versus observational) support for the diagnostic criteria for pathological gambling.29 Some critics noted that the empirical

25. DSIM-IV, supra note 6, at 617.
26. DSM-III-R, supra note 5, at 325; DSM-IV, supra note 6, at 618.
27. DSM-IV-TR, supra note 7, at 674.
28. Reilly & Smith, supra note 19, at 3.
29. Id. But see Stinchfield, supra note 12, at 180 ("The DSM-IV diagnostic criteria for pathological gambling, when operationalized into questions, demonstrated satisfactory reliability, validity, and classification accuracy, and a cutoff score of 4 improved diagnostic precision."); David R. Strong & Christopher W. Kahler, Evaluation of the Continuum of
literature that did exist suggested that problem gambling existed on a continuum and that subclinical instances of pathological gambling were relatively frequent. According to these critics, the DSM-IV overlooked this continuum and resulted in a nondiagnosis when an individual met fewer than five criteria. In addition, some critics questioned the inclusion of pathological gambling within "Impulse-Control Disorders Not Elsewhere Classified." Since the publication of the DSM-IV, scientists have observed that individuals with other impulse control disorders, such as kleptomania and pyromania, "felt overwhelmed by an impulse to act and often report a sense of relief after having acted." In contrast, scientists found that pathological gamblers enjoyed their gambling and only felt distress after their gambling was terminated or they incurred losses.

The DSM-5, published in 2013, takes pathological gambling in a new direction. First, the DSM-5 renames the condition "gambling disorder," reflecting concerns that the adjective "pathological" is pejorative and reinforces the social stigma associated with problem gambling.
lost in the shuffle

Second, the DSM-5 reclassifies gambling disorder and places it as the sole disorder within the “Non-Substance-Related Disorders” section within the larger “Substance-Related and Addictive Disorders” chapter. Now, gambling disorder follows alcohol use disorder, cannabis use disorder, opioid use disorder, stimulant use disorder, and tobacco use disorder, among other substance-related and addictive disorders. According to the APA, the change in gambling disorder’s classification reflects the fact that “little evidence exists on the associations between [trichotillomania, intermittent explosive disorder, kleptomania, and pyromania] and gambling disorder.” The change also reflects neuroimaging evidence that gambling behaviors activate neural reward systems similar to those activated by drugs of abuse and produce behavioral systems that appear comparable to those produced by the substance use disorders. Charles O’Brien, M.D., who chaired the Substance-Related Disorders Work Group for the DSM-5, explains:

The idea of a non-substance-related addiction may be new to some people, but those of us who are studying the mechanisms of addiction find strong evidence from animal and human research that addiction is a disorder of the brain reward system, and it doesn’t matter whether the system is repeatedly activated by gambling or alcohol or another substance. In functional brain imaging—whether with gamblers or drug addicts—when they are showed video or photograph cues associated with their addiction, the same brain areas are activated.

Third, although the DSM-IV required five of ten criteria to be present for a diagnosis, the DSM-5 eliminated the former eighth criterion relating to the commission of illegal acts such as forgery, theft, or embezzlement to finance gambling. The elimination

38. Petry et al., supra note 36, at 494 (“Over the past three decades, the term ‘pathological’ has become outdated and pejorative. Thus, the name of the disorder will be altered in DSM-5 to ‘gambling disorder.’”); Reilly & Smith, supra note 19, at 4.
39. Id. at 481-585; Constance Holden, Behavioral Addictions Debut in Proposed DSM-V, 327 Sci. 935, 935 (2010) (noting that gambling disorder would be the only disorder in the behavioral, or nonsubstance, portion of the substance-related and addictive disorders category).
40. Petry et al., supra note 36, at 495.
41. DSM-5, supra note 2, at 481; see also Kenneth Blum et al., Reward Deficiency Syndrome, 84 AM. SCIENTIST 132, 140 (1996) (noting the affinities between pathological gambling and alcohol and drug abuse).
43. Compare DSM-IV-TR, supra note 7, at 674, with DSM-5, supra note 2, at 585.
of this criterion reflects a lack of empirical evidence showing that assessing criminal behavior helps diagnose individuals with gambling disorder.\textsuperscript{45} The APA's explanatory text in the DSM-5 continues to state, however, that instances of deceit associated with gambling disorder may include "covering up illegal behaviors such as forgery, fraud, theft, or embezzlement to obtain money with which to gamble."\textsuperscript{46}

Fourth, the DSM-5 changes the prefatory description of the condition as well as the time period in which the symptoms and behaviors described in the diagnostic criteria must occur. The DSM-IV-TR simply described the disorder as "[p]ersistent and recurrent maladaptive gambling behavior as indicated by five (or more) of the [ten criteria]."\textsuperscript{47} The DSM-5 is more specific and requires "[p]ersistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of [nine criteria] in a 12-month period."\textsuperscript{48} Thus, an individual who had three symptoms last year and two different symptoms this year would meet the criteria for pathological gambling under the DSM-IV-TR but may not meet the criteria for gambling disorder under the DSM-5, depending on when those symptoms manifested.\textsuperscript{49}

Fifth, the DSM-5 reorders and changes the language of some of the remaining diagnostic criteria. For example, in the DSM-IV-TR, the first criterion required the individual to be "preoccupied with gambling."\textsuperscript{50} In the DSM-5, this criterion has been moved to the fourth criterion and now requires the individual only to be "often preoccupied with gambling"\textsuperscript{51} (similar to the DSM-III-R, which required "frequent preoccupation with gambling").\textsuperscript{52} As a result, an individual does not have to be preoccupied with gambling all the time in order to meet the

\footnotesize{
\begin{enumerate}
\item Reilly & Smith, \textit{supra} note 19, at 4; see Strong & Kahler, \textit{supra} note 29, at 717 (examining the gambling data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), finding that the former criterion relating to illegal acts was most helpful only for identifying individuals with the highest levels of gambling problem severity and that individuals who commit illegal acts as a result of their disordered gambling already reach the threshold of five or more symptoms, and concluding that the criterion does not improve the precision with which individuals are diagnosed with pathological gambling).
\item DSM-5, \textit{supra} note 2, at 586.
\item DSM-IV-TR, \textit{supra} note 7, at 674.
\item DSM-5, \textit{supra} note 2, at 585.
\item See Reilly & Smith, \textit{supra} note 19, at 4 (explaining the difference in the time frame requirements between the DSM-IV and the DSM-5).
\item DSM-IV-TR, \textit{supra} note 7, at 674.
\item DSM-5, \textit{supra} note 2, at 585.
\item DSM-III-R, \textit{supra} note 5, at 325.
\end{enumerate}
}
criterion. The individual only needs to be “often” preoccupied with gambling.

By further example, the fifth criterion in the DSM-IV-TR required the individual to “gamble[] as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guilt, anxiety, depression).” The DSM-5 simplifies this criterion to require the individual to “[o]ften gamble[] when feeling distressed (e.g., helpless, guilty, anxious, depressed).”

By final example, the seventh criterion of the DSM-IV-TR provided that the individual “lies to family members, therapist, or others to conceal the extent of involvement with gambling.” The DSM-5 simplifies this criterion, which now reads, “[l]ies to conceal the extent of involvement with gambling.”

Let us now return to Gary, the thirty-five-year-old New Orleans attorney who plays poker at Harrah’s New Orleans Hotel and Casino. Although he has vowed to stop gambling multiple times, Gary’s efforts thus far have been unsuccessful. As a result, Gary would meet the third diagnostic criterion in the DSM-5 relating to “repeated unsuccessful efforts to control, cut back, or stop gambling.” Remember that Gary also has persistent thoughts relating to his past poker wins and his future poker tournaments, which would satisfy the fourth criterion (“often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture[]}”). Remember, too, that Gary has lied to his wife, his law partners, and his clients regarding the sources of funds he uses to finance his gambling, which would satisfy the seventh diagnostic criterion (“[l]ies to conceal the extent of involvement with gambling”). Notwithstanding his efforts to stop, Gary’s gambling continues, and he now needs to gamble with more money than ever before in satisfaction of the first criterion (“[n]eeds to gamble with increasing amounts of money in order to achieve the desired excitement”). Finally, remember that Gary’s gambling debts

53. Reilly & Smith, supra note 19, at 4.
54. DSM-IV-TR, supra note 7, at 674.
55. DSM-5, supra note 2, at 585; see Reilly & Smith, supra note 19, at 4 (noting the change from the DSM-IV-TR to the DSM-5).
56. DSM-IV-TR, supra note 7, at 674.
57. DSM-5, supra note 2, at 585.
58. See id.
59. Id.
60. Id.
61. Id.
have grown so quickly that he borrowed money from his law firm clients' trust accounts in violation of Rule 1.15 of the Louisiana Rules of Professional Conduct,\textsuperscript{62} which resulted in Gary's forced leave of absence and, ultimately, the loss of his partnership. This turn of events satisfies the eighth diagnostic criterion ("[h]as jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling").\textsuperscript{63} Because he meets four or more of the nine diagnostic criteria, Gary's mental health professional has accurately diagnosed Gary with gambling disorder under the DSM-5.

Clinicians have known for several decades that gambling disorder can be "extremely incapacitating and result[ed] in [the] failure to maintain financial solvency" as well as the inability to "provide basic support for oneself or one's family."\textsuperscript{64} Clinicians also have known for quite some time that individuals like Gary who have gambling disorder tend to become alienated from family members and acquaintances and tend to lose what they have accomplished or attained in life, such as a previously happy marriage or a law firm partnership.\textsuperscript{65} Clinicians also have recognized for several decades the many complications of gambling disorder, including suicide attempts, association with fringe and illegal groups, and arrest for nonviolent crimes that may lead to imprisonment.\textsuperscript{66} Until somewhat recently, however, other basic statistical and scientific information relating to gambling disorder, including its causes, correlates, and treatments, has not been available.

\begin{itemize}
  \item \textsuperscript{63} DSM-5, supra note 2, at 585.
  \item \textsuperscript{64} \textit{See, e.g.}, DSM-III, supra note 3, at 292.
  \item \textsuperscript{65} \textit{Id}
  \item \textsuperscript{66} \textit{Id}
\end{itemize}
III. GAMBLING DISORDER: SCIENTIFIC UNDERSTANDING

Over time, problem gambling has been viewed through multiple lenses, including moral, mathematical, economic, social, psychological, cultural, genetic, and, more recently, neurobiological lenses. The final decade of the twentieth century and the first decade and a half of the twenty-first century have witnessed a tremendous growth in health and social science research relating to gambling disorder. This research has yielded reliable information regarding the prevalence of gambling disorder, its environmental and genetic influences, and its neural correlates, as well as the disorder's public health implications, diagnostic standards, and treatment modalities. This information is helpful for evaluating current health and disability laws and in proposing new health and disability laws and policies. Part III lays the scientific foundation for the legal and policy arguments made in Part VII.

One line of important research relates to gambling disorder comorbidities. In the context of gambling disorder, comorbidity research examines the existence of additional, concurrent disorders in an individual who has gambling disorder. It also analyzes the way in which gambling disorder and these other disorders may interact and the way in which treatment (or lack of treatment) for one disorder may help or interfere with treatment for another disorder. As one might
imagine, the existence of gambling comorbid disorders makes it difficult to determine whether the act of gambling causes a gambling disorder or whether another disorder may have caused the disordered gambling.\textsuperscript{71} Or, perhaps it is the existence of both gambling disorder and the other disorder that suggests an underlying addiction syndrome.\textsuperscript{72} Understanding the relationships between and among comorbid disorders can improve our understanding of the correlates and causes of gambling disorder and improve treatments for gambling disorder.\textsuperscript{73}

To this end, a number of important research studies have investigated the relationship between gambling disorder and other health conditions. For example, a study published in 2008 by scientists affiliated with Harvard Medical School, the Cambridge Health Alliance, and the University of Minnesota analyzed the gambling data included in the United States National Comorbidity Survey Replication (NCS-R), “a face-to-face household survey of 9,282 English-speaking respondents ages 18 years and older carried out between February 2001 and April 2003 in a nationally representative multi-stage clustered area probability sample of the US household population.”\textsuperscript{74} The purpose of the study was to increase knowledge of the prevalence and correlates of pathological gambling (the term then in effect under the DSM-IV-TR).\textsuperscript{75}

In the total sample examined, the lifetime prevalence (with standard error in parentheses) estimate of problem gambling was 2.3\% (0.3) and the lifetime prevalence estimate of pathological gambling was 0.6\% (0.1).\textsuperscript{76} The study authors also found that lifetime pathological gambling was significantly associated in the total sample with other disorders; that is, 96.3\% of respondents with lifetime pathological gambling also met lifetime criteria for one or more other Composite International Diagnostic Interview (CIDI)/DSM-IV

antisocial personality disorder, in population-representative samples of problem and pathological gamblers.”).

