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THE DSM-5: IMPLICATIONS FOR HEALTH LAW

Stacey A. Tovino*

Abstract

In May 2013, the American Psychiatric Association released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”). Among other changes, the DSM-5 includes new entries for hoarding disorder and premenstrual dysphoric disorder as well as a reclassified entry for gambling disorder. Using these changes as examples, this Article examines the implications of the DSM-5 for key issues in health law, including health insurance coverage, public and private disability benefit eligibility, and disability discrimination protection. As a descriptive matter, this Article illustrates how the addition of new disorders and the reclassification of existing disorders in the DSM-5 can significantly impact health insurance coverage and has some relevance to disability benefit eligibility and disability discrimination protection. From a normative perspective, this Article offers guidelines designed to prevent attorneys, judges, and other nonclinicians from abusing the DSM-5 in civil and administrative health law proceedings.

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I. INTRODUCTION

In May 2013, the American Psychiatric Association (APA) released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (the “DSM-5”).¹ Among other changes,² the DSM-5 includes new entries for hoarding disorder³ and premenstrual dysphoric disorder⁴ as well as a reclassified entry for gambling disorder.⁵ Using these changes as illustrators, this Article examines the implications of the DSM-5 for key issues in health law, including health insurance coverage, disability benefit eligibility, and disability discrimination protection.⁶

As a descriptive matter, this Article shows how the addition of new disorders and the reclassification of existing disorders in the DSM-5 can significantly impact the application of federal and state mental health parity laws and mandatory mental health and substance use disorder benefit laws as well as the interpretation of health insurance contracts. Federal mental health parity law, some state benchmark plans, and many health insurance contracts incorporate by reference the current edition of

¹ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter AM. PSYCHIATRIC ASS’N, DSM-5].

² AM. PSYCHIATRIC ASS’N, HIGHLIGHTS OF CHANGES FROM DSM-IV-TR TO DSM-5 (2013) [hereinafter AM. PSYCHIATRIC ASS’N, CHANGES], available at <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>, archived at <http://perma.cc/GD6G-NWDF> (providing a detailed description of the changes between the DSM-IV-TR and the DSM-5).

³ AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 1, at 247–51 (listing hoarding disorder as a separate diagnosis within a new chapter relating to obsessive-compulsive and related disorders).

⁴ *Id.* at 171–75 (listing premenstrual dysphoric disorder as a separate diagnosis within the depressive disorders chapter).

⁵ *Id.* at 585–89 (listing gambling disorder as a separate disorder within a new nonsubstance-related disorders section of the substance-related and addictive disorders chapter).

⁶ This Article draws on health insurance, disability benefit, and disability discrimination themes and arguments I have made in other articles. See, e.g., Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. ON LEGIS. 1 (2012) [hereinafter Tovino, *All Illnesses*]; Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 21 ANNALS HEALTH L. 147 (2012); Stacey A. Tovino, *The Impact of Neuroscience on Health Law*, 1 NEUROETHICS 101 (2008); Stacey A. Tovino, *Insurance and Parity Laws*, in 1 MENTAL HEALTH CARE ISSUES IN AMERICA: AN ENCYCLOPEDIA 350, 350–57 (Michael Shally-Jensen ed., 2013); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191 (2014) [hereinafter Tovino, *Lost in the Shuffle*]; Stacey A. Tovino, *Neuroscience and Health Law: An Integrative Approach?*, 42 AKRON L. REV. 469, 472 (2009); Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471 (2012) [hereinafter Tovino, *A Proposal*]; Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL’Y 455 (2011) [hereinafter Tovino, *Reforming State Mental Health Parity Law*].

the DSM when identifying conditions that are eligible for parity protections, mandatory benefits, and insurance coverage, respectively.

On the other hand, this Article demonstrates how the DSM-5 is usually not determinative with respect to the outcome of public disability benefit cases. In public disability benefit cases, the presence of a physical or mental impairment is simply a predicate to a more important legal determination; that is, whether the claimant's impairment is of such severity that the claimant cannot do her previous work and cannot perform other substantial gainful work that exists in the national economy. These secondary legal determinations are made based on proof provided by the claimant of her work limitations. Claimants who fail to provide objective evidence regarding their work limitations will not prevail regardless of whether their underlying conditions are listed in the current edition of the DSM.

This Article further demonstrates how the DSM-5 is not necessarily determinative with respect to the outcome of private disability benefit cases, either. Although some private disability plans internally reference the current edition of the DSM for purposes of determining whether an insured has a mental disability, this finding of disability usually is a predicate to other legal determinations, such as whether the disability is the reason the insured is unable to work. In many cases, courts agree that the insured has a disability but find that something else, such as the insured's commission of a crime, has made the insured ineligible to work. In these cases, the insured is not eligible for contractual disability benefits even if the insured's disability is listed in the current edition of the DSM.

As a final descriptive matter, this Article demonstrates how changes in the DSM-5 have not yet impacted the outcome of disability discrimination cases involving individuals with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder. Although individuals with hoarding disorder and premenstrual dysphoric disorder have been considered individuals with disabilities in cases decided prior to the publication of the DSM-5, individuals with gambling disorder continue to be excluded from protection under federal and state antidiscrimination law, even after the DSM-5. In addition, individuals with disabilities still bear the burden of proving that they are qualified individuals who can perform the essential functions of their jobs with or without reasonable accommodation. The DSM-5 is unhelpful with respect to these and other prerequisites to antidiscrimination protection.

As a normative matter, this Article agrees with the APA's cautionary statement regarding legal uses of the DSM-5 given the different goals and objectives of law and medicine⁷ and the fact that the DSM-5 was designed for use by clinicians, public

⁷ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 25 ("However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder . . . does not imply that an individual with such a

health professionals, and research investigators, not judges or attorneys.⁸ To this end, this Article raises new questions regarding legal uses of the DSM-5 and provides guidelines for attorneys and judges to follow to avoid abusing the DSM-5.

This Article proceeds as follows. Part II reviews the DSM-5's new entries for hoarding disorder and premenstrual dysphoric disorder and the DSM-5's reclassified entry for gambling disorder. Parts III, IV, and V examine the impact of these changes with respect to health insurance coverage, disability benefit eligibility, and disability discrimination protection, respectively. Part VI analyzes whether the DSM-5 is being used or abused in civil and administrative health law proceedings and offers guidelines for future uses of the DSM by nonclinicians.

II. CHANGES IN THE DSM-5

A. Hoarding Disorder

In the prior edition of the DSM (the "DSM-IV-TR"), the APA listed extreme hoarding behavior as a symptom of obsessive-compulsive disorder but did not contain a separate entry focused solely on hoarding.⁹ The DSM-5 is the first edition of the DSM to contain a separate chapter on obsessive-compulsive and related disorders¹⁰ and to include within that chapter a new disorder known as hoarding disorder.¹¹ According to the APA, hoarding disorder is characterized by "persistent difficulty discarding or parting with possessions due to a perceived need to save the items and distress associated with discarding them."¹² Clinicians and scientists believe that hoarding disorder may have unique neurobiological correlates and may respond to clinical intervention.¹³

condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability).").

⁸ *Id.* ("[I]t is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals.").

⁹ See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 728 (4th ed., text rev. 2000) [hereinafter AM. PSYCHIATRIC ASS'N, DSM-IV-TR] ("A diagnosis of Obsessive-Compulsive Disorder should be considered especially when hoarding is extreme (e.g., accumulated stacks of worthless objects present a fire hazard and make it difficult for others to walk through the house)."); AM. PSYCHIATRIC ASS'N, CHANGES, *supra* note 2, at 8 ("DSM-IV lists hoarding as one of the possible symptoms of obsessive-compulsive personality disorder and notes that extreme hoarding may occur in obsessive-compulsive disorder.").

¹⁰ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 235 ("The inclusion of a chapter on obsessive-compulsive and related disorders in DSM-5 reflects the increasing evidence of these disorders' relatedness to one another in terms of a range of diagnostic validators as well as the clinical utility of grouping these disorders in the same chapter.").

¹¹ AM. PSYCHIATRIC ASS'N, CHANGES, *supra* note 2, at 8 ("Hoarding disorder is a new diagnosis in DSM-5.").

¹² *Id.*

¹³ *Id.*

Under the DSM-5, a clinician may diagnose an individual with hoarding disorder if the individual meets six criteria.¹⁴ First, the individual must have persistent difficulty discarding or parting with possessions, regardless of their actual value.¹⁵ Second, this difficulty must be due to the individual's perceived need to save items and distress associated with discarding them.¹⁶ Third, the difficulty discarding possessions must result in the accumulation of possessions that congest and clutter active living areas and that substantially compromise their intended use.¹⁷ (If living areas are uncluttered, it is only because of the interventions of third parties, such as family members, cleaners, or authorities.¹⁸) Fourth, the hoarding must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning, including maintaining a safe environment for the individual or others.¹⁹ Fifth, the hoarding cannot be attributable to another medical condition such as a brain injury, cerebrovascular disease, or Prader-Willi syndrome.²⁰ Finally, the hoarding must not be better explained by the symptoms of another mental disorder, such as the obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia, cognitive deficits in major neurocognitive disorder, or restricted interests in autism spectrum disorder.²¹

Individuals with hoarding disorder frequently have difficulty moving through their cluttered houses as well as difficulty maintaining personal hygiene, cooking, cleaning, and sleeping.²² Individuals with severe hoarding disorder can be at risk of falling, poor sanitation, and even house fires.²³ According to the APA, associations exist between hoarding disorder and occupational impairment, poor physical health, high social service utilization, strained family relationships, and conflict with neighbors and local authorities.²⁴ The APA estimates that three-quarters of individuals with hoarding disorder have a comorbid disorder such as major depressive disorder, social anxiety disorder, or generalized anxiety disorder, and that approximately one in five individuals with hoarding disorder may meet diagnostic criteria for obsessive-compulsive disorder.²⁵

¹⁴ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 247.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.* at 250.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.* at 251.