\textsuperscript{71} Research & Resources, supra note 68, at 10.
\textsuperscript{72} Id.
\textsuperscript{73} Lorains, Cowlishaw & Thomas, supra note 70, at 490 (“Problem and pathological gamblers experience high levels of other comorbid mental health disorders and screening for comorbid disorders upon entering treatment for gambling problems is recommended.”); Research & Resources, supra note 68, at 10.
\textsuperscript{74} R.C. Kessler et al., DSM-IV Pathological Gambling in the National Comorbidity Survey Replication, 38 PSYCHOL. MED. 1351, 1351-52 (2008).
\textsuperscript{75} See id. at 1351.
\textsuperscript{76} Id. at 1353.
disorders and 64.4% suffered from three or more disorders. Among those who developed pathological gambling, 23.5% developed pathological gambling before any other psychiatric problem, 74.3% of respondents developed pathological gambling after experiencing other psychiatric problems, and 2.2% developed pathological gambling and other psychiatric problems at about the same time.

The study authors also found that respondents with other psychiatric disorders were 17.4 times more likely to develop pathological gambling than those without such problems. SubSTANCE use disorders, in particular, were significantly elevated among participants with pathological gambling; that is, 76.3% met criteria for any substance use disorder, 46.2% met criteria for alcohol or drug abuse, 31.8% met criteria for alcohol or drug dependence, and 63.0% met criteria for nicotine dependence. The study authors formally concluded that pathological gambling is a "comparatively rare, [but] seriously impairing, and undertreated disorder whose symptoms typically start during early adulthood and is frequently secondary to other mental or substance disorders that are associated with both [pathological gambling] onset and persistence."

A second, important line of research investigates how and why individuals develop gambling disorders. Family history studies, in particular, have been helpful in investigating the inheritance of disorders such as gambling disorder. In a study published in 2006, scientists at the University of Iowa College of Medicine and the Indiana University School of Medicine investigated whether pathological gambling (the term then in effect under the DSM-IV-TR) is familial. To that end, the study authors recruited thirty-one case probands diagnosed with pathological gambling under the DSM-IV and thirty-one control probands and conducted in-depth interviews of them and their first-degree relatives (FDRs).
The study authors found that "[t]he lifetime rates of [pathological gambling] and 'any gambling disorder' were significantly greater among the [FDRs] of case probands (8.3% and 12.4%, respectively) than among the control [FDRs] (2.1% and 3.5%, respectively)." That is, the study authors reported a rate of 8.3% for pathological gambling and 12.4% for any gambling disorder among the FDRs of pathological gamblers, compared to only 2.1% and 3.5%, respectively, among the control group. The study authors also found that pathological gambling FDRs had significantly higher lifetime rates of alcohol disorders, "any substance use disorder," antisocial personality disorder, and "any mental disorder." Finally, the study authors found that "any gambling disorder," alcohol disorder, and "any substance use disorder" remained significant even after a conservative Bonferroni correction. The study authors formally concluded that gambling disorders are familial and coaggregate with substance misuse. The results of this study are significant: demonstrating that pathological gambling runs in families is the first step toward identifying specific genes that could lead to the development of prevention and treatment strategies.

A third, important line of research uses functional magnetic resonance imaging (fMRI) to study changes in blood oxygenation that occur in the brain when individuals see gambling cues or otherwise participate in gambling activities. In preparing one of the first

85. Id.
86. Id. at 295, 299.
87. Id.
88. Id. In statistics, the Bonferroni correction is a method used to counteract the problem of multiple comparisons. More specifically, the "correction is used to reduce the chances of obtaining false-positive results . . . when multiple pair wise tests are performed on a single set of data." It is considered the simplest and most conservative method to control the family wise error rate. See, e.g., Matthew A. Napierala, What Is the Boneferroni Correction?, AM. ACAD. ORTHOPAEDIC SURGEONS (Apr. 2012), http://www.aaos.org/news/aaosnow/aprl2/research7.asp.
89. Black et al., supra note 82, at 295; Research & Resources, supra note 68, at 11.
91. See, e.g., David N. Crockford et al., Cue-Induced Brain Activity in Pathological Gamblers, 58 BIOLOGICAL PSYCHIATRY 787, 791-92 (2005) ("Pathological gambling subjects in comparison with matched control subjects exhibited increased activity in the right DLPFC [(dorsolateral prefrontal cortex)], right parahippocampal region, and left occipital cortex when exposed to visual gambling sensory cues. Findings were associated with a significantly greater baseline craving and mean change in craving for gambling in [pathological gambling] subjects despite the stimuli not specifically matching their preferred game(s) of choice. Pathological gambling subjects activated the dorsal visual processing stream in response to viewing a [video lottery terminal] being played, whereas control subjects activated the ventral visual processing stream when viewing gambling venues. Brain regions of activation in
neuroimaging studies of pathological gambling (ultimately published in 2003), scientists from Yale University School of Medicine, Vanderbilt University School of Medicine, and the Connecticut Council on Problem Gambling knew that gambling urges in pathological gambling (the term then in effect under the DSM-IV-TR) often immediately precede engagement in self-destructive gambling behavior. The scientists believed “[a]n improved understanding of the neural correlates of gambling urges in [pathological gambling] would advance [an] understanding of the brain mechanisms underlying [pathological gambling] and would help direct research into effective treatments.” The scientists, therefore, designed an fMRI study that “assess[ed] brain function during viewing of videotaped scenarios with gambling, happy, or sad content.” “Participants [were asked to] rate[] the quality and magnitude of their emotional [responses] and motivational responses.” After analyzing the data, the study authors found that male participants with pathological gambling reported “greater gambling urges after viewing [the] gambling scenarios [versus] control subjects [although] [t]he groups did not differ significantly in their subjective responses to the happy . . . or sad . . . videotapes.”

The study authors concluded: “In men with [pathological gambling], . . . cue presentation elicits gambling urges and leads to a temporally dynamic pattern of brain activity changes in frontal, paralimbic, and limbic brain structures. When viewing gambling cues, [pathological gambling] subjects demonstrate relatively decreased activity in brain regions implicated in impulse regulation compared with controls.” The study authors further concluded that their “finding of distinct patterns of neural responses to gambling-related stimuli that are unique from those to other internal (emotional) states has direct clinical implications and provides a basis for future

93. Id. at 828.
94. Id.
95. Id.
96. Id.
97. Id.
experimentation in the prevention and treatment of [pathological gambling]."

In a second neuroimaging study published two years earlier, in 2001, scientists from Massachusetts General Hospital, Harvard Medical School, Concordia University, and Princeton University used fMRI to monitor the brain activity of individuals without gambling disorder who played games of chance where money was at stake. The study authors reported that the brain activations of individuals who anticipate winning money in gambling-like scenarios are very similar to the brain activations of individuals who use cocaine. The study authors specifically concluded, "The overlap of the observed activations with those seen previously in response to ... euphoria-inducing drugs is consistent with a contribution of common circuitry to the processing of diverse rewards." The study results are important because they suggest that treatments for individuals with drug addiction may work for individuals with gambling disorder.

A fourth line of research investigates the efficacy of therapies and social interventions, including behavioral therapies, pharmacological therapies, and fellowship participation, for gambling disorder. In a study published in 2006, for example, scientists at the University of Connecticut Health Center investigated the efficacy of cognitive and cognitive-behavioral (CB) therapy for the treatment of gambling disorder. As background, the study authors knew that Gamblers Anonymous (GA) fellowship was the most popular gambling intervention at the time of the study. However, the study authors also knew that statistics showed that "less than 10% of [GA] attendees

98. Id. at 835.
100. Research & Resources, supra note 68, at 11; see Breiter et al., supra note 99, at 634 ("These common patterns of hemodynamic response are consistent with the view that dysfunction of neural mechanisms and psychological processes crucial to adaptive decision making and behavior may contribute to a broad range of impulse disorders such as drug abuse and compulsive gambling.").
103. See, e.g., PATHOLOGICAL GAMBLING: A CLINICAL GUIDE TO TREATMENT 169-205 (Jon E. Grant & Marc N. Potenza eds., 2004) (reviewing studies investigating the efficacy of cognitive and behavioral treatments for gambling disorder in chapter 12 and pharmacological treatments for gambling disorder in chapter 13); NANCY M. PETRY, PATHOLOGICAL GAMBLING: ETIOLOGY, COMORBIDITY, AND TREATMENT 137-226 (2005) (reviewing research on interventions for gambling disorder).
105. Id. at 555.
[were] actively involved in the fellowship” and that overall gambling abstinence rates remained low. The purpose of the University of Connecticut Health Center study, then, “was to evaluate the efficacy of a short-term, CB treatment . . . and compare its efficacy to a real-world control condition,” that is, referral to GA.

To that end, the study authors recruited 231 “[i]ndividuals who met [DSM-IV] criteria for pathological gambling, had gambled in the past 2 months, were 18 years or older, and could read at the 5th grade level.” The study authors randomly assigned the participants to one of three study arms: (1) referral to GA, (2) referral to GA plus a self-directed CB workbook, or (3) referral to GA plus eight sessions of individual CB therapy. The study authors then assessed gambling and related problems at baseline, one month later, posttreatment, and at six and twelve months posttreatment. The study authors found that participants who were assigned to the third arm (i.e., participants who received in-person, professional CB therapy while enrolled in GA) made significantly more progress in modifying their gambling behaviors than participants who only attended GA (i.e., participants in the first arm) or who attended GA and used a self-directed CB therapy workbook (i.e., participants in the second arm). Although the study authors recognized that additional studies would be required to more fully investigate the costs, benefits, and efficacy of CB therapy, their data does suggest efficacy of individual CB therapy in treating individuals with gambling disorder.

In addition to behavioral therapies, scientists are also investigating the efficacy of several classes of drugs, including opioid antagonists, serotonin reuptake inhibitors, and mood stabilizers, for the treatment of gambling disorder. In a detailed review essay published in 2006, for example, two University of Minnesota scientists summarized then-current study results investigating the efficacy of opioid-receptor antagonists, serotonin reuptake inhibitors, and mood stabilizers for the treatment of gambling disorder. Several of the
studies reviewed demonstrated the efficacy of pharmacological therapies for the treatment of gambling disorder.

For example, in a study published in 2001, scientists from the University of Minnesota Medical School and the Sungkyunkwan University School of Medicine wanted “to assess the efficacy and tolerability of naltrexone in the treatment of pathologic gambling,” the term then in effect under the DSM-IV-TR.\textsuperscript{115} The study authors therefore conducted a 1-week, single-blind placebo lead-in followed by an 11-week, double-blind, placebo-controlled trial of naltrexone, analyzing data relating to 45 subjects who were pathological gamblers.\textsuperscript{116} At the end of the study, 75\% of the participants taking naltrexone were “much” or “very much” improved on both the patient-rated Clinical Global Impression and clinician-rated Clinical Global Impression scales, compared with only 24\% of those on placebo.\textsuperscript{117} The study authors stated, “Results suggest that naltrexone is effective in reducing the symptoms of pathologic gambling”; however, the study authors also cautioned that their results should be interpreted cautiously until further studies corroborate their findings and given the identified side effects of naltrexone.\textsuperscript{118}

Other scientists have investigated the efficacy of nalmefene, another opioid antagonist, in the treatment of pathological gambling. In one illustrative study published in 2006, scientists from the University of Minnesota, Yale University, Mount Sinai School of Medicine, Washington University School of Medicine, and Bio-Tie Therapies Corporation in Finland studied the efficacy and tolerability of nalmefene for treating adult disordered gamblers.\textsuperscript{119} In “[a] 16-week, randomized, dose-ranging, double-blind, placebo-controlled trial ... conducted at 15 outpatient treatment centers across the United States between March 2002 and April 2003,” researchers randomly assigned 207 participants diagnosed with pathological gambling under the DSM-IV-TR to receive nalmefene at doses of 25 mg/day, 50 mg/day, or 100 mg/day, or to receive a placebo.\textsuperscript{120} The study authors formally concluded that low doses of nalmefene may be an effective

\textsuperscript{115} Suck Won Kim et al., \textit{Double-Blind Naltrexone and Placebo Comparison Study in the Treatment of Pathological Gambling}, 49 \textit{Biological Psychiatry} 814, 914 (2001).

\textsuperscript{116} Id.

\textsuperscript{117} Id.

\textsuperscript{118} Id.

\textsuperscript{119} Jon E. Grant et al., \textit{Multicenter Investigation of the Opioid Antagonist Nalmefene in the Treatment of Pathological Gambling}, 163 \textit{Am. J. Psychiatry} 303 (2006).

\textsuperscript{120} Id. at 303.
treatment for individuals with gambling disorder, although high doses appear to produce intolerable side effects.\textsuperscript{121}

These studies are illustrative, not exhaustive, examples of types of ongoing gambling disorder research studies.\textsuperscript{122} Given the advances in the scientific understanding of gambling disorder identified in these and other research studies, the question becomes whether distinctions between gambling disorder and other health conditions that are embedded in health insurance laws and policies, disability income insurance benefits laws and policies, and federal and state antidiscrimination laws are scientifically supportable. A review of the legal distinctions between gambling disorder and other health conditions follows in Parts IV through VI. Part VII argues that these legal distinctions are not supportable.

IV. HEALTH INSURANCE COVERAGE OF GAMBLING DISORDER TREATMENTS

Many health insurance policies and plans exclude treatments and services for gambling disorder from insurance coverage. A quick Google search reveals that Wellmark South Dakota's Blue Priority HSA Plan still excludes pathological gambling from coverage.\textsuperscript{123} The 2013-2014 Student Injury & Sickness Insurance Plan for students attending Embry-Riddle Aeronautical University in Florida also specifically excludes treatments and services for gambling from coverage.\textsuperscript{124} The health plan of the University of Pittsburgh Medical Center similarly excludes from coverage treatments for gambling

\textsuperscript{121} Id. at 311.

\textsuperscript{122} More complete reviews of gambling disorder research may be found at PATHOLOGICAL GAMBLING: A CLINICAL GUIDE TO TREATMENT, supra note 103, at 169-205 (reviewing studies investigating the efficacy of cognitive and behavioral treatments for gambling disorder in chapter 12 and pharmacological treatments for gambling disorder in chapter 13); PETRY, supra note 103, at 137-226 (reviewing research on interventions for gambling disorder); Research & Resources, supra note 68, at 6-19.

\textsuperscript{123} See Blue Priority HSA Health Plans for Individuals and Families: Blue Select HSA-Qualified PPO Plans, WELLMARK S.D. 9 (2012), http://www.wellmark.com/SouthDakotaPlans/OOC/BluePriorityHSA_M31118_10_12.pdf (excluding certain mental health and chemical dependency services, including "[i]mpulse-control disorders (such as pathological gambling")").

\textsuperscript{124} See 2013-2014 Student Injury and Sickness Insurance Plan, UNITED HEALTHCARE 16, https://www.uhc.com/uhc/Brochures/Public/ClientBrochures/2013-735-2-3%20Brochure-v3-NOC%203.pdf (last visited Oct. 25, 2014) (excluding coverage for "treatment, services or supplies for ... [a]ddiction, such as: nicotine addiction, except as specifically provided in the policy and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency").
disorder. As a result of these types of exclusions, many individuals are forced to pay for gambling treatments out of their own pockets or must limit their treatment to free twelve-step programs such as Gamblers Anonymous or state-funded treatments.

Although many states have enacted parity laws designed to put mental health conditions on equal footing with physical health conditions, some of these parity laws specifically exclude gambling disorder from protection. New Mexico's parity law, for example, requires group health plans in New Mexico to provide "mental health benefits" (and to provide them at parity with "medical and surgical benefits"); however, the New Mexico law specifically excludes treatments for gambling addiction from the definition of "mental health benefits." Similarly, Nevada's mental health parity law requires the provision of insurance benefits for certain "severe mental illness[es]," defined to include schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder. Individuals who have gambling

125. See Exclusions, UPMC HEALTH PLAN 1, http://www.upmchealthplan.com/pdf/Exclusions.pdf (last visited Oct. 25, 2014) (excluding from insurance coverage "[t]welve step model programs as sole therapy for conditions, including, but not limited to . . . addictive gambling").

126. Final Report, NAT'L GAMBLING IMPACT STUDY COMMISSION (Aug. 3, 1999), http://govinfo.library.unt.edu/ngisc/ (select "Final report"; then select "Full Report"; then scroll down and select "Chapter 4. Problem and Pathological Gambling"); see also About Us, GAMBLERS ANONYMOUS, http://www.gamblersanonymous.org/ga/content/about-us (last visited Oct. 25, 2014) ("Gamblers Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from a gambling problem. The only requirement for membership is a desire to stop gambling. There are no dues or fees for Gamblers Anonymous membership; we are self-supporting through our own contributions.").


128. N.M. STAT. § 59A-23E-18(A) (2013) ("A group health plan . . . shall provide both medical and surgical benefits and mental health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.").

129. Id. § 59A-23E-18(F) (defining "mental health benefits" as "mental health benefits as described in the group health plan, or group health insurance offered in connection with the plan; but [not including] benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction" (emphasis added)).

130. NEV. REV. STAT. § 689A.0455(1)-(2) (2014) (requiring certain health insurance policies to provide coverage for the treatment of conditions relating to "severe mental illness," and defining "severe mental illness" as "any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association: (a) Schizophrenia[,] (b) Schizoaffective disorder[,] (c) Bipolar
disorder, which is not included in Nevada's definition of "severe mental illness," do not benefit from these state-mandated health insurance benefits.

In an attempt to remedy the patchwork of state mental health parity laws and to counter the historically inferior health insurance benefits available to individuals with mental health conditions, the federal government took its first step towards establishing mental health parity on September 26, 1996, when President Bill Clinton signed the federal Mental Health Parity Act (MHPA) into law.\(^1\) As originally enacted, MHPA prohibited large group health plans that offered medical and surgical benefits as well as mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.\(^2\) For example, MHPA would have prohibited a large group health plan from imposing a $20,000 annual cap or a $100,000 lifetime cap on mental health care if the plan had no annual or lifetime caps for medical and surgical care or if the plan had higher caps, such as a $50,000 annual cap or a $500,000 lifetime cap, for medical and surgical care.\(^3\)

The problem with MHPA was that its application and scope were very limited. As originally enacted, MHPA did not apply to the group health plans of "small employers," which it further defined as those "who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ[] at least 2 employees on the first day of the plan year."\(^4\) MHPA also did not apply to individual health plans, the Medicare Program, Medicaid nonmanaged care plans, or any self-funded, nonfederal governmental plan whose sponsor opted out of MHPA.\(^5\) Finally, MHPA contained an "increased cost" exemption for covered group health plans or health insurance coverage offered in connection with such plans if the application of MHPA resulted in an increase in


\(^{132}\) See id. § 702(a), 29 U.S.C. § 1185a.

\(^{133}\) See id.

\(^{134}\) See id. § 702 (applying in each case to "a group health plan (or health insurance coverage offered in connection with such a plan)").

the cost under the plan of at least 1%. By November 1998, over two years after MHPA's enactment, only four plans across the United States had obtained exemptions due to cost increases of 1% or more.

In terms of its substantive provisions, MHPA was neither a mandated offer nor a mandated benefits law; that is, nothing in MHPA required a large group health plan to actually offer or provide any mental health benefits. Thus, health plans were free after the enactment of MHPA to simply not provide any benefits for gambling disorder or any other mental health condition. As originally enacted, MHPA also was not a comprehensive parity law because it expressly excluded from protection individuals with substance use and addictive disorders, such as alcohol use disorder and other drug use disorders. (MHPA did not specifically mention gambling disorder one way or another.) In addition, MHPA did not require parity between medical and surgical benefits and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.

Because of these limitations, President George W. Bush expanded MHPA twelve years later by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA built on MHPA by expressly protecting individuals with substance-related and addictive disorders and by imposing comprehensive parity requirements on large group health plans. In particular, MHPAEA provided that any financial

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138. See MHPA § 702(a), 29 U.S.C. § 1185a (“Nothing in this section shall be construed ... as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits ...”).
139. See id.
140. See id. § 702(a) (“The term ‘mental health benefits’ means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.”).
141. See id. (“Nothing in this section shall be construed ... as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage ...”).
143. See id. § 512(a)(5), 29 U.S.C. § 1185a (adding a new definition of “substance use disorder benefits”); id. § 512(a)(1), 29 U.S.C. § 1185a (regulating the financial requirements...
requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses)\textsuperscript{144} and treatment limitations (including inpatient day limitations and outpatient visit limitations)\textsuperscript{145} that large group health plans imposed on mental health and substance use disorder benefits must not be any more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially all medical and surgical benefits.\textsuperscript{146} MHPAEA thus would have prohibited large group health plans from imposing higher deductibles, copayments, or coinsurances, or lower inpatient day and outpatient visit maximums, on individuals seeking care for gambling disorder or any other mental health or substance use disorder listed in the current edition of the DSM or the International Classification of Diseases (ICD).\textsuperscript{147}

As originally enacted, MHPAEA did not apply to the group health plans of “small employers,” which it, like MHPA, defined as those “who employed an average of at least 2 . . . but not more than 50 employees on business days during the preceding calendar year.”\textsuperscript{148} MHPAEA, like MHPA, also did not apply to individual health plans, the Medicare Program, Medicaid nonmanaged care plans, or any self-funded, nonfederal governmental plans whose sponsors had opted out of MHPAEA.\textsuperscript{149} In terms of its substantive provisions, MHPAEA also

\begin{itemize}
\item \textsuperscript{144} See id. § 512(a)(1), 29 U.S.C. § 1185a (including within the definition of “financial requirements” deductibles, copayments, coinsurance, and out-of-pocket expenses).
\item \textsuperscript{145} See id. (including within the definition of “[t]reatment limitation . . . limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment”).
\item \textsuperscript{146} See id. (requiring both financial requirements and treatment limitations applicable to mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all physical health benefits covered by the plan).
\item \textsuperscript{147} See, e.g., Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 Fed. Reg. 68,240, 68,286 (Nov. 13, 2013) (codified at 45 C.F.R. § 146.136) (“Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines.
\item \textsuperscript{148} MHPAEA § 512, 29 U.S.C. § 1185a (applying only to group health plans or health insurance coverage offered in connection with such plans).
\item \textsuperscript{149} Colleen L. Barry et al., A Political History of Federal Mental Health and Addiction Insurance Parity, 88 MILBANK Q. 404, 407 (2010) (explaining that the MHPAEA “applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children’s Health Insurance Program, and state and local government
was neither a mandated offer nor a mandated benefits law; that is, nothing in MHPAEA required a covered group health plan to actually offer or provide any gambling disorder benefits or other mental health benefits. Like MHPA, MHPAEA also contained an "increased cost" exemption for covered group health plans and health insurance coverage offered in connection with such plans, but under MHPAEA the amount of the required cost increase increased, at least for the first year. That is, a covered plan that could demonstrate a cost increase of at least 2% in the first plan year and 1% in each subsequent plan year of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits would be eligible for an exemption from MHPAEA for such year. MHPAEA required determinations of exemption-qualifying cost increases to be made and certified in writing by a qualified and

plans," but not to Medicaid nonmanaged care plans); Letter from Cindy Mann, Dir., Ctr. for Medicaid & State Operations, Dep't of Health & Human Servs., to State Health Officials, CENTERS FOR MEDICARE & MEDICAID SERVICES (Nov. 4, 2009), http://downloads.cms.gov/ cmsgov/archived-downloads/SMDL/downloads/SHO110409.pdf ("The MHPAEA requirements apply to Medicaid only insofar as a State's Medicaid agency contracts with one or more managed care organizations (MCOs) or Prepaid Inpatient Health Plans (PIHPs), to provide medical/surgical benefits as well as mental health or substance use disorder benefits. . . . MHPAEA parity requirements do not apply to the Medicaid State plan if a State does not use MCOs or PIHPs to provide these benefits."); see The Center for Consumer Information & Insurance Oversight: The Mental Health Parity and Addiction Equity Act, CENTERS FOR MEDICARE & MEDICAID SERVICES, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html (last visited Oct. 26, 2014) ("MHPAEA does not apply directly to small group health plans . . . . Non-Federal governmental employers that provide self-funded group health plan coverage to their employees (coverage that is not provided through an insurer) may elect to exempt their plan (opt-out) from the requirements of MHPAEA . . . . Medicare, Medicaid . . . are not . . . issuers of health insurance. They are public health plans through which individuals obtain health coverage. However, . . . Medicaid benchmark benefit plans . . . require compliance with certain requirements of MHPAEA.").


152. Id.
Before President Obama signed the health care reform bill into law, then, gambling disorder and other mental health insurance benefits were regulated by MHPA—as expanded by MHPAEA—and more stringent state law. That is, unless a more stringent state law required a health plan to provide gambling disorder benefits (which state law usually did not), a health plan was not required to provide gambling disorder benefits.

In late March 2010, President Obama responded to this limitation by signing the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) into law (as consolidated, commonly known as the Affordable Care Act (ACA)). Best known for its controversial individual health insurance mandate, ACA has two sets of provisions that relate to mental health parity and mandatory mental health and substance use disorder benefits. Upheld by the United States Supreme Court on June 28, 2012, these two sets of provisions eliminate some of the limitations of MHPA and MHPAEA.