B. Premenstrual Dysphoric Disorder

In the DSM-IV-TR, the APA listed premenstrual dysphoric disorder in Appendix B, an appendix that identified conditions that were under study but did not have sufficient evidence to warrant a separate diagnostic entry.²⁶ In the DSM-5, the APA removed premenstrual dysphoric disorder from Appendix B and included it as a stand-alone entry within the Depressive Disorders chapter,²⁷ which is newly separated from the Bipolar and Related Disorder chapter.²⁸ According to the APA, “[t]he essential features of premenstrual dysphoric disorder are the expression of mood lability, irritability, dysphoria, and anxiety symptoms that occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter.”²⁹

For a diagnosis of premenstrual dysphoric disorder, the DSM-5 specifically requires, in the majority of an individual’s menstrual cycles during the preceding year: (A) at least five symptoms (1) to be present in the final week before the onset of menses, (2) to start to improve within a few days after the onset of menses, and (3) to become minimal or absent in the week postmenses.³⁰ These symptoms include: (B) one or more of: (1) marked affective lability; (2) marked irritability or anger or increased interpersonal conflicts; (3) marked depressed mood, feelings of hopelessness, or self-deprecating thoughts; and (4) marked anxiety, tension, and/or feelings of being keyed up or on edge; and (C) one or more of the following symptoms, to reach a total of five symptoms when combined with the symptoms in (B): (1) decreased interest in usual activities, such as work, school, friends, or hobbies; (2) subjective difficulty in concentration; (3) lethargy, easy fatigability, or marked lack of energy; (4) overeating, specific food cravings, or marked change in appetite; (5) hypersomnia or insomnia; (6) a sense of being overwhelmed or out of control; and (7) physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of bloating, or weight gain.³¹

In addition to the presence of five of these symptoms at the specified time periods, the DSM-5 also would require: (1) the symptoms to be associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others; (2) the disturbance to be not merely an exacerbation of the symptoms of another disorder, such as major depressive

²⁶ See AM. PSYCHIATRIC ASS’N, DSM-IV-TR, *supra* note 9, at 11, 703, 715–18.

²⁷ AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 1, at 171–75 (listing premenstrual dysphoric disorder within the depressive disorders); AM. PSYCHIATRIC ASS’N, CHANGES, *supra* note 2, at 4 (“DSM-5 contains several new depressive disorders, including disruptive mood dysregulation disorder and premenstrual dysphoric disorder.”).

²⁸ AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 1, at 155 (“Unlike in DSM-IV, this chapter ‘Depressive Disorders’ has been separated from the previous chapter ‘Bipolar and Related Disorders.’”).

²⁹ *Id.* at 172.

³⁰ *Id.* at 171–72 (listing the diagnostic criteria for premenstrual dysphoric disorder).

³¹ *Id.* at 171–72.

disorder, panic disorder, persistent depressive disorder, or a personality disorder, although it may co-occur with any of these disorders; and (3) the symptoms not to be attributable to the physiological effects of a substance or another medical condition.³²

The APA estimates that the twelve-month prevalence of premenstrual dysphoric disorder is between 1.8% and 5.8% of menstruating women.³³ Premenstrual dysphoric disorder has several negative functional consequences, including clinically meaningful distress and/or an obvious and marked impairment in the ability to function socially or occupationally in the week prior to menses.³⁴

C. Gambling Disorder³⁵

First recognized by the APA in the DSM-III in 1980,³⁶ a condition then named “pathological gambling” was classified within the disorders of impulse control not elsewhere classified chapter.³⁷ 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.³⁸ Predisposing factors were thought to include loss of parent by death, separation, divorce, or desertion before the individual turned fifteen 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.³⁹ Pathological gambling remained in the disorders of impulse control not elsewhere classified sections of the DSM-III-R (1987), the DSM-IV (1994), and the DSM-IV-TR (2000).⁴⁰

The DSM-5 takes pathological gambling in a new direction. First, the DSM-5 renames the condition “gambling disorder,”⁴¹ reflecting concerns that the adjective “pathological” is pejorative and reinforces the social stigma associated with problem

³² *Id.* at 172.

³³ *Id.* at 173.

³⁴ *Id.* at 174.

³⁵ The next three paragraphs were first printed at Tovino, *Lost in the Shuffle*, *supra* note 6, at 196–97, 200–201. Slight technical and conforming changes have been made.

³⁶ See Randy Stinchfield, *Reliability, Validity, and Classification Accuracy of a Measure of DSM-IV Diagnostic Criteria for Pathological Gambling*, 160 AM. J. PSYCHIATRY 180, 180 (2003) (“Pathological gambling was formally recognized as a mental disorder by APA in DSM-III.”).

³⁷ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 291–93 (3d. ed. 1980).

³⁸ *Id.* at 291–92.

³⁹ *Id.* at 292.

⁴⁰ Tovino, *Lost in the Shuffle*, *supra* note 6, at 196–204.

⁴¹ See AM. PSYCHIATRIC ASS’N, DSM-5, *supra* note 1, at 585.

gambling.⁴² Second, the DSM-5 reclassifies gambling disorder and places it as the sole disorder within the nonsubstance-related disorders section within the larger Substance-Related and Addictive Disorders chapter.⁴³ 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.⁴⁴

According to the APA, the change in gambling disorder's classification reflects neuroimaging evidence that gambling behaviors activate neural reward systems similar to those activated by drugs of abuse and produces behavioral systems that appear comparable to those produced by the substance use disorders.⁴⁵ Dr. Charles O'Brien, 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.⁴⁶

According to the APA, gambling disorder has a past-year prevalence rate of 0.2% to 0.3% as well as a lifetime prevalence rate of 0.4% to 1.0% among the general population.⁴⁷ The functional consequences of gambling disorder include, but are not limited to, loss of important relationships and adverse impact on work or school

⁴² See CHRISTINE REILLY & NATHAN SMITH, NAT'L CTR. FOR RESPONSIBLE GAMING, THE EVOLVING DEFINITION OF PATHOLOGICAL GAMBLING IN THE DSM-5, at 4 (2013), available at http://www.ncrg.org/sites/default/files/uploads/docs/white_papers/ncrg_wpdsm5_may2013.pdf, archived at <http://perma.cc/LR7E-2LJ6>; Nancy M. Petry et al., *An Overview of and Rationale for Changes Proposed for Pathological Gambling in DSM-5*, 30 J. GAMBLING STUD. 493, 494 (2014) ("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.'").

⁴³ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 481.

⁴⁴ *Id.* at 483–585; Constance Holden, *Behavioral Addictions Debut in Proposed DSM-V*, 327 SCIENCE 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).

⁴⁵ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, 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).

⁴⁶ Mark Moran, *Gambling Disorder to be Included in Addictions Chapter*, PSYCHIATRIC NEWS, Apr. 19, 2013, at 5, 5.

⁴⁷ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 587.

performance.⁴⁸ Gambling disorder is associated with poor general health and high utilization of medical services.⁴⁹

III. HEALTH INSURANCE COVERAGE

This Part demonstrates how the addition of hoarding disorder and premenstrual dysphoric disorder and the reclassification of gambling disorder in the DSM-5 can significantly impact the application of health insurance laws, including federal and state mental health parity laws and mandatory mental health and substance use disorder benefit laws, as well as the interpretation of health insurance contracts. Some background information is necessary before proceeding to these points.

Historically, many public health care programs and private health plans distinguished between physical and mental disorders and provided inferior insurance benefits for mental disorders.⁵⁰ For example, Medicare Part B formerly imposed a 50% beneficiary coinsurance on outpatient mental health services, including individual, family, and group psychotherapy services, instead of the 20% beneficiary coinsurance traditionally applied to nonmental health outpatient services.⁵¹ Private health plans also used to provide inferior health insurance benefits for individuals with mental disorders by completely excluding their treatments and services from

⁴⁸ *Id.* at 589.

⁴⁹ *Id.*

⁵⁰ Tovino, *A Proposal*, *supra* note 6, at 475; Tovino, *All Illnesses*, *supra* note 6, at 3. Much of the background information regarding mental health parity law and mandated benefit law set forth in the next sixteen paragraphs were previously published in the following articles, although technical and conforming changes have been made: Tovino, *All Illnesses*, *supra* note 6, at 3–9; Tovino, *Lost in the Shuffle*, *supra* note 6, at 213–24; Tovino, *A Proposal*, *supra* note 6, at 481–97.

⁵¹ See Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 110-275, § 102, 122 Stat. 2494, 2498 (codified as amended at 42 U.S.C. §1395l(c) (2012)) (calculating Medicare incurred expenses as only 62.5% of the outpatient expenses associated with the treatment of mental, psychoneurotic, and personality disorders). Until 2010, Medicare was thus responsible for only 50% (i.e., 62.5% x 80%, with 80% being the Medicare approved amount) of the cost of most outpatient mental health services, and the Medicare beneficiary was responsible for the remaining 50%. *Id.* In 2008, President George W. Bush signed into law the Medicare Improvements for Patients and Providers Act of 2008, Section 102 of which increased Medicare's portion of incurred expenses for outpatient mental health services to 68.75% in 2010 and 2011 (resulting in a 45% beneficiary coinsurance), 75% in 2012 (resulting in a 40% beneficiary coinsurance), 81.25% in 2013 (resulting in a 35% beneficiary coinsurance), and 100% in 2014 and thereafter (resulting in a 20% coinsurance). *Id.* Since 2014, Medicare has been paying 80% of (and Medicare beneficiaries are only paying a 20% coinsurance on) all outpatient mental health services. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE GENERAL INFORMATION, ELIGIBILITY, AND ENTITLEMENT MANUAL ch. 3, § 30 (rev. ed. 2014), available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf>, archived at <http://perma.cc/HZ9L-8MZB>.

coverage or by providing less comprehensive coverage of their treatments and services.⁵²

Historically, these health insurance benefit disparities existed in the context of many mental disorders, including hoarding disorder, premenstrual dysphoric disorder, and gambling disorder. For example, Kaiser Permanente's 2012 Small Group Colorado Health Benefit Plan ("Kaiser Plan") provided insurance coverage of "biologically-based mental illnesses," but the Kaiser Plan only included six illnesses (i.e., schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder) within that definition.⁵³ Hoarding disorder, premenstrual dysphoric disorder, and gambling disorder were not included in that definition. UnitedHealthcare Insurance Company's standard Certificate of Coverage also provided coverage for "biologically-based mental illnesses," but similarly defined the phrase to include schizophrenia, bipolar disorder, pervasive developmental disorder, autism, paranoia, panic disorder, obsessive-compulsive disorder, and major depressive disorder.⁵⁴ Again, hoarding disorder, premenstrual dysphoric disorder, and gambling disorder were not included in this definition.