The first set of ACA provisions extends MHPA's and MHPAEA's mental health parity provisions to the individual and small group health plans offered on and off the health insurance exchanges. Now,
many individual and small group health plans that previously discriminated against individuals with gambling disorder and other mental health conditions through higher deductibles, copayments, and coinsurance rates, as well as lower inpatient day limitations and outpatient visit limitations, must comply with MHPA and MHPAEA.\textsuperscript{159}

The second set of relevant ACA provisions requires certain health plans to actually provide mental health and substance use disorder benefits. That is, the ACA now requires individual and small group health plans,\textsuperscript{160} exchange-offered qualified health plans,\textsuperscript{161} state basic health plans,\textsuperscript{162} and Medicaid benchmark plans\textsuperscript{163} to offer "[m]ental health and substance use disorder services, including behavioral health treatment[s]" in addition to nine other categories of essential health benefits (EHBs).\textsuperscript{164} Unfortunately, not every individual with health insurance will benefit from these ten required EHB categories because grandfathered health plans, large group health plans, and self-insured health plans are exempt from the requirement to provide the ten EHB categories.\textsuperscript{165}

\begin{itemize}
\item \textsuperscript{159} See supra text accompanying note 158.
\item \textsuperscript{160} ACA § 1201, 42 U.S.C. §§ 300gg to 300gg-5 (noting amendments to the Public Health Service Act § 2707(a), 42 U.S.C. § 300gg-6(a)).
\item \textsuperscript{161} Id. § 1301(a)(1), 42 U.S.C. § 18021(a)(1).
\item \textsuperscript{162} Individuals eligible for state basic health plan coverage include individuals who are not eligible for Medicaid and whose household income falls between 133\% and 200\% of the federal poverty line for the family involved as well as low-income legal resident immigrants. Id. § 1331(e), 42 U.S.C. § 18051.
\item \textsuperscript{163} Id. § 2001(c)(3), 42 U.S.C. § 1396u-7(b)(5).
\item \textsuperscript{164} Id. § 1302(b)(1), 42 U.S.C. § 18022.
\item \textsuperscript{165} Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,562-63 (June 17, 2010) (noting amendments to 29 C.F.R. § 2590.715-1251(a), which defines "grandfathered health plan coverage" as "coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010"); id. at 34,559 (explaining that section 2707 of the Public Health Service Act does not apply to grandfathered health plans); id. at 34,563 (noting amendments to 29 C.F.R. § 2590.715-1251(c)(1), which states that "the provisions of PHS Act section[] . . . 2707 . . . do not apply to grandfathered health plans"); Application of the New Health Reform Provisions of Part A of Title XXVII of the PHS Act to Grandfathered Plans, U.S. DEPARTMENT LAB. 1, http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf (last visited Oct. 26, 2014) (explaining that ACA's essential benefits package requirement is not applicable to grandfathered plans); Sara Rosenbaum, Joel Teitelbaum & Katherine Hayes, The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities, COMMONWEALTH FUND 3 (Mar. 2011), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2011/mar/1485_rosenbaum_essential_hit_benefits_provisions_aca_disabilities_reform_brief_v2.pdf ("The act exempts large-group health plans, as well as self-insured ERISA plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements."); see CHERYL ULMER ET AL., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST
For those health plans that must provide benefits within the ten EHB categories, the statutory EHB requirements are unclear as to whether particular benefits, such as gambling disorder benefits, are required. As a result, the federal Department of Health and Human Services (HHS) issued final regulations implementing ACA's EHB requirements (Final Regulations) on February 25, 2013.166 These Final Regulations permit states to select a benchmark plan167 that provides coverage for the ten EHB categories, including mental health and substance use disorder services,168 that will serve as a reference plan for health plans in the state. According to the Final Regulations, health plans in the state that are required to provide the ten EHB categories shall provide health benefits that are substantially equal to those provided by the state’s benchmark plan, including the benchmark plan’s covered benefits and excluded benefits.169

Thus, the question of whether a particular health insurance policy or plan must provide gambling disorder benefits after the ACA requires an analysis of whether the plan is required to provide the ten EHB categories as well as the content of each state’s selected benchmark plan. Given the popularity of gaming in Las Vegas, let us begin with an analysis of the benchmark plan selected by the state of Nevada. The state of Nevada selected the Health Plan of Nevada Point of Service Group 1C XV 500 HCR Plan (Nevada Benchmark Plan) as its benchmark plan.170 If, as written on March 31, 2012, the Nevada Benchmark Plan included gambling disorder benefits, then individual, small group, and other health plans in the state of Nevada that are required to provide the ten EHB categories could have to provide gambling disorder benefits in years 2014 and 2015.171

166. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,836 (Feb. 25, 2013) (codified as amended at 45 C.F.R. pts. 147, 155-156 (2013)).
167. Id. at 12,866 (adopting 45 C.F.R. § 156.100).
168. Id. (adopting 45 C.F.R. § 156.110(a)(5)).
169. Id. at 12,867 (adopting 45 C.F.R. § 156.115(a)).
171. See E-mail from Glenn Shippey, Nev. Div. of Ins., to author (Oct. 2, 2013, 4:12 PM) (on file with author) (explaining the application of the EHB requirements in the state of Nevada).
hand, if the Nevada Benchmark Plan did not include gambling disorder benefits on March 31, 2012, then gambling disorder benefits would not be essential health benefits in the state of Nevada, and individuals such as Gary in this Article’s opening hypothetical will not have such benefits in years 2014 and 2015 unless their health plans voluntarily include such benefits. 172

On March 31, 2012, the Nevada Benchmark Plan included coverage for outpatient and inpatient treatment of substance-related conditions, including alcohol use disorder and the drug use disorders. 173 On March 31, 2012, however, the Nevada Benchmark Plan excluded coverage for a class of mental health conditions known as the “impulse control disorders.” 174 Because the then-current (2012) edition of the DSM, the DSM-IV-TR, classified “pathological gambling” as an impulse control disorder, the Nevada Benchmark Plan excludes coverage for treatments for gambling disorders, at least for years 2014 and 2015. That is, in years 2014 and 2015, Nevada residents will not benefit from any mandatory gambling disorder benefits and will only have them to the extent that their health plans voluntarily provide gambling disorder benefits. A quick Google search revealed that other state benchmark plans, such as the Iowa Benchmark Plan, 175 also exclude coverage of treatments for the impulse control disorders and, therefore, treatments for gambling disorder.

Now, let us turn to the state of Louisiana, where Gary currently lives. Louisiana’s Benchmark Plan does not appear to exclude from coverage treatments for the impulse control disorders generally or gambling disorder specifically. 176 Only “counseling services[,] such as career counseling, marriage counseling, divorce counseling, parental counseling and job counseling[,] [and] [e]ducation services and supplies[,] including training or re-training for a vocation,” appear to

172. See Amanda Cassidy, Essential Health Benefits, HEALTH AFF. 2 (May 2, 2013), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf (noting that HHS has indicated that the benchmark plan approach may be changed in 2016 and in future years based on evaluation and feedback).

173. See Nevada EHB Benchmark Plan, supra note 170, at 3, rows 26-27.

174. See E-mail from Glenn Shippey to author, supra note 171 (noting the Nevada Benchmark Plan’s exclusion of “[i]mpulse control disorders”).


be excluded from the mental health benefits set forth in Louisiana's Benchmark Plan. As a result, health plans that are required by the ACA to offer the ten EHB categories would be required to cover gambling disorder benefits.

Returning to the hypothetical that opens this Article, remember that Gary's mental health professional recommended that Gary participate in a twenty-two-day residential treatment program located on the Northshore of Lake Pontchartrain for individuals with gambling disorder. Unfortunately, if Gary lived in Las Vegas, it is likely that his health plan would exclude inpatient and outpatient treatments for gambling disorder from coverage and that this exclusion would be legally permissible given that the Nevada Benchmark plan excludes treatments for the impulse control disorders from coverage. The result is that Gary would not have private insurance coverage of gambling disorder and would have to pay for the costs of his treatment out of his own (now empty) pocket unless the state in which Gary lived provided state-funded coverage for gambling treatments and Gary was able to access those state-funded services. In Gary's case, remember that he spent his savings chasing gambling losses and has a heavily mortgaged house located in an affluent neighborhood. The result is that unless Gary can generate some other source of income or he lives in a state that funds gambling treatment services, he likely will not obtain any gambling treatments other than those provided through free twelve-step programs such as Gamblers Anonymous.

In Louisiana, on the other hand, Gary's gambling disorder treatments would appear to be covered by private health insurance policies that, under the ACA, must comply with the essential health benefits requirements. As discussed in more detail in Part VII, I propose that the Louisiana benchmark plan

177. See id. at 10, row 25.
178. See, e.g., Five Year Strategic Plan for Problem Gambling Treatment Services Within the State of Nevada: Fiscal Years 2012—2016, NEV. DEPARTMENT HEALTH & HUM. SERVICES (Apr. 29, 2011), http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Resources/State_Plans/NV_DHHS_GamblingTreatmentStrategicPlan.pdf (providing information regarding state-funded problem gambling treatment services in Nevada). Currently, Nevada funds are paying for gambling treatments for individuals who have private insurance but whose insurance refuses to cover gambling disorder. When insured individuals use these limited state funds, less money is available for use by individuals with the most dire gambling disorder needs, including those who lack employment, insurance coverage, or both. For fiscal year 2014, approximately $900,000 of state funding was awarded to five gambling treatment programs throughout Nevada. It is the hope of policy makers in Nevada that private insurers will begin to cover gambling disorder, leaving the bulk of state funds for uninsured individuals with gambling disorder who have the highest needs.
179. See About Us, supra note 126 ("There are no dues or fees for Gamblers Anonymous membership; we are self-supporting through our own contributions.").
be used as a model for revising the Nevada, Iowa, and other similar benchmark plans.

V. DISABILITY INCOME INSURANCE BENEFITS FOR INDIVIDUALS WITH GAMBLING DISORDER

Assume for the moment that Gary lives in Las Vegas and does not have access to private gambling disorder health insurance benefits. Unable to pay for his recommended gambling disorder treatment and worried about his ability to pay his mortgage and support his family, Gary explores other income options, including applying for public and private disability income insurance benefits. As background, Title II of the Social Security Act (SSA) provides for the payment of federal Social Security Disability Insurance (SSDI) benefits to certain individuals with physical and mental disabilities. The SSA defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment." An applicant's impairment or impairments must be "of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy." The applicant's impairment must have lasted or be expected to last for a continuous period of at least twelve months, or be expected to result in death.

The Commissioner of Social Security (Commissioner) has established a five-step sequential evaluation for determining whether an individual has a disability that qualifies for the receipt of SSDI benefits. First, a determination is made regarding whether the

180. Disability income insurance protects an individual's income. That is, if an individual becomes unable to work due to a sickness or injury, disability income insurance can provide cash benefits that the individual may use to pay a mortgage and other bills, including expenses for food, clothing, and utilities. Designed to provide financial security until the individual returns to work, disability income insurance typically pays a monthly cash benefit after an initial waiting period that is equivalent to a percentage of the individual's salary. See, e.g., Disability Insurance, MetLife (Apr. 2014), https://www.metlife.com/individual/insurance/disability-insurance/index.html#basics; Individual Disability Insurance, MetLife (Jan. 2014), https://www.metlife.com/individual/insurance/disability-insurance/individual-disability-insurance.html#basics.
183. Id. § 423(d)(2)(A).
184. Id. § 423(d)(1)(A).
individual is engaged in "substantial gainful activity." If so, benefits are denied. Second, if the individual is not engaged in substantial gainful activity, a determination is made regarding whether the individual has a medically severe impairment or combination of impairments. If the individual does not have a severe impairment or combination of impairments, benefits are denied. Third, if the individual has a severe impairment, a determination is made regarding whether the impairment meets or equals one of a number of "listed impairments" in 20 C.F.R. part 404, subpart P, appendix 1. If the impairment meets or equals a "listed impairment," the individual is conclusively presumed to have a disability. Fourth, if the impairment does not meet or equal a "listed impairment," a determination is made regarding whether the impairment prevents the individual from performing past relevant work. If the individual can perform past relevant work, benefits are denied. Fifth, if the individual cannot perform past relevant work, the burden shifts to the Commissioner to show that the individual is able to perform other kinds of work. The individual is entitled to SSDI benefits only if the person is unable to perform other work.

Neither Congress in the SSA, nor HHS in the SSA's implementing regulations, expressly excludes individuals with gambling disorder from qualifying for SSDI benefits. Instead, SSDI claimants with gambling disorder, like most other SSDI claimants, are assessed using the case-by-case, five-step sequential evaluation process.

§ 404.1520(a)(4) (2014) (listing the five-step sequential evaluation process); id. § 416.920(a)(4) (explaining the five-step sequential evaluation process).

186. Bowen, 482 U.S. at 138.
188. Bowen, 482 U.S. at 140-41.
190. Bowen, 482 U.S. at 141.
192. Bowen, 482 U.S. at 142.
194. Bowen, 482 U.S. at 142.
196. Under the 1996 amendments to the SSA, however, "[a]n individual shall not be considered to be disabled ... if alcoholism or drug addiction would ... be a contributing factor material to the Commissioner's determination that the individual is disabled." 42 U.S.C. § 423(d)(2)(C) (2012) (establishing the exclusion); see Johansen v. Astrue, No. 10-2076 (DWF/SER), 2011 WL 4583828, at *1 n.1 (D. Minn. Sept. 30, 2011) (referencing the exclusion).
Johansen v. Astrue provides an illustrative review of an application for SSDI benefits by an individual with gambling disorder. Tammy Lee Ann Johansen, who had worked in the past as a court receptionist, had been diagnosed with gambling disorder in addition to a number of other conditions, including depression, obsessive compulsive disorder, substance abuse, attention deficit disorder, and anxiety, that made her unable on some (but not all) days to do housework, cook, read, or even leave her home. To determine whether Johansen was eligible to receive SSDI benefits, an administrative law judge (ALJ) applied the five-step sequential evaluation set forth in the HHS regulations. At step one, the ALJ found that Johansen had not engaged in substantial gainful activity since the onset of her illness on November 1, 2008. At step two, the ALJ found that Johansen had severe impairments including "pathological gambling disorder; major depressive disorder; attention deficit disorder; anxiety; and a history of treatment for chemical dependence." At the third step, however, "the ALJ concluded that none of [Johansen's] impairments or combination of impairments met or equaled an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1." That is, the ALJ determined, "Johansen had only mild restrictions in the activities of daily living because she was able to do some household activities, she could prepare meals, clean, do laundry and go shopping." The ALJ also determined, "Johansen had moderate restrictions in social functioning [and] moderate difficulties with regard to concentration [and that she] had not had any periods of decompensation." Because Johansen did not have an impairment that was listed in the federal regulations and maintained her coping mechanisms, the ALJ found that she did not satisfy the third step of the analysis. At step four, the ALJ—giving significant weight to the opinions of the state agency medical consultants—found that Johansen "had the residual functional capacity . . . to perform a full range of work." At step five, the ALJ determined that although Johansen

198. Id. at *1.
199. Id. at *9.
200. Id.
201. Id.
203. Id.
204. Id.
205. Id.
206. Id. (internal quotation marks omitted).
could not perform her past relevant work as a court receptionist, she "could perform work as a hand packager, a laundry worker, [or] as an assembler, and that there were significant jobs in the national economy that a person with [her] age, education, work experience, and [residual functional capacity] could perform."\textsuperscript{207} As a result, the ALJ declined Johansen's application for SSDI benefits.\textsuperscript{208}

Johansen appealed. On appeal, the Commissioner upheld the ALJ's findings.\textsuperscript{209} On review, the United States District Court for the District of Minnesota upheld the decision of the Commissioner.\textsuperscript{210} Other cases involving individuals with gambling disorder and other comorbid disorders who have applied for SSDI benefits have had similar results.\textsuperscript{211}

The Johansen case involves an individual's application for federal SSDI benefits. Many individuals such as Gary also have private disability income insurance policies that provide short- and long-term cash disability insurance benefits pursuant to the contractual language set forth in their policies. One question is whether individuals with gambling disorder are expressly excluded from disability income benefits under these private policies or whether they are subject to an individualized disability assessment, such as that set forth under federal law in the SSA. The answer depends on the contractual language set forth in each private disability income insurance policy as applied to the applicant who has gambling disorder. As a general matter, research reveals that gambling disorder tends not to be expressly excluded from the definition of disability in these private policies.\textsuperscript{212} Research also reveals that individuals with gambling disorder may not be successful in their claims for private disability income insurance benefits if the reason for their loss of income includes termination of employment due to a criminal or other illegal

\begin{footnotesize}
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\item\textsuperscript{207} \textit{Id.} at *11.
\item\textsuperscript{208} \textit{Id.} at *9-11.
\item\textsuperscript{209} \textit{Id.} at *1.
\item\textsuperscript{210} \textit{Id.}
\item\textsuperscript{211} See, \textit{eg.}, Gorton v. Astrue, No. 06-CV-4903 (PJS/JSM), 2008 WL 583703, at *4, *27 (D. Minn. Feb. 28, 2008) (noting that a plaintiff with gambling disorder and other comorbid physical and mental accidents and disorders, including a vehicle accident, scoliosis, a depressive disorder, an anxiety disorder, and a mixed personality disorder, applied for SSDI benefits; the United States District Court for the District of Minnesota upheld the Commissioner's denial of her benefits in part because the medical record evidence did not support the plaintiff's subjective complaints).
\end{enumerate}
\end{footnotesize}
However, they may be successful if they do not engage in criminal or other illegal activities and can prove that their gambling disorders caused their loss of income.

For example, in *Reilly v. Northwestern Mutual Life Insurance Co.*, plaintiff Michael Reilly sought to receive monthly cash benefits under his private disability income insurance policy issued by defendant Northwestern Mutual. As background, Reilly was an attorney with gambling disorder whose license to practice law was revoked by the Iowa Supreme Court after he misappropriated over $90,000 of a client’s trust funds to pay for his own personal gambling debts. Benefits were payable under Reilly’s disability income insurance policy if “the Insured [became] disabled while [the] policy [was] in force; the Insured [was] under the care of a licensed physician other than himself [when he had the disability]; [the Insured’s] disability result[ed] from an accident or sickness; and [the Insured’s] disability [was not otherwise excluded under the policy].”

Gambling disorder was not specifically excluded from the definition of disability under Reilly’s policy. Reilly thus argued that his gambling disorder constituted a disabling “sickness,” that he developed this disabling sickness while his disability income insurance policy was in effect, that he was under the care of a physician, and that his sickness caused him to lose his license to practice law, thus necessitating cash income benefits. In opposition, defendant Northwestern Mutual argued that it was not obligated to pay Reilly cash benefits because Reilly’s inability to perform his occupation resulted not from an accident or sickness but, instead, from criminal or other illegal conduct; that is, Reilly misappropriated his client’s trust fund account.

The United States District Court for the Southern District of Iowa agreed with defendant Northwestern Mutual, citing analogous case law holding that an insured’s loss of income caused by a legal consequence of the insured’s behavior, such as the loss of the insured’s license to practice law that followed from the insured’s misappro-
plication of client trust fund accounts, is not a disability.\textsuperscript{220} The court ultimately found that Reilly "was not disabled by the gambling addiction, only by the license revocation," pointing to the fact that Reilly would still be practicing law with his full income, "notwithstanding his excessive gambling, except for his wrongful conversion of client funds."\textsuperscript{221} The court reasoned that the public policy of the state of Iowa required such a finding.\textsuperscript{222} The result might have been different, however, had Reilly not testified at his license revocation hearing that he had overcome his gambling disorder with treatment.\textsuperscript{223} Indeed, the court went on to suggest that disability benefits might be payable in situations in which the work life of a professional is ended only by addiction, not by a license revocation or other criminal or illegal act.\textsuperscript{224}

This suggestion proved true in \textit{McClaugherty v. Unum Life Insurance Co. of America.}\textsuperscript{225} In \textit{McClaugherty}, plaintiff John McClaugherty sued Unum Life Insurance Company following its denial of McClaugherty's application for short-term disability benefits.\textsuperscript{226} McClaugherty had been diagnosed with gambling disorder among other comorbid disorders, including bipolar affective disorder, alcohol use disorder, and substance use disorder.\textsuperscript{227} McClaugherty had not, however, engaged in any criminal or other illegal acts; instead, he simply resigned from his employment in order to enter a treatment center for his gambling disorder and other comorbid disorders. He then applied for short-term cash disability benefits to pay for such treatment.\textsuperscript{228} Defendant Unum tried to argue that McClaugherty did not have a disability within the meaning of the policy. On review, the United States District Court for the Southern District of West Virginia

\begin{footnotesize}
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\item[221.] \textit{Id.} at *3.
\item[222.] \textit{Id.} (quoting \textit{Millstein}, 129 F.3d at 691 ("[A] rule which would allow a lawyer to steal from his clients, even when such theft occurs in the throes of a drug addiction, and then recover disability benefits for income lost due to the [license] suspension resulting from such theft, would be against public policy.").
\item[223.] \textit{Id.} ("Plaintiff so testified at his license revocation hearing and by deposition; treatment for his addiction had overcome his gambling habit.").
\item[224.] \textit{Id.} ("This is consistent with public policy that does not allow recovery on a disability insurance policy when license revocation, not a treatable addiction, ends the work life of a professional.").
\item[226.] \textit{Id.} at *1.
\item[227.] \textit{Id.} at *1-3.
\item[228.] \textit{Id.} at *1.
\end{enumerate}
\end{footnotesize}
found that defendant Unum failed to consider important medical record evidence showing that McClaugherty had received intensive outpatient treatment for his gambling and comorbid disorders that would corroborate McClaugherty’s disability claim. The court ultimately remanded the case, instructing defendant Unum to explicitly consider a particular set of outpatient treatment records as evidence of McClaugherty’s disability.

As discussed in more detail in Part VII, below, I approve of the lack of express exclusions for gambling disorder that exist, and the conduct of individualized assessments of disability that occur, in the context of applications for public and private disability income insurance. I further argue that federal and state health insurance laws, state benchmark health plans, and federal and state antidiscrimination laws should follow suit, removing express exclusions for gambling disorder and conducting individualized assessments of eligibility for individuals with gambling disorder.

VI. DISABILITY DISCRIMINATION PROTECTIONS FOR INDIVIDUALS WITH GAMBLING DISORDER

In the hypothetical that opens this Article, Gary seeks treatment for gambling disorder and discovers that, in some states, health plans may legally exclude gambling disorder treatments from coverage. Gary then seeks cash disability income insurance benefits to pay for his gambling treatment and his other living expenses, only to learn that his misappropriation of client trust funds makes him ineligible for such benefits. Gary then considers suing his old law firm for disability discrimination based on the law firm’s termination of his partnership agreement. As discussed in more detail in this Part, Gary’s gambling disorder makes Gary ineligible for protected status under federal and most states’ antidiscrimination laws.

As background, a range of antidiscrimination protections and accommodations are available to qualified individuals who have physical and mental disabilities under a variety of federal and state laws. Signed into law by President Richard Nixon on September 26, 1973, section 504 of the Rehabilitation Act prohibits employers and organizations that receive federal financial assistance from discriminating on the basis of disability against qualified individuals.

229. Id. at *4-5.
230. Id. at *5.
with disabilities.  

The ADA, signed into law by President George H.W. Bush on July 26, 1990, also prohibits certain employers, state and local government agencies, and places of public accommodation from discriminating on the same basis. The ADAAA, signed into law by President George W. Bush on September 25, 2008, clarifies that the ADA’s definition of disability should be broadly construed in favor of individuals with physical and mental impairments who seek protection under the ADA and generally shall not require extensive analysis. State laws such as the California Fair Housing and Employment Act also provide individuals with protection from harassment and discrimination in the contexts of housing and employment because of physical or mental disability. One theme underlying these federal and state statutes is that it is wrong to discriminate against individuals because of their physical and mental disabilities and that it is right to accommodate them to help them participate more fully in society.

To determine whether an individual such as Gary would be entitled to protection under one of these statutes, each statute’s definition of “disability” must be examined. For example, the original ADA defined a disability as “(A) a physical or mental impairment that substantially limits one or more major life activities of [an] individual; (B) a record of such an impairment; or (C) being

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231. Rehabilitation Act of 1973, § 504, Pub. L. No. 93-112, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 794 (2012)) (“No otherwise qualified handicapped individual in the United States ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”).


235. See, e.g., Timothy P. Ward, Needing a Fix: Congress Should Amend the Americans with Disabilities Act of 1990 To Remove a Record of Addiction as a Protected Disability, 36 RUTGERS L.J. 683, 719 (2005) (“Implicit in Congress’s legitimate goal of protecting the disabled from discrimination is the idea that discrimination against disabled persons is unfair because it is wrong to treat a person differently based on circumstances or conditions over which he has no control.”).

236. The definitions of “disability” that are used by the SSA and by private disability income insurance benefit insurers, discussed supra Part V, are different from the definitions used by federal and state antidiscrimination laws and are not applicable here. See, e.g., Labit v. Akzo-Nobel Salt, Inc., No. 99-30047, at *1 (5th Cir. Feb. 7, 2000) (distinguishing Social Security disability determinations from ADA disability determinations and noting, for example, that “social security disability determinations do not take into account such workplace accommodations”).
regarded as having such an impairment." The regulations implementing the original ADA defined "physical or mental impairment" to include, in relevant part, "[a]ny physiological disorder, or condition . . . affecting [the] neurological [system]" or "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities." These regulations also defined "major life activities" to include "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."

Title I of the ADA, relating to employment, prohibited covered entities from "discriminating against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment." Several different portions of the original ADA's implementing regulations promulgated by the Equal Employment Opportunity Commission (EEOC), a lengthy set of interpretive guidelines, and hundreds of judicial opinions were dedicated to distinguishing the conditions that would and would not result in an individual's protection under the statute.