Some private health plans specifically excluded one or more of these three conditions from coverage. For example, Wellmark South Dakota's Blue Priority HSA Plan expressly excluded pathological gambling from coverage.⁵⁵ The 2013–2014 Student Injury and Sickness Insurance Plan for students attending Embry-Riddle Aeronautical University in Florida also expressly excluded from coverage treatments and services for gambling.⁵⁶ The University of Pittsburgh Medical

⁵² See Tovino, *A Proposal*, *supra* note 6, at 475; Tovino, *All Illnesses*, *supra* note 6, at 3.

⁵³ KAISER PERMANENTE, 2012 COLORADO HEALTH BENEFIT PLAN DESCRIPTION FORM pt. B.18 & n.9 (2012), available at [http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Option+A-Kaiser+Permanente+\(Small+Group\)+Summary+Description+Form.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251815021667&ssbinary=true](http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Option+A-Kaiser+Permanente+(Small+Group)+Summary+Description+Form.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251815021667&ssbinary=true), archived at <http://perma.cc/K9LB-Y95V> (defining biologically based mental illness).

⁵⁴ UNITEDHEALTHCARE INS. CO., CERTIFICATE OF COVERAGE 17–18, available at <https://www.uhc.com/content/dam/uhc.com/en/Legal/PDF/MY-7.pdf>, archived at <https://perma.cc/CBE9-EXL4> (last visited Jan. 30, 2015).

⁵⁵ See WELLMARK S.D., BLUE SELECT HSA-QUALIFIED PPO PLANS: OUTLINE OF COVERAGE FOR NON-GRANDFATHERED PLANS 9 (2012), available at http://www.wellmark.com/SouthDakotaPlans/OOC/BluePriorityHSA_M31118_10_12.pdf, archived at <http://perma.cc/AN85-9QNJ> (excluding certain mental health and chemical dependency services, including "Impulse-control disorders (such as pathological gambling)").

⁵⁶ See UNITEDHEALTHCARE INS. CO., CERTIFICATE OF COVERAGE: 2013–2014 STUDENT INJURY & SICKNESS INSURANCE PLAN 16 (2013), available at <https://www.uhcsr.com/uhcSrBrochures/Public/ClientBrochures/2013-735-2-3%20Brochure-v3.pdf>, archived at <https://perma.cc/TEV6-YB5D> (excluding coverage for "treatment, services or supplies for . . . [a]ddiction, such as[] nicotine addiction, except as

Center's health plan also excluded from coverage treatments for gambling disorder.⁵⁷ 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 excluded gambling disorder from protection as well.⁵⁸ 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");⁵⁹ however, the New Mexico law specifically excludes treatments for gambling addiction from the definition of "mental health benefits."⁶⁰

During the past two decades, developments in health insurance law, including mental health parity law and mandatory mental health and substance use disorder benefit law, have eliminated most, but still not all, of these mental health benefit disparities. The federal government took its first step toward establishing mental health parity on September 26, 1996, when President Bill Clinton signed the federal Mental Health Parity Act (MHPA) into law.⁶¹ As originally enacted, the 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.⁶² For example, the 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.⁶³

specifically provided in the policy and caffeine addiction; non-chemical addiction, such as[] gambling, sexual, spending, shopping, working and religious; [and] codependency").

⁵⁷ See UPMC HEALTH PLAN, EXCLUSIONS 1, available at <http://www.upmchealthplan.com/pdf/Exclusions.pdf>, archived at <http://perma.cc/FZR6-DUHG> (last visited Jan. 30, 2015) (excluding from insurance coverage "[t]welve step model programs as sole therapy for conditions, including, but not limited to . . . addictive gambling").

⁵⁸ See, e.g., Nancy Bateman, *Behavioral Healthcare Parity*, NAT'L ASS'N SOC. WORKERS, http://www.naswdc.org/practice/behavioral_health/behavioral.asp, archived at <http://perma.cc/HMU3-FPW4> (last visited Mar. 10, 2015) ("New Mexico's parity legislation provides coverage for all mental health, but excludes coverage for substance abuse and gambling.").

⁵⁹ N.M. STAT. ANN. § 59A-23E-18(A) (1978 & Supp. 2000) ("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.").

⁶⁰ *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)).

⁶¹ See Mental Health Parity Act (MHPA) of 1996, Pub. L. No. 104-204, 110 Stat. 2944, (codified as amended at 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)).

⁶² See *id.* § 712(a)(1), (2).

⁶³ See *id.*

The problem with the MHPA was that its application and scope were very limited. As originally enacted, the MHPA regulated only insured and self-insured group health plans of large employers, then defined as those employers that employed an average of fifty-one or more employees.⁶⁴ The MHPA thus did not apply to the group health plans of small employers.⁶⁵ The 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 the MHPA.⁶⁶ Finally, the 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 the MHPA resulted in an increase in the cost under the plan of at least 1%.⁶⁷ By November 1998, over two years following the MHPA’s enactment, only four plans across the United States had obtained exemptions due to cost increases of 1% or more.⁶⁸

In terms of its substantive provisions, the MHPA was neither a mandated offer nor a mandated benefit law; that is, nothing in the MHPA required a large group health plan to actually offer or provide any mental health benefits for conditions such as hoarding disorder, premenstrual dysphoric disorder, or gambling disorder.⁶⁹ Thus, health plans were free, even after the enactment of the MHPA, to simply not provide any benefits for these three conditions or any other mental health condition.⁷⁰ As originally enacted, the 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.⁷¹ In addition, the MHPA did not require parity between medical and surgical benefits

⁶⁴ See *id.* § 712(b)(1), (2) (applying in each case to “a group health plan (or health insurance coverage offered in connection with such a plan)”).

⁶⁵ See *id.* § 712(c)(1)(A), (B) (exempting from the MHPA application group health plans of small employers; defining small employers as those who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year).

⁶⁶ See, e.g., 42 U.S.C. § 300gg-21(a)(2)(A) (permitting sponsors of self-insured nonfederal governmental health plans to opt out of particular federal requirements); 45 C.F.R. § 146.180(a)(1)(v) (2013) (permitting sponsors of self-insured, nonfederal governmental health plans to opt out of federal mental health parity requirements).

⁶⁷ MHPA § 712(c)(2).

⁶⁸ See Colleen L. Barry, *The Political Evolution of Mental Health Parity*, 14 HARV. REV. PSYCHIATRY 185, 187 (2006).

⁶⁹ See MHPA § 712(b)(1) (“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 . . .”).

⁷⁰ See *id.*

⁷¹ See *id.* § 712(e)(4) (“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.”).

and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, or outpatient visit limitations.⁷²

Because of these limitations, President George W. Bush expanded the MHPA twelve years later by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).⁷³ The MHPAEA built on the MHPA by expressly protecting individuals with substance-related and addictive disorders and by imposing comprehensive parity requirements on large group health plans.⁷⁴ In particular, the MHPAEA provided that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses)⁷⁵ and treatment limitations (including inpatient day and outpatient visit limitations)⁷⁶ 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.⁷⁷ The MHPAEA thus would have prohibited a large group health plan from imposing higher deductibles, copayments, or coinsurances, or lower inpatient day and outpatient visit maximums, on individuals seeking care for any mental health or substance use disorder listed in the current edition of the DSM or the International Classification of Diseases (ICD).⁷⁸ The previous sentence is very important: if a covered large group health plan actually

⁷² See *id.* § 712(b)(2) (“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 . . .”).

⁷³ See Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, Pub. L. No. 110-343, 122 Stat. 3881 (codified as amended at 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012)).

⁷⁴ See *id.* § 512(a)(4) (adding a new definition of “substance use disorder benefits”); *id.* § 512(a)(1) (regulating the financial requirements and treatment limitations that are applied to both mental health and substance use disorder benefits).

⁷⁵ See *id.* § 512(a)(1) (including within the definition of “financial requirements” deductibles, copayments, coinsurance, and out-of-pocket expenses).

⁷⁶ See *id.* (including within the definition of “treatment limitations” limits on the frequency of treatment, number of visits, days of coverage, and other similar limits on the scope or duration of treatment).

⁷⁷ 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).

⁷⁸ See, e.g., Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,286–87 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146 and 147) (adopting 45 C.F.R. § 146.136, a federal regulation implementing the MHPAEA that requires a plan’s definition of “mental health benefits” and “substance use disorder benefits” 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).”).

offered insurance benefits for hoarding disorder, premenstrual dysphoric disorder, or gambling disorder, then the DSM-5's inclusion of these conditions now means that the health plan would be prohibited from imposing higher financial requirements or more stringent treatment limitations on individuals seeking services for these conditions.

Like the MHPA, the MHPAEA's application and scope were very limited. As originally enacted, the MHPAEA regulated only insured and self-insured group health plans of large employers, defined as those employers that employ an average of fifty-one or more employees.⁷⁹ The MHPAEA, like the MHPA, did not apply to small group health plans, individual health plans, the Medicare Program, Medicaid nonmanaged care plans, or any self-funded, nonfederal governmental plans whose sponsors had opted out of the MHPAEA.⁸⁰ In terms of its substantive provisions, the MHPAEA also was neither a mandated offer nor a mandated benefit law; nothing in the MHPAEA required a covered group health plan to actually offer or provide any benefits for conditions such as hoarding disorder, premenstrual dysphoric disorder, or gambling disorder, even after the publication of the DSM-5.⁸¹ Like the MHPA,

⁷⁹ MHPAEA § 512(a)(1) (stating that the MHPAEA applies only to group health plans or health insurance coverage offered in connection with such plans).