For example, Title I of the original ADA clarified that the term "qualified individual with a disability" did "not include any employee or applicant who is currently engaging in the illegal use of drugs, when

237. ADA § 3(2)(A)-(C).
238. 29 C.F.R. § 1630.2(h)(1)-(2) (2007) (establishing, prior to the ADAAA Regulations, the definition of physical or mental impairment).
239. Id. § 1630.2(h)(2)(i).
240. Title I of the ADA defined a "qualified individual with a disability" as "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." ADA § 101(8) (internal quotation marks omitted).
242. See, e.g., 29 C.F.R. § 1630.2(h)(2) (clarifying that a protected mental impairment includes "[a]ny mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities").
243. See, e.g., Interpretive Guidance on Title I of the Americans with Disabilities Act, 29 C.F.R. app. pt. 1630 (2013) ("It is important to distinguish between conditions that are impairments and physical, psychological, environmental, cultural, and economic characteristics that are not impairments. . . . The definition, likewise, does not include characteristic predisposition to illness or disease. . . . The definition . . . does not include common personality traits such as poor judgment or a quick temper where these are not symptoms of a mental or psychological disorder. Environmental, cultural, or economic disadvantages such as poverty, lack of education, or a prison record are not impairments.").
244. See, e.g., 42 U.S.C.A. § 12102 (West 2013) (listing in the Notes of Decisions 44-149 hundreds of cases that distinguish protected disabilities from unprotected conditions).
the covered entity acts on the basis of such use.\textsuperscript{245} Title I of the original ADA, however, also clarified that an individual who qualified according to the following criteria should not be excluded from protection:

1. has successfully completed a supervised drug rehabilitation program and is no longer engaging in the illegal use of drugs, or has otherwise been rehabilitated successfully and is no longer engaging in such use;
2. is participating in a supervised rehabilitation program and is no longer engaging in such use; or
3. is erroneously regarded as engaging in such use, but is not engaging in such use . . . .\textsuperscript{246}

Importantly, Title I of the ADA also specifically excluded “compulsive gambling” (as well as kleptomania and pyromania) from the definition of disability.\textsuperscript{247} The exclusion is complete; that is, individuals who have successfully completed a gambling rehabilitation program and are no longer engaged in gambling are not excepted from the exclusion (i.e., are not protected) in the same way that individuals who have successfully completed a drug rehabilitation program and are no longer engaged in the use of drugs are excepted from the exclusion.\textsuperscript{248} Case law interpreting the original ADA confirms that individuals with gambling disorder are not protected.\textsuperscript{249}

The reason for the ADA's exclusion of compulsive gambling from the definition of disability is unclear, although the exclusion may have its origins in \textit{Rezza v. U.S. Department of Justice.}\textsuperscript{250} In \textit{Rezza}, a special agent of the FBI named Anthony Rezza was employed as an FBI agent beginning in 1964.\textsuperscript{251} On July 11, 1985, Rezza bet (and lost) $2,000 in government funds at a casino located in Atlantic City.\textsuperscript{252} On July 12, 1985, Rezza entered a twenty-two-day treatment program and

\textsuperscript{245}. ADA § 104(a), 42 U.S.C. § 12114.
\textsuperscript{246}. Id. § 104(b), 42 U.S.C. § 12114.
\textsuperscript{247}. Id. § 511(b)(2), 42 U.S.C. § 12210.
\textsuperscript{248}. Id. § 104(b), 42 U.S.C. § 12114.
\textsuperscript{249}. See, e.g., Labit v. Akzo-Nobel Salt, Inc., No. 99-30047, at *2 & n.13 (5th Cir. Feb. 7, 2000) (“Congress specifically excluded compulsive gambling as a disability under the [ADA].”); Trammell v. Raytheon Missile Sys., 721 F. Supp. 2d 876, 878, 882 (D. Ariz. 2010) (“Congress expressly excluded compulsive gambling, along with various sexual disorders, kleptomania, pyromania, and psychoactive substance use disorders resulting from current drug use, from the ADAs definition of disability. . . . Plaintiff's theory . . . is that compulsive gambling is synonymous with depression. . . . [T]he Court rejects this approach given the ADAs express exclusion of compulsive gambling as a disability.”).
\textsuperscript{251}. Id. at *1.
\textsuperscript{252}. Id.
then returned to active duty on September 3, 1985.253 Thereafter, Rezza performed his job duties satisfactorily while attending twice-weekly Gamblers Anonymous meetings and remaining abstinent from gambling.254 The FBI terminated Rezza’s employment on August 15, 1986.255

Following his termination, Rezza sued the FBI, the Department of Justice, and other defendants, arguing that he was a compulsive gambler and that his termination resulted from an incident caused by his compulsive gambling in violation of section 504 of the Rehabilitation Act of 1973.256 Rezza then filed a motion for summary judgment, contending that under section 504, compulsive gambling is a protected handicap.257 The United States District Court for the Eastern District of Pennsylvania relied on the APA’s inclusion of pathological gambling in the then-current DSM-III-R (1987) to state that Rezza’s “‘compulsive gambling’ . . . may come within the abstract definition of ‘psychological impairment’” necessary for a mental impairment.258 However, the court ultimately denied Rezza’s motion for summary judgment due to the existence of a material fact issue as to whether Rezza was “otherwise qualified” to be an FBI agent.259

Rezza’s complaint, filed in 1986 and adjudicated and ultimately settled in 1988260—prior to the 1990 enactment of the ADA—may be the source of the ADA’s exclusion of “compulsive gambling” from the ADA’s definition of “disability.” Indeed, at least one ADA historian has stated that the conditions that are excluded from the definition of disability, including the impulse control disorder exclusions, were “reportedly derived from court cases regarding similar legislation.”261 The ADA’s complete exclusion of compulsive gambling from the definition of disability also may be due to its original classification as an impulse control disorder. As discussed in Part II of this Article, the APA initially classified pathological gambling as an impulse control

253. Id.
254. Id.
255. Id.
257. Id.
259. Id. at *3, *6.
260. Id.
disorder (alongside kleptomania, pyromania, and intermittent explosive disorder) in the DSM-III. As late as 2000—ten years after the enactment of the original ADA—the APA continued to classify pathological gambling in the DSM-IV-TR as an impulse control disorder (still alongside kleptomania, pyromania, intermittent explosive disorder, and trichotillomania). Not until May 2013, in the DSM-5, did the APA rename the condition gambling disorder and reclassify it under “Non-Substance-Related Disorders” within “Substance-Related and Addictive Disorders.” Gambling disorder certainly may have suffered in its treatment by Congress due to the disorder’s linkage to the other impulse control disorders. That is, stealing, fire setting, and hair pulling may not have “sounded” in disability as much as other traditional neurological and psychiatric conditions.

With respect to other health conditions that were not specifically excluded from protection, the question of whether individuals with such conditions would be protected by the ADA required a case-by-case analysis of whether the condition constituted a physical or mental impairment and, if so, whether the impairment substantially limited a major life activity. The case law interpreting the original ADA made clear that individuals with episodic symptoms, as well as individuals who took medications that controlled their symptoms, were not protected individuals with disabilities. In Johnson v. North Carolina Department of Health & Human Services, for example, the United

262. Kleptomania, according to the DSM-III, is the “recurrent failure to resist impulses to steal objects that are not for immediate use or their monetary value.” DSM-III, supra note 3, at 293.

263. Pyromania, according to the DSM-III, is the “recurrent failure to resist impulses to set fires and intense fascination with setting fires and seeing them burn.” Id. at 294.

264. Intermittent explosive disorder, according to the DSM-III, is characterized by “several discrete episodes of loss of control of aggressive impulses that result in serious assault or destruction of property.” Id. at 295.

265. Trichotillomania, according to the DSM-IV-TR, “is the recurrent pulling out of one’s own hair” for pleasure, gratification, or relief of tension “that results in noticeable hair loss.” DSM-IV-TR, supra note 7, at 674.

266. See id.

267. DSM-5, supra note 2, at 585.

268. See, e.g., Head v. Glacier Nw., Inc., 413 F.3d 1053, 1058-61 (9th Cir. 2005) (finding genuine issues of material fact regarding whether an individual’s mental health conditions substantially limited the individual’s ability to interact with others); McGeshick v. Principi, 357 F.3d 1146, 1150 (10th Cir. 2004) (“To be substantially limited in a major life activity, ‘an individual must have an impairment that prevents or severely restricts the individual from doing activities that are of central importance to most people’s daily lives.’ The impairment’s impact must ‘be permanent or long term.’” (quoting Toyota Motor Mfg., Ky., Inc. v. Williams, 534 U.S. 184, 185 (2002))).
States District Court for the Middle District of North Carolina held that a social worker did not meet the definition of an individual with a disability under the ADA because her bipolar disorder and migraines did not substantially limit a major life activity.\footnote{454 F. Supp. 2d 467 (M.D.N.C. 2006).} Similarly, in \textit{Doebele v. Sprint/United Management Co.}, the United States Court of Appeals for the Tenth Circuit held that none of an employee’s mental health conditions substantially limited the employee’s major life activity of communicating with others.\footnote{342 F.3d 1117 (10th Cir. 2003).} More broadly, in \textit{Olson v. General Electric Astrospace}, the United States Court of Appeals for the Third Circuit clarified that neither multiple personality disorder nor a sleep disorder constituted a disability without proof that the disorder also substantially limited a major life activity.\footnote{101 F.3d 947, 952-53 (3d Cir. 1996).}

By 2008, Congress had grown weary of the limitations placed by courts on the classes of individuals eligible to receive protections under the ADA.\footnote{ADAAA § 2(a)-(b), 42 U.S.C. § 12101 (2012).} On September 25, 2008, President George W. Bush signed the ADAAA into law.\footnote{Id. § 1, 42 U.S.C. § 12101.} The ADAAA continued to use a three-prong definition of disability including, “with respect to an individual[,] . . . a physical or mental impairment that substantially limits one or more major life activities of such individual; . . . a record of such an impairment; or . . . being regarded as having such an impairment.”\footnote{Id. § 3, 42 U.S.C. § 12102.} The ADAAA further stated, “The definition of disability . . . shall be construed in favor of broad coverage of individuals . . . to the maximum extent permitted by the terms of [the ADAAA].”\footnote{Id. § 1, 42 U.S.C. § 12101.}

The ADAAA also expanded the list of activities that constituted major life activities by adding “concentrating” and “thinking”\footnote{Id. § 3, 42 U.S.C. § 12102.} as well as the “operation of a major bodily function,” which was defined in relevant part to include “neurological [and] brain . . . functions.”\footnote{ADAAA § 3, 42 U.S.C. § 12102.} In addition, the ADAAA expressly stated that “[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active” and that “[t]he determination of whether an impairment substantially limits a major life activity shall be
made without regard to the ameliorative effects of mitigating measures such as ... medication ... or ... learned behavioral or adaptive neurological modifications." The ADAAA became effective January 1, 2009.279

On March 25, 2011, the EEOC published final regulations implementing the ADAAA in the employment context.280 In relevant part, these regulations define a “physical or mental impairment” as “[a]ny physiological disorder or condition ... affecting [the] neurological [system]” as well as “[a]ny mental or psychological disorder, such as an intellectual disability (formerly termed ‘mental retardation’), organic brain syndrome, emotional or mental illness, and specific learning disabilities.”281 In relevant part, these regulations also define a “major life activity” that must be substantially limited by the physical or mental impairment to include “concentrating, thinking, communicating, interacting with others, and working,” as well as “[t]he operation of a major bodily function,” including “neurological [and] brain ... functions.”282 These regulations clarify that the “term ‘substantially limits’ shall be construed broadly in favor of expansive coverage” and “is not meant to be a demanding standard.”283 These regulations further state that the “primary object of attention in cases brought under the ADA should be whether covered entities have complied with their obligations and whether discrimination has occurred, not whether an individual’s impairment substantially limits a major life activity.”284 According to the EEOC, “the threshold issue of whether an impairment ‘substantially limits’ a major life activity should not demand extensive analysis.”285 Finally, these regulations state, “The determination of whether an impairment substantially limits a major life activity requires an individualized assessment.”286

Even after the enactment of the ADAAA, however, Congress continued to exclude certain conditions from the definition of disability. Today, the ADA as amended continues to exclude “compulsive gambling, kleptomania, or pyromania” from the

278.  ld.
281.  29 C.F.R. § 1630.2(h)(1)-(2) (2012).
282.  ld. § 1630.2(i)(1)(i)-(ii).
283.  ld. § 1630.2(j).
284.  ld. § 1630.2(j)(1)(iii).
285.  ld.
286.  ld. § 1630.2(j)(1)(iv).
definition of disability.\textsuperscript{287} Many state laws also continue to exclude individuals with gambling disorder from protected status. For example, the California Fair Employment and Housing Act,\textsuperscript{288} which was designed "to protect and safeguard the right and opportunity of all persons to seek, obtain, and hold employment without discrimination or abridgment on account of . . . physical [or] mental disability [among other indicators],"\textsuperscript{289} continues to exclude "compulsive gambling" from the definition of both "mental disability"\textsuperscript{290} and "physical disability."\textsuperscript{291}

As discussed in more detail in the final Part, immediately below, I argue that individuals with gambling disorder should be subject to an individualized assessment of whether they have a physical or mental impairment that substantially limits a major life activity and, if so, whether they are qualified individuals,\textsuperscript{292} instead of being expressly excluded from protection under the ADA as amended and analogous state antidiscrimination laws.\textsuperscript{293} If a particular individual has an impairment that meets the definition of a disability and falls within the definition of a qualified individual, then I argue that the law should be applied to prohibit discrimination based on such disability.\textsuperscript{294}

VII. ARGUMENTS AND PROPOSALS

This Article argues that the exclusion of individuals with gambling disorder from state mental health parity laws and state benchmark health plans (as described in Part IV) and from federal and state antidiscrimination laws (as described in Part VI) is wrong for seven reasons.