⁸⁰ See Ctr. for Consumer Oversight & Ins. 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, archived at <http://perma.cc/9FHQ-7GLH> (last visited Mar. 10, 2015) [hereinafter CMS, *MHPAEA*] (“MHPAEA does not apply directly to small group health plans . . .”). The CMS further notes that Medicare and Medicaid are not issuers of health insurance: “They are public health plans through which individuals obtain health coverage. . . . Medicaid benchmark benefit plans, [however,] . . . require compliance with certain requirements of MHPAEA.” *Id.* “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 . . .” *Id.*; Colleen L. Barry et al., *A Political History of Federal Mental Health and Addiction Insurance Parity*, 88 *MILBANK Q.* 404, 407 (2010) (explaining that 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 plans, but not Medicaid nonmanaged care plans); Letter from Cindy Mann, Dir., Ctrs. for Medicare & Medicaid Servs., to State Health Officials 2 (Nov. 4, 2009), available at <https://www.cms.gov/SMDL/downloads/SHO110409.pdf>, archived at <https://perma.cc/A4AH-W3N9> (“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.”).

⁸¹ See MHPAEA § 512(a)(1) (regulating only those group health plans that offer both physical health and mental health benefits); *Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)*, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>, archived at <http://perma.cc/TQ8R-JN38> (last updated Sept. 24, 2014) (noting that “[s]elf-insured non-federal government employee plans can opt out of the federal

the 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.⁸² 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 the MHPAEA for such year.⁸³ The MHPAEA required determinations of exemption-qualifying cost increases to be made and certified in writing by a qualified and licensed actuary who in good standing belongs to the American Academy of Actuaries.⁸⁴

Before President Barack Obama signed the health care reform bill into law, mental health insurance benefits were regulated by the MHPA as expanded by the MHPAEA, as well as by more stringent state law.⁸⁵ Unless a more stringent state law required a health plan to provide hoarding disorder, premenstrual dysphoric disorder, or gambling disorder benefits (and state laws uniformly did not), a health plan was not required to provide such 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, the Affordable Care Act (ACA)).⁸⁶ Best known for its controversial individual health insurance mandate,⁸⁷ the ACA has two sets of provisions that relate to mental health parity and mandatory mental health and substance use disorder benefits. Upheld by the Supreme Court of the United States on June 28, 2012,⁸⁸ these two sets of provisions improve upon some of the limitations of the MHPA and MHPAEA.

The first set of the ACA provisions extends the MHPA’s and MHPAEA’s mental health parity provisions to the individual and small group health plans offered

parity law” and that the MHPAEA’s requirements do not apply to “[s]mall employer plans created before March 23, 2010,” “[c]hurch-sponsored plans and self-insured plans sponsored by state and local governments,” “[r]etiree-only plans,” TriCare, Medicare, and “[t]raditional Medicaid (fee-for-service, nonmanaged care)”); CMS, *MHPAEA*, *supra* note 80 (noting the same limitations).

⁸² See MHPAEA § 512(a)(3) (establishing new cost exemption provisions).

⁸³ *Id.*

⁸⁴ *Id.*

⁸⁵ See Tovino, *Mental Health Parity Law*, *supra* note 6, at 455, at 461–78 (describing the patchwork of state mental health parity law and providing examples of state laws that are more and less stringent than federal law).

⁸⁶ See Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

⁸⁷ *Id.* § 5000(a), 124 Stat. at 244 (adding the following to the Internal Revenue Code: “[a]n applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.”).

⁸⁸ Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

on and off the health insurance exchanges.⁸⁹ Now, many individual and small group health plans that previously discriminated against individuals with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder through higher deductibles, copayments, and coinsurance rates, as well as lower inpatient day and outpatient visit limitations, must comply with the MHPA and MHPAEA.⁹⁰

The second set of relevant ACA provisions requires certain health plans to actually provide mental health and substance use disorder benefits. The ACA now requires individual and small group health plans,⁹¹ exchange-offered qualified health plans,⁹² state basic health plans,⁹³ and Medicaid benchmark plans⁹⁴ to offer “[m]ental health and substance use disorder services, including behavioral health treatment” in addition to nine other categories of essential health benefits (EHBs).⁹⁵ 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.⁹⁶

⁸⁹ 42 U.S.C. § 300gg-26 (2012) (noting that former 42 U.S.C. § 300gg-5 was transferred to 42 U.S.C. § 300gg-26); ACA § 1311(j) (“[MHPAEA] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.”); ACA § 1563(c)(4) (identifying the conforming and technical changes that will be made to former 42 U.S.C. 300gg-5, now codified at 42 U.S.C. § 300gg-26); *see also* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 12 (2011), *available at* http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf, *archived at* <http://perma.cc/2LM9-MLHE> (“The Affordable Care Act also specifically extends MHPAEA to the individual market.”).

⁹⁰ *See* sources cited *supra* note 89.

⁹¹ ACA § 1201(2)(A) (noting amendments to the Public Health Service Act § 2707(a) (codified at 42 U.S.C. § 300gg-6(a)).

⁹² *Id.* § 1301(a)(1)(B) (adding new 42 U.S.C. § 18021(a)(1)(B)).

⁹³ 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).

⁹⁴ *Id.* § 2001(c)(3) (adding new 42 U.S.C. § 1396u-7(b)(5)).

⁹⁵ *Id.* § 1302(b)(1)(A)–(J).

⁹⁶ 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 (June 17, 2010) (to be codified at 29 C.F.R. pt. 2590) (adopting 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 Public Health Service Act § 2707 does not apply to grandfathered health plans); *id.* at 34,568 (adopting 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.”); U.S. DEP’T LABOR, APPLICATION OF THE NEW HEALTH REFORM PROVISIONS OF PART A OF TITLE XXVII OF THE PHS ACT TO GRANDFATHERED PLANS 1, *available at* <http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf>, *archived at* <http://perma.cc/9GXN-RTCJ> (explaining that ACA’s essential benefit package requirement is not applicable to grandfathered plans); *see* INST. OF

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 hoarding disorder benefits, premenstrual dysphoric disorder benefits, or gambling disorder benefits, are required. As a result, the federal Department of Health and Human Services (HHS) issued final regulations implementing the ACA's EHB requirements ("Final Regulations") on February 25, 2013.⁹⁷ These Final Regulations required states to select (or be defaulted into) a benchmark plan⁹⁸ that provides coverage for the ten EHB categories, including mental health and substance use disorder services,⁹⁹ and 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.¹⁰⁰ Thus, the question of whether a particular health insurance policy or plan must provide benefits for a particular mental disorder, such as hoarding disorder, premenstrual dysphoric disorder, or gambling disorder, under 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.

This is where the APA's addition of new and reclassification of old mental disorders in the DSM-5 comes into play. Since I live and work in Las Vegas, I will use the State of Nevada's current benchmark plan to illustrate the application of these rules. Nevada's current benchmark plan is the Health Plan of Nevada Point of Service Group 1 C XV 500 HCR Plan ("Nevada Benchmark Plan").¹⁰¹ If, as written on March 31, 2012, the Nevada Benchmark Plan included hoarding disorder, premenstrual dysphoric disorder, and gambling disorder benefits, then individual,

MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 19 (2012) (listing the health plan settings to which ACA's EHB requirement do not apply); Sara Rosenbaum et al., *The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities*, COMMONWEALTH FUND, Mar. 2011, at 1, 3 ("The act exempts large-group health plans, as well as self-insured [Employee Retirement Income Security Act] plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.").

⁹⁷ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

⁹⁸ *Id.* at 12,866 (adopting 45 C.F.R. § 156.100).

⁹⁹ *Id.* (adopting 45 C.F.R. § 156.110(a)(5)).

¹⁰⁰ *Id.* at 12,867 (adopting 45 C.F.R. § 156.115(a)).

¹⁰¹ See CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA EHB BENCHMARK PLAN, available at <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nevada-ehb-benchmark-plan.pdf>, archived at <http://perma.cc/2KF6-6WUJ> [hereinafter NEVADA EHB BENCHMARK PLAN]; Letter from Scott J. Kipper, Comm'r, Div. of Ins., Dep't of Bus. & Indus., State of Nev., to Kathleen Sebelius, Sec'y, U.S. Dep't of Health & Human Servs. 2 (Dec. 14, 2012), available at http://doi.nv.gov/uploadedFiles/doingov/_public-documents/Healthcare-Reform/12.14.12_kipper_letter_re_ehb.pdf, archived at <http://perma.cc/C6TH-SS7F> (identifying Nevada's Benchmark Plan selection).

small group, and other health plans in Nevada that are required to provide the ten EHB categories must provide benefits for these conditions in years 2014, 2015, and 2016.¹⁰² On the other hand, if the Nevada Benchmark Plan did not include hoarding disorder, premenstrual dysphoric disorder, and gambling disorder benefits on March 31, 2012, then benefits for these disorders are not essential health benefits in Nevada, and individuals with these disorders will not have coverage in years 2014, 2015, and 2016 unless their health plans voluntarily include such benefits¹⁰³ or unless they can access separate state funds for relevant treatments and services.¹⁰⁴

On March 31, 2012, the Nevada Benchmark Plan included coverage for outpatient and inpatient treatment of mental health conditions, including substance-related conditions (such as alcohol use disorder and the drug use disorders).¹⁰⁵ Because the then-current edition of the DSM—the DSM-IV-TR—did not include hoarding disorder and premenstrual dysphoric disorder as mental disorders, the Nevada Benchmark Plan could be interpreted to exclude coverage for treatments for these conditions, at least for years 2014, 2015, and 2016.

In addition, on March 31, 2012, the Nevada Benchmark Plan also excluded coverage for a class of mental health conditions known as the “impulse control disorders.”¹⁰⁶ Because the then-current edition of the DSM—the DSM-IV-TR—classified “pathological gambling” as an impulse control disorder, the result is that the Nevada Benchmark Plan excludes coverage for treatments of gambling disorders, at least for years 2014, 2015, and 2016. In other words, in years 2014, 2015, and 2016, Nevada residents and residents of other states with similar benchmark plan limitations¹⁰⁷ will not benefit from any mandatory gambling disorder benefits and will only have them to the extent their health plans voluntarily

¹⁰² See E-mail from Glenn Shippey, Nev. Div. of Ins., to author (Oct. 3, 2013, 8:37 AM) (on file with the Utah Law Review) [hereinafter Shippey Email] (explaining the application of the EHB requirements in the State of Nevada).

¹⁰³ See Amanda Cassidy, *Essential Health Benefits. States Have Determined the Minimum Set of Benefits to be Included in Individual and Small-Group Insurance Plans. What's Next?*, HEALTH AFF., May 2, 2013, at 1, 2 (noting that HHS has indicated that the benchmark plan approach may be changed in 2016 and in future years based on evaluation and feedback).

¹⁰⁴ See, e.g., BO J. BERNHARD & SARAH ST. JOHN, SOC. HEALTH OF NEV., PROBLEM GAMBLING AND TREATMENT IN NEVADA 4–5 (2012), available at http://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1048&context=social_health_nevada_reports, archived at <http://perma.cc/CF57-VXRP> (discussing problem gambling treatments that are partially or fully supported by the State of Nevada).

¹⁰⁵ See NEVADA EHB BENCHMARK PLAN, *supra* note 101, at 3.

¹⁰⁶ See Shippey Email, *supra* note 102 (noting the Nevada Benchmark Plan’s exclusion of “impulse control disorders”).

¹⁰⁷ See, e.g., CTRS. FOR MEDICARE & MEDICAID SERVS., IOWA EHB BENCHMARK PLAN 4, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/iowa-ehb-benchmark-plan.pdf>, archived at <https://perma.cc/6P4Q-NV25> (excluding from coverage “[c]ommunication disorders, impulse control disorders, sexual identification or gender disorders, and residential facility services”).

provide gambling disorder benefits or they access state-funded gambling disorder benefits.

However, due to the DSM-5's addition of hoarding disorder and premenstrual dysphoric disorder and its reclassification of gambling disorder to the Substance-Related and Addictive Disorders chapter, the story may be very different for years 2017 and beyond in jurisdictions in which coverage for these disorders is not already an essential health benefit. On February 27, 2015, HHS required states to select a new benchmark plan for the 2017 plan year.¹⁰⁸ The deadline for that selection was June 1, 2015.¹⁰⁹ Assuming that benchmark plans are now analyzed using the DSM-5, then any benchmark plan that internally references the DSM-5 or is interpreted using the DSM-5 would likely mandate coverage of hoarding disorder, premenstrual dysphoric disorder, and gambling disorder, unless these conditions are specifically excluded from coverage. Nevada's 2017 benchmark plan, for example, includes "mental/behavioral health services" other than the "impulse control disorders." Because the DSM-5 no longer categorizes gambling disorder as an impulse control disorder, inpatient and outpatient treatments for all three conditions likely are now essential health benefits in Nevada.¹¹⁰

The above discussion focused on the minimum benefits that must be offered by health plans that are required to comply with the EHB requirements set forth in the ACA. Of course, health plans may voluntarily provide benefits above the federal minimum, and many do. Indeed, many health plans simply tie their benefits to the current version of the DSM. For example, the Tufts Health Plan Coverage Guidelines for Outpatient Psychotherapy ("Coverage Guidelines") allow for coverage of psychotherapy when "clinical data provide clear evidence of signs and symptoms consistent with a mental health or substance use disorder as defined in the most recent DSM."¹¹¹ These Coverage Guidelines further state, "Medically Necessary Outpatient psychotherapy services are covered for the diagnosis and treatment of mental health and substance abuse disorders specified in the most recent

¹⁰⁸ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812–13 (Feb. 27, 2015).

¹⁰⁹ See, e.g., JoAnn Volk, *States Need to Select Essential Health Benefit Benchmark Plans for 2017 Soon!*, GEO. U. HEALTH POL'Y INST. (May 7, 2015), <http://ccf.georgetown.edu/all/states-need-select-essential-health-benefit-benchmark-plans-2017-soon/>, archived at <http://perma.cc/UQU5-V7GV>; *Essential Health Benefits*, NEV. DIV. OF INS., DEP'T OF BUS. AND INDUS., <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/>, archived at <http://perma.cc/X9G6-DF2X> (illustrating Nevada's benchmark plan selection for 2017) (last visited Oct. 12, 2015).

¹¹⁰ CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA 2017 EHB BENCHMARK PLAN 3, available at http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/HHS%20Final%202017%20NV%20EHB%20Benchmark%20Plan.pdf, archived at <http://perma.cc/VER5-N4SM> (last visited Oct. 12, 2015).

¹¹¹ TUFTS HEALTH PLAN, COVERAGE GUIDELINES FOR OUTPATIENT PSYCHOTHERAPY 1 (2014), available at http://www.tuftshealthplan.com/providers/pdf/mng/outpatient_psychotherapy.pdf, archived at <http://perma.cc/J9YD-TC5C>.

Diagnostic and Statistical Manual (DSM).”¹¹² The APA’s addition of hoarding disorder and premenstrual dysphoric disorder to the DSM-5 would result in these conditions being newly covered under the Tufts Health Plan as long as the treatment, service, or procedure recommended by the treating mental health professional is medically necessary. Gambling disorder also would be covered, although its predecessor (pathological gambling) would have been covered in the past by virtue of its inclusion in the DSM-IV-TR.

By further example, the University of Pittsburgh Medical Center for Kids Pennsylvania CHIP Program Plan (“UPMC for Kids Plan”) excludes “[a]ny service related to disorders that are not treatable Diagnostic and Statistical Manual of Mental Disorders (DSM) defined mental disorders according to the most recent version of DSM.”¹¹³ Since hoarding disorder, premenstrual dysphoric disorder, and gambling disorder are listed in the DSM-5, they would appear to fall outside this exclusion and would also be covered under the UPMC for Kids Plan.

IV. DISABILITY BENEFIT LAW

The previous Part showed how the addition of new disorders and the reclassification of existing disorders in the DSM-5 can significantly affect health insurance coverage. This Part focuses on the impact of the DSM on the application of public and private disability benefit law.¹¹⁴ As background, disability benefits can be public, such as the cash disability benefits provided by the Social Security Administration to individuals who meet the Social Security Act’s (SSA) definition of disability.¹¹⁵ Disability benefits also can be private, such as the cash disability benefits provided by administrators of short-and long-term disability insurance plans to individuals who participate in such plans as a benefit of employment or who purchase such plans on the open insurance market.¹¹⁶ Illustrative cases involving disability claimants with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder are discussed below.

¹¹² *Id.*

¹¹³ UPMC FOR KIDS, EXCLUSIONS 1 (2013), available at http://www.upmchealthplan.com/docs/inf/chip_exclusions.pdf, archived at <http://perma.cc/FEF3-Y97W>.

¹¹⁴ The next three paragraphs were first printed in Tovino, *Lost in the Shuffle*, *supra* note 6, at 224–25. Technical and conforming changes have been made.

¹¹⁵ See 42 U.S.C. § 423(d)(1), (2) (2012).

¹¹⁶ Disability income insurance protects an individual’s income. If an individual becomes unable to work due to a sickness or injury, disability income insurance provides cash benefits that the individual may use to pay for housing, food, clothing, and utilities, among other living expenses. 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 Overview*, METLIFE, <https://www.metlife.com/individual/insurance/disability-insurance/index.html>, archived at <https://perma.cc/4NS8-UCAG> (last visited Mar. 21, 2015).

A. Public Disability Benefits

Title II of the SSA provides for the payment of federal Social Security Disability Insurance (SSDI) benefits to certain individuals with physical and mental disabilities.¹¹⁷ The SSA defines “disability” as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment.”¹¹⁸ 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.”¹¹⁹ 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.¹²⁰

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.¹²¹ First, a determination is made regarding whether the individual is engaged in “substantial gainful activity.” If so, benefits are denied.¹²² 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.¹²³ 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.¹²⁴ 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.¹²⁵ 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.¹²⁶

¹¹⁷ See, e.g., *Locher v. Sullivan*, 968 F.2d 725, 727 (8th Cir. 1992).

¹¹⁸ 42 U.S.C. § 423(d)(1)(A).

¹¹⁹ *Id.* § 423(d)(2)(A).

¹²⁰ *Id.* § 423(d)(1)(A).

¹²¹ 20 C.F.R. § 404.1520(a)(4) (2014) (listing the five-step sequential evaluation process); *id.* § 416.920(a)(4) (explaining the five-step sequential evaluation process); see also *Bowen v. Yuckert*, 482 U.S. 137, 140–42 (1987) (explaining the five-step sequential evaluation process in the context of a particular claimant).

¹²² 20 C.F.R. § 416.920(a)(4)(i).

¹²³ *Id.* § 416.920(a)(4)(ii).

¹²⁴ *Id.* § 416.920(a)(4)(iii).

¹²⁵ *Id.* § 416.920(a)(4)(iv).

¹²⁶ *Id.* § 416.920(a)(4)(v).

Neither Congress in the SSA nor the HHS in the Social Security Administration's implementing regulations expressly exclude individuals with hoarding disorder, premenstrual dysphoric disorder, or gambling disorder from qualifying for SSDI benefits.¹²⁷ Instead, SSDI claimants with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder, like most other SSDI claimants, are assessed using the case-by-case, five-step sequential evaluation process.

Unlike health insurance coverage, discussed in Part III, research does not reveal that additions to or reclassifications within the DSM-5 are determinative with respect to public disability benefit eligibility. Instead, the presence of a physical or mental impairment is simply a predicate to a more important legal determination; specifically, whether the individual's impairment is of such severity that the individual cannot do his or her previous work and cannot perform other substantial gainful work that exists in the national economy.