\textsuperscript{288} CAL. GOV'T CODE § 12900 (2012).
\textsuperscript{289} Id. § 12920.
\textsuperscript{290} Id. § 12926(j) ("Mental disability' does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.").
\textsuperscript{291} Id. § 12926(m)(6) ("Physical disability' does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.").
\textsuperscript{292} See 29 C.F.R. § 1630.2(j)(1)(iv) (2014) ("The determination of whether an impairment substantially limits a major life activity requires an individualized assessment. However, in making this assessment, the term 'substantially limits' shall be interpreted and applied to require a degree of functional limitation that is lower than the standard for 'substantially limits' applied prior to the ADAAA."); see also 42 U.S.C. § 12111(8) (defining a "qualified individual" under the ADAAA).
\textsuperscript{293} See sources cited supra notes 287-291.
\textsuperscript{294} See, e.g., ADA § 102(a), 42 U.S.C. § 12112 (setting forth the ADA's antidiscrimination provisions in the context of employment).
First, the exclusion of individuals with gambling disorder from legal protections is not supported by the current scientific literature. As discussed in detail in Part III, scientists now understand gambling disorder in terms of its similarities to the substance-related and addictive disorders, not the impulse control disorders. Indeed, the APA has specifically stated that gambling disorder's new name and classification reflects clinical research findings suggesting "that gambling disorder is similar [to alcohol use disorder and other] substance-related disorders in clinical expression, brain origin, comorbidity, physiology, and treatment." Dr. Charles O'Brien, who chaired the DSM-5's Substance-Related Disorders Workgroup, has also stated that research suggests that "gambling behaviors activate [neural] reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to those produced by the substance use disorders." Data is emerging that gambling and substance use disorders have common underlying genetic vulnerabilities and that both are associated with similar biological markers and cognitive deficits. Promising treatments for gambling also have been based on those for substance-related and addictive disorders. Finally, the APA has firmly stated, "[L]ittle evidence exists on the associations between [the impulse control disorders of trichotillomania, intermittent explosive disorder, kleptomania, and pyromania] and gambling disorder." In summary, the scientific literature does not support health and disability law's exclusion of individuals with gambling disorder from protections that are available to individuals with other substance-related and addictive disorders.

Yet, the exclusions remain. As discussed in Part IV, Nevada's current benchmark health plan provides health insurance benefits for individuals with substance-related and addictive disorders, but not gambling disorder. By further example, Nevada's and New Mexico's mental health parity and essential health benefits laws exclude individuals with gambling disorder from mandated health insurance benefits and mental health parity protections. As discussed in Part VI, the ADA as amended and analogous state antidiscrimination laws

295. See Substance-Related and Addictive Disorders, supra note 8, at 1.
296. DSM-5, supra note 2, at 481.
297. Id.
298. Id.
299. Petry et al., supra note 36, at 495.
continue to exclude individuals with gambling disorder as well as individuals with other impulse control disorders from disability discrimination protections, even though these laws protect individuals with non-impulse-control disorders. These exclusions are simply unsupported by the current scientific literature.

Second, and related to the first, many of the distinctions in health insurance and antidiscrimination laws between protected and nonprotected conditions exist due to early findings regarding the neurobiological basis of the protected conditions. For example, Nevada's mental health parity law requires health insurance benefits to be provided for only six traditional mental health conditions (schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, and obsessive-compulsive disorder) because the Nevada State Assembly believed these conditions, but not others, were "biologically based." In the fifteen years since the Nevada State Assembly enacted this law, functional neuroimaging studies have shown that gambling disorder has a biological basis. For example, neuroimaging studies of groups of individuals with gambling disorder show "decreased activation[] of the ventromedial prefrontal cortex of the brain, which is located in the frontal lobe and is implicated as a critical component in the processing of risk and decision making." Neuroimaging data also shows "diminished ventral striatal activation observed in individuals with gambling and drug addictions[,] suggest[ing] that the mesocortico-limbic dopamine system is involved in both substance and behavioral addictions." Other neuroimaging studies have "measured higher levels of activity in parts of the brain's limbic system and prefrontal cortex when monetary rewards were present versus computer points, suggesting increased sensory and limbic activation with increased risks and rewards." Still "[o]ther [brain] imaging studies have implicated brain regions that are involved in attention processing when comparing non-problem gamblers" with individuals with gambling disorder. "Collectively, these [neuroimaging] findings suggest [that] a complex
network of brain regions is activated during gambling and related behaviors." Therefore, laws such as the Nevada mental health parity law that state or suggest that gambling disorder is not "biologically based" are not supported in the current scientific literature.

In addition to these scientific reasons, there are other clinical, ethical, and economic arguments against health and disability laws’ exclusion of individuals with gambling disorder from legal protections. In the clinical context, gambling disorder is viewed as a serious mental health condition that can have devastating health, social, occupational, and legal consequences for the disordered gambler. Gambling disorder is estimated to affect approximately 1% of the general adult population in the United States, and "approximately 2.6 million [disordered] gamblers are estimated to need treatment each year." "Up to half of individuals in treatment for gambling disorder have suicidal ideation, and about 17% have attempted suicide." In the past, a lack of health insurance coverage of gambling disorder treatments may have reflected the lack of scientific research regarding the efficacy of available treatments. Insurers understandably did not want to pay for treatments that were not proven safe and efficacious. Now, clinicians view gambling disorder as a highly treatable disease, and current research studies suggest a number of promising therapies, including behavioral therapies and drug therapies.

Given these advances in the understanding of gambling disorder, my third argument is that it does not make clinical sense for health insurance policies and plans to exclude individuals with gambling

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306. Id.
307. See DSM-5, supra note 2, at 589 (listing serious functional consequences of gambling disorder, including impacted areas of psychosocial, health, and mental health; the loss of important relationships; and the adverse impact on employment and educational activities).
308. Gambling and Health in the Workplace: A Research-Based Guide About Gambling Disorders for Human Resources and Employee Assistance Professionals, supra note 30, at 1. "An additional 2.3 percent have had some problems with gambling in their lifetime but have not met diagnostic criteria for pathological gambling. [These individuals are referred to as] 'subclinical' or 'problem gamblers.'" Id. at 5.
310. DSM-5, supra note 2, at 587.
311. See, e.g., Leena M. Sumitra & Shannon C. Miller, Pathologic Gambling Disorder: How To Help Patients Curb Risky Behavior When the Future Is at Stake, POSTGRADUATE MED. (July 2005), http://www.jurispro.com/uploadArticles/Miller-Pathologic.pdf ("[C]linical experience suggests that pathologic gambling disorder is highly treatable.").
312. See discussion supra Part III.
disorder from insurance coverage. Individuals like Gary who live in states like Nevada and do not have private health insurance coverage of gambling disorder may not obtain early treatment, resulting in the worsening of symptoms and possible death by suicide. By comparison, when an individual is diagnosed with stage I cancer, private health insurance will immediately cover cancer treatments that are proven to be safe and efficacious in order to prevent the metastasis of that cancer and the ultimate death of that individual.

Similarly, when an individual has major depression, private health insurance will cover depression treatments that are proven to be efficacious in order to prevent the individual from having suicidal ideations and from eventually committing suicide. Likewise, when an individual has gambling disorder, private health insurance should cover gambling treatments that are proven to be safe and efficacious in order to prevent the individual’s gambling disorder from worsening, including preventing the individual from committing an illegal act that could exclude the individual from disability income insurance benefits and antidiscrimination protections. Again, as current studies show, “Up to half of individuals in treatment for gambling disorder have suicidal ideation, and about 17% have attempted suicide.” Additional studies show, “The majority of crimes committed by problem gamblers are fueled by their gambling (either to obtain money to gamble with or to pay gambling debts).” If death and a life of crime are not clinically and socially acceptable options for individuals with cancer or major depression, they should not be acceptable options for individuals with gambling disorder.

My fourth argument against health and antidiscrimination law’s current treatment of individuals with gambling disorder is also a clinical argument. As discussed in Part III, individuals with gambling disorder are likely to have other mental conditions as well, including substance use disorders and depressive disorders. In some individuals, the other disorder may manifest before the gambling disorder. In other individuals, the manifestation of gambling disorder occurs first. As detailed in Part III, one study found that

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313. DSM-5, supra note 2, at 587.
315. DSM-5, supra note 2, at 589.
316. Id.
317. Id.
96.3% of individuals with gambling disorder also suffered from some other psychiatric or addictive disorder.  

Remember that Nevada's benchmark health plan does provide health insurance benefits for inpatient and outpatient treatment of alcohol use disorder and other substance related disorders, but that the plan does not provide insurance benefits for inpatient or outpatient treatment of gambling disorder or any other health condition that was classified as an impulse control disorder as of March 31, 2012. Because treatment for a comorbid disorder may be qualitatively or quantitatively different, or less successful, given the presence of gambling disorder, the lack of private insurance benefits for gambling disorder does not make clinical sense. If gambling disorder always manifested itself after the presence of another disorder, such as alcohol use disorder or another substance use disorder, an argument could be made that greater health insurance benefits should be provided for the first disorder under the theory that treatment of the first disorder could lessen the occurrence or severity of gambling disorder. Research suggests, however, that approximately 23.5% of individuals with gambling disorder develop gambling disorder before any other psychiatric problem and that 2.2% of individuals with gambling disorder develop gambling disorder and other psychiatric problems at about the same time. These two groups of individuals in particular may benefit from private health insurance coverage of gambling disorder because early treatment of the gambling disorder could lower the occurrence or the severity of a comorbid disorder.

A fifth argument against health and disability law's treatment of individuals with gambling disorder is grounded in principles of biomedical ethics, including the principle of justice. That is, when insurance companies and lawmakers choose to protect most individuals with physical and mental health conditions but not individuals with gambling disorder, there is a question as to whether individuals with gambling disorder are being treated justly and fairly. According to ethical guidelines used in clinical and research contexts, "An injustice occurs when some benefit to which a person is entitled is

318. Kessler et al., supra note 74, at 1356-57.
320. See E-mail from Glenn Shippey to author, supra note 171 (noting the section 8.18 list of exclusions that includes “[i]mpulse control disorders”).
321. See Kessler et al., supra note 74, at 1357.
denied without good reason . . . .”322 A second way in which an injustice occurs is when equals are not treated equally.323 These guidelines beg the following questions: should individuals with non-gambling-related mental health conditions be treated better than individuals with gambling disorder? And, does the fact that an individual’s disease relates to gambling disorder mean that the general starting point of equality no longer applies?

To analyze questions such as these, there are several widely accepted maxims of distributing benefits and protections in the health care, disability, and biomedical and behavioral research contexts that provide guidance, including: “(1) to each person an equal share, (2) to each person according to individual need, (3) to each person according to individual effort, (4) to each person according to societal contribution, and (5) to each person according to merit.”324 The first two of these five methods of distributing benefits are particularly illustrative in the context of gambling disorder. If each individual should receive an equal share of legal protections and benefits, then individuals with gambling disorder should have the same legal protections as individuals with cancer, quadriplegia, bipolar disorder, and Alzheimer’s disease. If each individual should receive protections according to individual need, the analysis becomes more difficult.

A needs-based method of allocating legal protections would require difficult choices to be made between the legal needs of, for example, (1) a stage-IV cancer patient versus (2) an individual with complete quadriplegia versus (3) an individual with bipolar disorder whose symptoms may be well-controlled by medication versus (4) an individual with gambling disorder whose symptoms may be mild (i.e., only four DSM-5 diagnostic criteria may be present) versus (5) an individual with gambling disorder whose symptoms may be severe (i.e., a history of attempted suicide combined with eight or nine DSM-5 diagnostic criteria). Given that the current scientific literature shows that gambling disorder is a severe and potentially disabling condition and that up to 17% of individuals in treatment for gambling disorder

323. The Belmont Report, supra note 322, at 6.
324. Id.
have attempted suicide," outright exclusions that apply to all individuals with gambling disorder, regardless of the severity of symptoms, but not all individuals with other physical and mental health conditions, cannot be justified. A more just approach would involve a case-by-case analysis of the severity of the health condition of the individual with gambling disorder instead of an outright exclusion.