For example, in *Bakke v. Colvin*,¹²⁸ Cynthia Bakke sought judicial review of the Commissioner's final decision denying her application for SSDI benefits.¹²⁹ In a hearing held in August 2011, prior to the publication of the DSM-5 and the manual's inclusion of premenstrual dysphoric disorder, an administrative law judge (ALJ) found that Bakke had premenstrual dysphoric disorder as well as other mental disorders.¹³⁰ However, the ALJ did not find Bakke's statements regarding the limiting effects of the symptoms of her disorder to be credible; therefore, the ALJ "concluded that Bakke had the residual functional capacity" to work.¹³¹ On review, the District Court of Minnesota agreed, finding a lack of objective and subjective evidence in the medical record to substantiate Bakke's claims regarding the severity and limiting effect of her symptoms.¹³²

Because the ALJ found that Bakke had a mental impairment even though her mental condition was not yet listed in the DSM-5, this case demonstrates that the DSM is not determinative with respect to the issue of whether an SSDI claimant has a qualifying mental impairment. This case also demonstrates how SSDI claimants have an additional burden; that is, the burden to prove the existence of severe work limitations. The DSM-5 is not helpful in this regard.

Other cases support these points. In *Young v. Colvin*,¹³³ Tanya Black Young sought review of the Commissioner's final decision denying her SSDI benefits.¹³⁴

¹²⁷ The 1996 amendments to the SSA provide, however, that "[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); *Johansen v. Astrue*, No. 10-2076 (DWF/SER), 2011 WL 4583828, at *1 n.1 (D. Minn. Sept. 30, 2011).

¹²⁸ No. 12-538 (JNE/TNL), 2013 WL 4436178 (D. Minn. Aug. 16, 2013).

¹²⁹ *Id.* at *1.

¹³⁰ *Id.* at *1-2.

¹³¹ *Id.* at *1.

¹³² *Id.* at *5.

¹³³ No. 2:11CV889-CSC, 2013 WL 1336798 (M.D. Ala. Mar. 29, 2013).

¹³⁴ *Id.* at *1

In a hearing held during November 2009, before the publication of the DSM-5, an ALJ found that Young had certain impairments, including osteoarthritis, but that she did not have other impairments, including premenstrual dysphoric disorder, dysmenorrhea, and menorrhagia.¹³⁵ The ALJ also found that Young had residual functional work capacity.¹³⁶ Even though the DSM-5 had not yet been released, the District Court for the Middle District of Alabama held that the ALJ committed reversible error when the ALJ failed to consider Young's subjective testimony about the limiting effects of her premenstrual dysphoric disorder, dysmenorrhea, and menorrhagia, and when the ALJ failed to explain why he did not account for these limiting effects in determining Young's residual functional capacity.¹³⁷ This case demonstrates that the lack of inclusion of a condition in the current edition of the DSM has little relevance to a determination regarding whether an SSDI claimant's ability to work is severely limited by that condition.

Similarly, in *Best v. Astrue*,¹³⁸ Mary Elizabeth Best sought review of the Commissioner's final decision denying her application for SSDI benefits.¹³⁹ In a hearing held during June 2007, prior to the publication of the DSM-5, an ALJ found that Best had obesity and depressive disorder, but that she did not have premenstrual dysphoric disorder.¹⁴⁰ The District Court for the Western District of Washington upheld the ALJ's finding on the ground that Best failed to offer evidence by "an acceptable medical source" of her premenstrual dysphoric disorder.¹⁴¹ Best had offered a handwritten note authored by a mental health counselor but not a medical record by a physician or other provider considered acceptable by the Social Security Administration.¹⁴² In addition, Best failed to offer any evidence of any work limitations caused by her premenstrual dysphoric disorder.¹⁴³ The lack of inclusion of premenstrual dysphoric disorder in the then-current edition of the DSM (DSM-IV-TR) played no role in either of these findings. Again, this case illustrates that the lack of inclusion of a condition in the current edition of the DSM has little relevance to a judicial determination regarding whether an SSDI claimant has an impairment or whether the claimant's ability to work is severely limited by the alleged impairment.

Likewise, in *Banta v. Astrue*,¹⁴⁴ Lisa Linnette Banta sought review of the Commissioner's final decision denying her application for SSDI benefits.¹⁴⁵ In a hearing held during September 2010, an ALJ found that Banta had some severe impairments, including seizure disorder, hypertension, and migraine headaches, but

¹³⁵ *Id.* at *2.

¹³⁶ *Id.*

¹³⁷ *Id.* at *8.

¹³⁸ No. C10-836-MJP-BAT, 2010 WL 5185446 (W.D. Wash. Dec. 1, 2010).

¹³⁹ *Id.* at *1.

¹⁴⁰ *Id.*

¹⁴¹ *Id.* at *2.

¹⁴² *Id.*

¹⁴³ *Id.* at *2-3.

¹⁴⁴ No. EDCV 11-1302 JPR, 2012 WL 1967763 (C.D. Cal. June 1, 2012).

¹⁴⁵ *Id.* at *1.

that she did not have other alleged impairments, including hoarding disorder, obsessive-compulsive disorder, and back pain.¹⁴⁶ Although obsessive-compulsive disorder was listed in the then-current edition of the DSM (the DSM-IV-TR), the ALJ still found that Banta did not present objective medical evidence supporting her alleged obsessive-compulsive disorder.¹⁴⁷ And, although hoarding disorder was not yet listed in the DSM-IV-TR, this lack of listing was not relevant to the ALJ's determination, either. In summary, this case demonstrates that the inclusion (or lack thereof) of a condition in the current edition of the DSM has little relevance to a determination regarding whether an SSDI claimant's ability to work is severely limited by such condition.

B. Private Disability Benefits

The cases discussed in Part IV(A) involved applications for public disability (SSDI) benefits. Many individuals also have private disability income insurance plans that provide short- and long-term cash disability insurance benefits pursuant to the contractual language set forth in the plans. One question is whether changes in the DSM-5 will affect the interpretation of these disability plans. The answer depends on the contractual language set forth in each private disability plan as applied to the applicant.

For example, in *Reid v. Metropolitan Life Insurance, Co.*,¹⁴⁸ defendant MetLife administered a long-term disability plan ("Plan") that distinguished between physical and mental disabilities by providing long-term disability benefits for participants with permanent physical disabilities but only two years of disability benefits for participants with "Mental or Nervous Disorders or Diseases."¹⁴⁹ The question before the court was whether the claimant had a physical or mental disability. The Plan referenced the then-current edition of the DSM (the DSM-IV-TR) for purposes of determining whether a claimant had a physical or mental disability.¹⁵⁰

Although *Reid* involved a claimant who had dementia, not the conditions that are the subject of this Article, one could imagine how the DSM-5 could positively impact private disability benefit determinations in cases involving individuals with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder if those individuals were insured under a plan like the plan in *Reid*. That is, consider a private disability benefit plan that provides disability benefits to individuals with disorders listed in the "current version of the DSM." Since hoarding disorder, premenstrual dysphoric disorder, and gambling disorder are listed in the DSM-5, individuals with

¹⁴⁶ *Id.* at *2.

¹⁴⁷ *Id.*

¹⁴⁸ 944 F. Supp. 2d 1279 (N.D. Ga. 2013).

¹⁴⁹ *Id.* at 1282.

¹⁵⁰ *Id.* (referencing the Plan provision stating that "Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual of Mental Disorders as of the date of Your Disability" (emphasis omitted)).

these conditions may become eligible for disability benefits if they can prove that they are also unable to work as a result of these conditions.

Proving this latter requirement—an inability to work as a result of a disability—is not always easy. For example, in *Reilly v. Northwestern Mutual Life Insurance Co.*,¹⁵¹ plaintiff Michael Reilly sought to receive monthly cash benefits under his private disability income insurance policy issued by defendant Northwestern Mutual.¹⁵² 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.¹⁵³ Benefits were payable under Reilly’s disability income insurance policy if: (1) the insured became “disabled” while the policy was in effect; (2) the insured was under the care of a licensed physician other than himself when he had the disability; (3) the insured’s disability resulted from an “accident or sickness”; and (4) the insured’s alleged disability was not otherwise excluded under the policy.¹⁵⁴

Gambling disorder was not specifically included or excluded from the definition of disability under Reilly’s disability policy.¹⁵⁵ 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.¹⁵⁶ In opposition, defendant Northwestern Mutual argued that it was not obligated to pay Reilly cash benefits because his inability to perform his occupation resulted not from an accident or sickness but, instead, criminal or other illegal conduct; that is, Reilly misappropriated his clients’ trust funds.¹⁵⁷ Neither party referenced the current edition of the DSM (the DSM-IV-TR), which included pathological gambling as a disorder in the impulse control disorders chapter) to argue that Reilly’s gambling addiction should or should not make him eligible for disability benefits.

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 misappropriation of client trust fund accounts, is not a disability.¹⁵⁸ The court ultimately found that Reilly “was not disabled by the gambling addiction, only by

¹⁵¹ No. 1-06-CV-14-CRWRAW, 2007 WL 1485103 (S.D. Iowa May 16, 2007).

¹⁵² *Id.* The next four paragraphs were first printed in Tovino, *Lost in the Shuffle*, *supra* note 6, at 228–30. Technical and conforming changes have been made.

¹⁵³ *Reilly*, 2007 WL 1485103, at *1.

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* at *2.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ *Id.* (citing *Mass. Mut. Life Ins. Co. v. Millstein*, 129 F.3d 688 (2d Cir. 1997); *Zembko v. Nw. Mut. Life. Ins. Co.*, No. 3:05CV918(AHN), 2007 WL 948323 (D. Conn. Mar. 26, 2007)).

the license revocation,” pointing to the fact that he “would still be practicing law” with his full income, “notwithstanding his excessive gambling, except for his wrongful conversion of client funds.”¹⁵⁹ The court reasoned that the public policy of the State of Iowa required such a finding.¹⁶⁰ 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.¹⁶¹ 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.¹⁶² This case supports the principles identified in Part IV(A), including the lack of determinativeness of the DSM in disability benefit proceedings.