My sixth argument is based in economics. Disordered gamblers produce significant economic costs that are borne by society. "These costs . . . carry over to family members, friends, employers, creditors, health systems, criminal justice systems, and the community as a whole." One question is whether the costs associated with treating and insuring individuals with gambling disorder may have long-term societal returns. Studies conducted in the context of alcohol and drug use disorders do show that treating alcohol and drug use disorders can yield significant clinical and economic returns on an employer’s group health plan or a public health care program's initial treatment investment.

For example, a group of researchers published in 2000 the results of a study conducted in the state of Washington that examined the clinical and economic returns on addiction treatment provided to 263 Medicaid-eligible drug addiction treatment clients. The clinical and economic returns were calculated based on an analysis of several variables (each of which was assigned a cost), including:

- number of days experiencing medical problems,
- overnight hospitalizations for medical treatment,
- emergency room visits for medical treatment,
- clinic or physician visits for medical treatment,
- days experiencing psychological or emotional problems,
- days in inpatient psychiatric treatment,
- days in hospital outpatient psychiatric treatment,
- days in outpatient psychiatric treatment,
- income received from employment,
- money spent on alcohol,
- money spent on drugs,
- and days engaged in illegal activities.

The study demonstrated that each dollar invested in full-continuum (FC) addiction care (defined as care that begins with an inpatient hospital or residential stay, is followed by intensive outpatient services, and is followed by outpatient aftercare) and partial-continuum (PC) addiction care can yield significant clinical and economic returns on an employer’s group health plan or a public health care program's initial treatment investment.

325. See DSM-5, supra note 2, at 587.
326. See, e.g., Marotta et al., supra note 309, at 1.
328. See id. at 617-18.
addiction care (defined as care that begins with intensive outpatient care and is followed by additional less intensive outpatient care) yielded returns of approximately 9.7 and 23.3 times their initial investments, respectively.329 The study also demonstrated that the average cost of treatment amounted to $2,530 for FC addiction care and $1,137 for PC addiction care, and that the average economic benefit amounted to $20,363 for FC addiction care and $12,310 for PC addiction care, producing a net economic benefit of both FC and PC addiction care.330 The study authors formally concluded that their results strongly suggest that both FC and PC addiction care can generate positive and significant net benefits to society.331 My sixth argument, then, is that before insurers and lawmakers point to cost reasons to support their discrimination against individuals with gambling disorder, additional research needs to be conducted. This research may show that a short-term investment in the inpatient and outpatient treatment and health insurance coverage of individuals with gambling disorder produces long-term societal returns.

My seventh and final argument relates to eliminating the stigma associated with gambling disorder. Gambling disorder was previously thought to be a social, not a medical problem.332 Even today, some individuals view gambling disorder as a sign of moral failing, weakness, or lack of willpower, rather than a medical disease with a neurobiological basis.333 Efforts to treat and insure gambling disorder have been hampered by the general stigma against mental illness and the particular stigma against gambling.334 Elsewhere, I traced and closely examined the roots of the stigma associated with mental illness.335 "Historically, individuals with mental [illness] were [regarded] with contempt, fear, and cruelty, perhaps due to the belief that mental [illness] stemmed from parental misdeeds, demonic possession, or deficient character."336 Notwithstanding the

329. See id. at 625-26.
330. See id. at 625.
331. See id. at 609, 627 ("It therefore appears that the State of Washington is receiving value for its treatment investments in both clinical and financial terms—at least to the extent that these samples are representative of patients entering treatment.").
333. See id.
334. Id.
336. Id.
research studies discussed in Part III, mental illness, including gambling disorder, remains poorly understood today.\textsuperscript{337} It is my hope that the legal proposals set forth below will continue to help dismantle the stigma against gambling disorder and other addictive conditions.

In light of the seven arguments listed above, I make the following five proposals that are designed to eliminate discrimination against individuals with gambling disorder under health and disability law.

As discussed in Part IV, the ACA does require certain health plans to provide some "[m]ental health and substance use disorder services, including behavioral health treatment."\textsuperscript{338} The ACA is unclear, however, about whether particular benefits, such as gambling disorder benefits, fall within this provision. As a result, HHS allowed each state to select a benchmark plan that would serve as a reference plan in terms of benefits that are required to be included (and permitted to be excluded).\textsuperscript{339} Health plans in each state that are required to comply with the ACA's EHB provision must provide the benefits that are included in the state's benchmark plan.\textsuperscript{340} Unfortunately, the content of each state's benchmark plan was determined as of March 31, 2012, which ties offered benefits to the DSM-IV-TR, thus excluding gambling disorder benefits from any benchmark plan that excludes coverage for the impulse control disorders.\textsuperscript{341}

Thus, my first proposal is to amend the federal regulations implementing the ACA's EHB provision to clarify that the content of each state's benchmark plans must be tied to the DSM-5, which classifies gambling disorder as a "Substance-Related and Addictive Disorder." The result will be that any state benchmark plan that excludes coverage for the impulse control disorders will not exclude coverage for gambling disorder. Specifically, I propose to amend 45 C.F.R. § 156.100 to add a new paragraph (c), and to revise paragraph (b) and renumber paragraph (d), as follows:

45 C.F.R. § 156.100. EHB-Benchmark Plan Standards.

\begin{itemize}
  \item (b) \textit{EHB-benchmark selection standards.} In order to become an EHB-benchmark plan as defined in § 156.20 of this subchapter, a state-selected base-benchmark plan must meet
\end{itemize}

\textsuperscript{337} Id.
\textsuperscript{339} Essential Health Benefits Bulletin, supra note 158.
\textsuperscript{340} Id.
\textsuperscript{341} See E-mail from Glenn Shippey to author, supra note 171.
the requirements for coverage of benefits and limits described in § 156.110 of this subpart; and

[c] **EHB-benchmark content.** The content of each state’s selected benchmark plan shall be determined with reference to the DSM-5; and

(e) [(d)] **Default base-benchmark plan.** If a State does not make a selection using the process defined in § 156.100 of this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State’s small group market. If Guam, the U.S. Virgin Islands, American Samoa, or the Northern Marianna Islands do not make a benchmark selection, the default base-benchmark plan will be the largest FEHBP plan by enrollment.

Second, I propose to revise all state mental health parity laws that expressly exclude individuals with gambling disorder from state-mandated insurance benefits. As an illustrative example, I propose that New Mexico’s mental health parity law be amended to delete the term “gambling addiction,” as follows:

**N.M. STAT. § 59A-23E-18.**

A. A group health plan for a plan year of an employer beginning or renewed on or after October 1, 2000, or group health insurance offered in connection with that plan, shall provide both medical and surgical benefits and mental health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

F. As used in this section, “mental health benefits” means mental health benefits as described in the group health plan, or group health insurance offered in connection with the plan; but does not include benefits with respect to treatment of substance abuse; [or] chemical dependency— or gambling addiction.

I propose deleting New Mexico’s exclusionary language for gambling addiction (but not substance abuse or chemical dependence) only because this Article focuses on gambling disorder. Because the ACA’s EHB provision now requires many health plans to offer “substance use disorder benefits,” New Mexico’s remaining exclusionary language relating to “substance abuse” and “chemical dependency” is, in large part, preempted by the ACA and does not have current effect.
Third, I propose to revise any state-mandated health benefit law that does not expressly include gambling disorder and other mental health conditions that have a biological basis. As an illustration, I propose to revise Nevada’s mental health parity law as follows:

NEV. REV. STAT. § 689A.0455. Coverage for treatment of conditions relating to severe mental illness.

1. A policy of health insurance delivered or issued for delivery in this state pursuant to this chapter must provide coverage for the treatment of conditions relating to severe mental illness.

2. As used in this section, “severe mental illness” means any of the following mental illnesses that are biologically based and for which diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association: (a) Schizophrenia; (b) Schizoaffective disorder; (c) Bipolar disorder; (d) Major depressive disorders; (e) Panic disorder; (f) Obsessive-compulsive disorder.

These health insurance proposals may encourage individuals with gambling disorder to obtain early (or earlier) treatment, perhaps lessening the chance that they engage in illegal acts that may exclude them from other legal benefits and protections.

Fourth, I propose amending the ADA and analogous state laws to delete the exclusion from the definition of disability for “compulsive gambling.” That is, I propose the amendment of 42 U.S.C. § 12211(b)(2) to delete the term “compulsive gambling,” as follows:

42 U.S.C. § 12211. Definitions

(b) Certain conditions
Under this chapter, the term “disability” shall not include . . .

(2) compulsive gambling, kleptomania; or pyromania; or

Analogous state antidiscrimination laws, such as the California Fair Employment and Housing Act,342 also should be amended to delete gambling disorder from exclusionary language, as follows:

CAL. GOV'T CODE § 12926. Definitions

(j)(5) "Mental disability" does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.

(m)(6) "Physical disability" does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.

Gambling disorder, now understood as a substance-related and addictive disorder, should not continue to be treated like an impulse control disorder under federal and state antidiscrimination law.

Fifth, instead of being expressly excluded from disability antidiscrimination legislation, individuals with gambling disorder should be subject to an individualized assessment of whether their gambling disorder constitutes a disability, that is, whether they have (1) a physical or mental impairment (2) that substantially limits (3) a major life activity. If the gambling disorder is determined to fall within the definition of a disability, then the individuals should be assessed as to whether they are "qualified individuals," that is, whether they, "with or without reasonable accommodation, can perform the essential functions of the employment position that [they] hold[ ] or desire[]." These individualized assessments may be modeled after the case-by-case approaches followed by the SSA in the context of SSDI benefits and by private disability income insurers who review claims for benefits by individuals with gambling disorder, as discussed in Part V.

Because gambling disorder is listed as a mental disorder in the DSM-5, gambling disorder should be regarded as a "mental impairment" in satisfaction of the first element of the definition of disability under the ADA. As discussed in Parts II and III of this Article, gambling disorder could impact the major life activities of

344. In addition, the individual should also be assessed as to whether the individual has a record of an impairment or is regarded as having such an impairment. See ADAAA § 4, 42 U.S.C. §§ 12102-12103 (2012).
345. See 42 U.S.C. § 12111(8) ("'Qualified individual' means an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.").
346. See 29 C.F.R. § 1630.2(h)(1)-(2).
concentrating, thinking, and working, as well as neurological and brain functions for purposes of the third element of the definition of disability. In terms of the second element ("substantially limits"), a court that assesses claims by individuals with gambling disorders that their gambling disorders substantially limit one or more of these major life activities shall view the claims "broadly in favor of expansive coverage," as required by the ADAAA. A court that assesses such claims should not require "extensive analysis." Next, a reviewing court should determine whether the individual is a "qualified individual," that is, whether the individual, "with or without reasonable accommodation, can perform the essential functions of the [job the] individual . . . desires." If so, the reviewing court should undertake one final assessment, that is, whether a covered entity has discriminated against the qualified individual on the basis of disability.

Many courts distinguish between "conduct" and "disability"; that is, they permit an employer to discriminate against an individual who has committed a crime (described as "conduct") but not an individual because of his or her physical or mental impairment that substantially limits a major life activity (a "disability"). The distinction between "conduct" and "disability" has its roots in cases involving individuals with alcohol use disorder who have been terminated from employment following an arrest for driving while intoxicated or other similar crime. I anticipate that this distinction would come up in some cases involving individuals with gambling disorder. In cases involving individuals with gambling disorder who have not misappropriated funds or committed other crimes, the individual may easily be able to prove termination on the basis of disability. In cases involving individuals with gambling disorder who have committed crimes, the individual may be denied protection if the individual is unable to prove

347. See id. § 1630.2(i)(1)(i)-(ii).
348. Id. § 1630.2(j).
349. Id. § 1630.2(j)(1)(ii).
351. See id. § 12112(a) ("No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.").
353. See, e.g., id. at 331 (providing an excellent discussion of cases that distinguish "conduct" from "disability" under the original ADA).
that the discrimination was based on disability. That is, the court may side with the defendant employer, who will argue that the termination was on the basis of the illegal act. The conduct/disability distinction in disability income insurance law and antidiscrimination law is yet another reason that individuals with mild gambling disorder should be encouraged to seek treatment before they commit any gambling-related crimes.

VIII. CONCLUSION

For a long time, individuals with gambling disorder have not had significant legal protections under health and disability law. Private health insurance policies and plans have frequently excluded treatment for gambling disorder from health insurance coverage. Individuals with gambling disorder who have sought disability income insurance benefits from public and private disability income insurers tended not to be successful in their claims. In addition, federal and state antidiscrimination laws continue to exclude individuals with gambling disorder from disability discrimination protections.

This Article is the first law review article to challenge the legal treatment of individuals with gambling disorder by showing how health insurance and antidiscrimination laws can hurt problem gamblers. Using neuroscience, economics, and principles of biomedical ethics to argue that individuals with gambling disorder should have the same legal protections as individuals with substance-related and other addictive disorders, this Article has proposed important amendments to federal and state health insurance laws and antidiscrimination laws.