Indeed, the United States District Court for the Southern District of Iowa’s suggestion proved true in *McClagherty v. Unum Life Insurance Co. of America*.¹⁶³ In *McClagherty*, plaintiff John McClagherty sued Unum Life Insurance Company following its denial of McClagherty’s application for short-term disability benefits.¹⁶⁴ McClagherty had been diagnosed with gambling disorder among other comorbid disorders including bipolar affective disorder, alcohol use disorder, and substance use disorder.¹⁶⁵ McClagherty 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, and then he applied for short-term cash disability benefits to pay for such treatment.¹⁶⁶ Defendant Unum tried to argue that McClagherty 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 found that defendant Unum failed to consider important medical record evidence showing that McClagherty had received intensive outpatient treatment for his gambling and comorbid disorders that would corroborate his disability claim.¹⁶⁷ The court ultimately remanded the case, instructing defendant Unum to explicitly consider a particular set of outpatient

¹⁵⁹ *Id.* at *3.

¹⁶⁰ *Id.* at *2–3. The court quoted *Millstein*, in which the Second Circuit Court of Appeals stated, “[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.” *Id.* (quoting *Millstein*, 129 F.3d at 691).

¹⁶¹ *See id.* at *3 (“Plaintiff so testified at his license revocation hearing and by deposition; treatment for his addiction had overcome his gambling habit.”).

¹⁶² *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.”).

¹⁶³ No. 2:09-cv-01292, 2010 WL 2787632 (S.D.W. Va. July 14, 2010).

¹⁶⁴ *Id.* at *1.

¹⁶⁵ *Id.* at *1–3.

¹⁶⁶ *Id.* at *1.

¹⁶⁷ *Id.* at *4.

treatment records as evidence of McClaugherty's disability.¹⁶⁸ The DSM was not relevant to any of the court's rulings.

V. DISABILITY DISCRIMINATION LAW

Parts III and IV of this Article analyzed the potential impact of the DSM-5 on health insurance coverage and public and private disability benefit eligibility. This Part focuses on the potential impact of the DSM-5 on protection under federal and state disability discrimination law.

As I explain in detail elsewhere,¹⁶⁹ 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.¹⁷⁰ 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 with disabilities.¹⁷¹ The original Americans with Disabilities Act of 1990 (ADA), signed into law by President George H.W. Bush on July 26, 1990, prohibits certain employers, state and local government agencies, and places of public accommodation from discriminating on the basis of disability against qualified individuals with disabilities.¹⁷² The ADA Amendments Act of 2008 (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 and generally shall not require extensive analysis.¹⁷³ 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.¹⁷⁴

¹⁶⁸ *Id.*

¹⁶⁹ See, e.g., Tovino, *Lost in the Shuffle*, *supra* note 6, at 230–38.

¹⁷⁰ The background information regarding disability discrimination law set forth in this paragraph and the next paragraph was first published in Tovino, *Lost in the Shuffle*, *supra* note 6, at 230–32. Technical and conforming changes have been made.

¹⁷¹ Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified as amended at 29 U.S.C. § 701 (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.”).

¹⁷² Americans with Disabilities Act (ADA) of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–12213 (2012)).

¹⁷³ ADA Amendments Act (ADAAA) of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified at 29 U.S.C. §§ 705–706 and in scattered sections of 42 U.S.C.).

¹⁷⁴ CAL. GOV'T CODE § 12940 (West 2011 & Supp. 2015).

To determine whether an individual is entitled to protection under one of these statutes, each statute's definition of "disability" must be examined.¹⁷⁵ For example, the ADAAA uses a three-prong definition of disability including, with respect to an individual: "(A) a physical or *mental impairment* that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."¹⁷⁶ The ADAAA explains that the definition of disability in the ADAAA "shall be construed in favor of broad coverage of individuals . . . to the maximum extent permitted by the terms of [the ADAAA]."¹⁷⁷

The Equal Employment Opportunity Commission (EEOC) has stated in guidance documents interpreting the ADAAA's predecessor, the ADA, that the current edition of the DSM is relevant for identifying qualifying mental impairments.¹⁷⁸ Courts interpreting disability discrimination law also have stated that weight may be given to the DSM in determining which impairments qualify as mental impairments.¹⁷⁹ However, a finding of a "mental impairment" is not determinative of a plaintiff's disability discrimination claim. The plaintiff still must prove that she is a "qualified individual" with a disability and that a covered entity has discriminated against her "on the basis of disability."¹⁸⁰ The term "qualified individual" means that the individual "satisfies the requisite skill, experience, education, and other job-related requirements of the employment position such individual holds or desires and, with or without reasonable accommodation, can perform the essential functions of such position."¹⁸¹ The requirement that the individual be discriminated against "on the basis of disability" means that the individual was not discriminated against for some other reason unrelated to disability.

¹⁷⁵ The definitions of "disability" that are used by the Social Security Administration and by private disability income insurance benefit insurers, discussed in Part IV, are different than the definitions used by federal and state antidiscrimination laws and are not applicable here. *See, e.g.,* *Labit v. Akzo-Nobel Salt, Inc.*, 209 F.3d 719 (5th Cir. 2000) (unpublished table decision) (per curiam) (distinguishing Social Security disability determinations from ADA disability determinations and noting, for example, that Social Security disability determinations do not take into account workplace accommodations).

¹⁷⁶ ADAAA § 3, 122 Stat. at 3555 (emphasis added).

¹⁷⁷ *Id.*

¹⁷⁸ U.S. EQUAL EMP'T OPPORTUNITY COMM'N, EEOC ENFORCEMENT GUIDANCE ON THE AMERICANS WITH DISABILITIES ACT AND PSYCHIATRIC DISABILITIES, EEOC NOTICE NO. 915.002 (1997) [hereinafter EEOC NOTICE], available at <http://www.eeoc.gov/policy/docs/psych.html>, archived at <http://perma.cc/KTQ4-VGJY> ("The current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (now the fourth-edition, DSM-IV) is relevant for identifying these disorders.").

¹⁷⁹ *E.g.,* *Boldini v. Postmaster Gen. U.S. Postal Serv.*, 928 F. Supp. 125, 130 (D.N.H. 1995) ("As plaintiff correctly points out, in circumstances of mental impairment, a court may give weight to a diagnosis of mental impairment which is described in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.").

¹⁸⁰ 29 C.F.R. § 1630.4(a)(1) (2013).

¹⁸¹ *Id.* § 1630.2(m).

A few disability discrimination cases have been brought by individuals with hoarding disorder, premenstrual dysphoric disorder, and gambling disorder. The DSM was not dispositive of, or even relevant to, the outcomes of these cases. In *Marzano v. Universal Studio, Inc.*,¹⁸² for example, plaintiff Damon Marzano sued Universal Studio, Inc., his former employer, arguing that he was terminated from his job as a mailroom clerk in violation of federal and state disability discrimination law.¹⁸³ Marzano, who had obsessive-compulsive disorder, including extreme hoarding behaviors, was unable to stop taking items from the garbage at work even though he had been instructed not to take items from the garbage.¹⁸⁴ Marzano also admitted that his need to hoard interfered with his job duties, including keeping the mailroom tidy and orderly, and that his compulsions made him arrive late to work and delayed the completion of tasks, such as sealing envelopes.¹⁸⁵

Although its opinion was published a decade before the release of the DSM-5, neither the plaintiff's employer nor the United States District Court for the District of Massachusetts objected to Marzano's characterization of his hoarding as a disability. Instead, the court found that he was unable to carry his burden of proving that he could perform the essential functions of his job with or without accommodation.¹⁸⁶ With respect to his inability to stop collecting garbage from the trash, the court specifically explained that "[a]n obligation to refrain from engaging in certain behaviors or activities is as much a part of a job's essential functions as the adequate performance of assigned tasks."¹⁸⁷ The court also held that he failed to identify any accommodation that would have made him capable of complying with his employer's workplace rules.¹⁸⁸ As in other cases discussed in Part IV of this Article, a finding that Marzano had a mental impairment was a simple predicate to a more important legal determination; specifically, whether Marzano could prove that he could perform the essential functions of his job with or without reasonable accommodation.¹⁸⁹ The APA's inclusion of hoarding disorder in the DSM-5 would not have changed the outcome of this case.

The same is true of cases involving premenstrual dysphoric disorder. In *Bielich v. Johnson & Johnson, Inc.*,¹⁹⁰ plaintiff Norma Bielich sued her employer under several statutes, including the ADA.¹⁹¹ In relevant part, Bielich alleged that her employer failed to accommodate her disability, which was premenstrual dysphoric disorder.¹⁹² The United States District Court for the Western District of Pennsylvania assumed for purposes of summary judgment disposition that Bielich was a qualified

¹⁸² No. Civ.A. 02-10449-GAO, 2003 WL 21696213 (D. Mass. May 28, 2003).

¹⁸³ *Id.* at *1.

¹⁸⁴ *Id.* at *2-3.

¹⁸⁵ *Id.* at *3.

¹⁸⁶ *Id.* at *3-4.

¹⁸⁷ *Id.* at *3.

¹⁸⁸ *Id.*

¹⁸⁹ *Id.* at *4.

¹⁹⁰ 6 F. Supp. 3d 589 (W.D. Pa. 2014).

¹⁹¹ *Id.* at 594.

¹⁹² *Id.* at 594, 597.

individual with a disability who could perform the essential functions of her job.¹⁹³ As a result, the court focused solely on whether she could prove that her employer's proffered reasons for her termination were a pretext for disability discrimination.¹⁹⁴ As with the previous case, the APA's inclusion of premenstrual dysphoric disorder in the DSM-5 could not be used to answer this question and therefore would not have impacted the outcome of the case.

Similarly, in *Millington v. Temple University School of Dentistry*,¹⁹⁵ an academically uncompetitive dental student with premenstrual dysphoric disorder and other physical and mental disabilities sued her school under the ADA and the Rehabilitation Act, alleging that she was discriminated against on the basis of her disabilities.¹⁹⁶ The United States Court of Appeals for the Third Circuit found that the student failed to provide documentation of her alleged disabilities and that some of the medical records that she did provide contradicted her disability claims.¹⁹⁷ The Third Circuit also found that even if the student did prove that she had a disability, she failed to meet her burden of proving that she was otherwise qualified to participate in the dental school's program.¹⁹⁸ Finally, the Third Circuit found that even after the dental school accommodated all of the student's requests, including by providing a dental assistant for her clinical duties, the student's academic performance did not improve.¹⁹⁹ The DSM-5 would not have impacted any of these determinations.

The above cases involved individuals with hoarding disorder and premenstrual dysphoric disorder. Cases involving individuals with gambling disorder are different because Congress expressly excludes the condition it calls "compulsive gambling" (as well as kleptomania and pyromania, all three of which were classified in the impulse control disorders chapter of the DSM-IV-TR) from the definition of disability.²⁰⁰ Many state disability discrimination laws also continue to exclude individuals with gambling disorder from protected status. For example, the California Fair Employment and Housing Act,²⁰¹ 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 disability, mental disability," and other indicators,²⁰² continues to exclude

¹⁹³ *Id.* at 607, 611.

¹⁹⁴ *Id.* at 607.

¹⁹⁵ 261 F. App'x 363 (3d Cir. 2008).

¹⁹⁶ *Id.* at 363–64.

¹⁹⁷ *Id.* at 366.

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ 42 U.S.C. § 12211(b)(2) (2012).

²⁰¹ CAL. GOV'T CODE §§ 12900–12996 (West 2011 & Supp. 2015).

²⁰² *Id.* § 12920.

“compulsive gambling” from the definition of both “mental disability”²⁰³ and “physical disability.”²⁰⁴

The courts have upheld these exclusions in cases in which they have been challenged. For example, in *Trammell v. Raytheon Missile Systems*,²⁰⁵ which involved a plaintiff with gambling disorder and other mental disorders, the United States District Court for the District of Arizona was unsympathetic to the plaintiff’s claim that his gambling disorder should be protected under the ADA: “Congress expressly excluded compulsive gambling . . . from the ADA’s definition of disability.”²⁰⁶ The court published its opinion in *Trammell* in 2010, thirty years after the APA first introduced pathological gambling in the DSM-III. The inclusion of pathological gambling in the DSM clearly has no impact on the treatment of individuals with gambling disorder under the ADA.

The EEOC also appears unsympathetic toward individuals with gambling disorder.²⁰⁷ In a guidance document interpreting the original ADA that was released by the EEOC in 1997, seventeen years after the APA first introduced pathological gambling in the DSM-III, the EEOC explained, with respect to which conditions constituted mental impairments:

The current edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (now the fourth edition, DSM-IV) is relevant for identifying these disorders. The DSM-IV has been recognized as an important reference by courts and is widely used by American mental health professionals for diagnostic and insurance reimbursement purposes.

*Not all conditions listed in the DSM-IV, however, are disabilities, or even impairments, for purposes of the ADA. For example, the DSM-IV lists several conditions that Congress expressly excluded from the ADA’s definition of “disability.”*²⁰⁸

In a prior publication, I spent a considerable amount of time using neuroscience, economics, and principles of biomedical ethics to argue that individuals with gambling disorder should have the same legal protections as

²⁰³ *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.”).

²⁰⁴ *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.”).

²⁰⁵ 721 F. Supp. 2d 876 (D. Ariz. 2010).

²⁰⁶ *Id.* at 878.

²⁰⁷ See generally Tovino, *Lost In the Shuffle*, *supra* note 6, at 196–204 (discussing the history of the classification of pathological gambling and gambling disorder in the DSM-III, the DSM-III-R, the DSM-IV, the DSM-IV-TR, and the DSM-5).

²⁰⁸ EEOC NOTICE, *supra* note 178 (emphasis added).

individuals with substance-related and other addictive disorders under disability discrimination law.²⁰⁹ In that work, I specifically pointed out that the APA's move of gambling disorder away from the impulse control disorders chapter and into the Substance-Related and Addictive Disorder chapter signaled that gambling disorder should be treated like other substance-related and addictive conditions under the law.²¹⁰ In addition, I formally proposed the amendment of federal and state disability discrimination laws in ways that would protect individuals with gambling disorder.²¹¹

Other gaming scholars also have argued that advances in the scientific understanding of gambling disorder call for reconsideration of the exclusion in disability discrimination law. Professors Christian Hardigree, Bo Bernhard, and Shannon Bybee at the University of Nevada, Las Vegas, have argued, for example, that the ADA exception for gambling disorder should be reexamined due to advances in the scientific understanding of the condition.²¹² Professors Hardigree, Bernhard, and Bybee explain:

While debates over these issues are ongoing . . . , it is becoming less clear why “compulsive” gambling is specifically excluded by the ADA. As the psychological and medical community increasingly embraces pathological gambling as a legitimate and potentially devastating disorder, it seems that we would be wise to allow ADA mechanisms to respond accordingly. The time has come for a thoughtful and scientifically informed re-evaluation of pathological gambling's ADA status.²¹³

Although my research has not yet revealed a lawmaker, lobbyist, or litigant who has tried to use the DSM-5's reclassification of gambling disorder to challenge its exclusion under disability discrimination law, I do anticipate that lawmakers, lobbyists, and litigants will make these types of arguments in the near future. For purposes of this Article, however, it must be noted that the DSM-5's reclassification of gambling disorder has not yet affected the lack of protection given to individuals with the disorder.

VI. CONCLUSION

This Article has attempted to assess the impact of changes in the DSM-5 on three areas of health law, including health insurance law, disability benefit law, and

²⁰⁹ See Tovino, *Lost In the Shuffle*, *supra* note 6.

²¹⁰ *Id.* at 238–52.

²¹¹ *Id.*

²¹² Christian E. Hardigree et al., *Sicknesses and Sanctions: The Exclusion of Pathological Gambling Under the Americans with Disabilities Act*, 1 ELECTRONIC J. HOSPITALITY LEGAL, SAFETY & SECURITY RES. (2003), available at http://hospitalitylawyer.com/wp-content/uploads/Volume_I_Article_2.pdf, archived at <http://perma.cc/3R8Q-L2Z5>.

²¹³ *Id.*

disability discrimination law. This Article has shown how the addition of new disorders and the reclassification of existing disorders in the DSM-5 can significantly impact the application of federal and state mental health parity laws, mandatory mental health and substance use disorder benefit laws, as well as the interpretation of health insurance contracts. That is, federal mental health parity law, some state benchmark plans, and some health insurance contracts incorporate by reference the current edition of the DSM when identifying conditions that are eligible for parity protections, mandatory benefits, and insurance coverage, respectively.

On the other hand, this Article also has demonstrated how the DSM-5 is not determinative with respect to the outcome of public disability benefit cases. In public disability benefit cases, the presence of a physical or mental impairment is simply a predicate to a more important legal determination; namely, whether the individual's impairment is of such severity that the individual cannot do his or her previous work and cannot perform other substantial gainful work that exists in the national economy. This secondary legal determination is made based on proof provided by the claimant of the claimant's work limitations. Claimants who fail to provide objective evidence regarding their work limitations will not prevail regardless of whether their underlying conditions are listed in the current edition of the DSM.

This Article has further demonstrated how the DSM-5 is not necessarily determinative with respect to the outcome of private disability benefit cases, either. Although some private disability plans internally reference the current edition of the DSM for purposes of determining whether an insured has a mental disability, this finding of disability may be a predicate to other legal determinations, such as whether the disability makes the insured unable to work. In many cases, courts agree that the insured has a disability but find that something else, such as the insured's commission of a crime, makes the individual unable to work. In these cases, the insured is not eligible for contractual disability benefits even if the insured's disability is listed in the current edition of the DSM.

As a final descriptive matter, this Article has demonstrated how changes in the DSM-5 have not yet impacted disability discrimination cases, at least in cases involving individuals with hoarding disorder, premenstrual dysphoric disorder, or gambling disorder. Although hoarding disorder and premenstrual dysphoric disorder were considered disabilities even before the publication of the DSM-5, individuals with gambling disorder are excluded from protection under federal and state antidiscrimination law even after the DSM-5. In addition, all individuals with disabilities still bear the burden of proving that they are qualified individuals with disabilities who can perform the essential functions of their jobs with or without reasonable accommodation. The DSM-5 is unhelpful with respect to these and other similar requirements.

In addition, this Article agrees with the APA's cautionary statement regarding legal uses of the DSM-5.²¹⁴ In the beginning of the DSM-5, the APA explains that

²¹⁴ AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 1, at 25.

the diagnostic criteria and textual descriptions in the DSM-5 can be useful for certain limited legal purposes:

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders.²¹⁵

However, the APA emphasizes the risks and limitations of using the DSM-5 in forensic settings:

When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.²¹⁶

Finally, the APA also advises against the use of the DSM-5 by nonclinical personnel:

Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised. Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of

²¹⁵ *Id.*

²¹⁶ *Id.*

control over behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.²¹⁷

In agreement (and in keeping) with these cautionary statements, this Article concludes by identifying four permissible uses and possible abuses of the DSM-5 in civil and administrative health law proceedings.

First, attorneys and judges should continue to legally interpret health insurance contracts that internally reference the DSM and make related legal arguments and decisions regarding the coverage of particular conditions. For example, a lawyer who represents a plaintiff who has been diagnosed by a mental health professional with hoarding disorder, premenstrual dysphoric disorder, or gambling disorder in a dispute involving an insurance contract that provides coverage for "all mental disorders listed in the DSM-5" should feel comfortable arguing that the client's disorder is covered under the terms of the contract. The lawyer's argument is a legal argument, not a clinical decision. On the other hand, a judge should be cautioned against using the DSM to make his or her own decision about whether a plaintiff has a listed condition. Instead, the judge should rely on the medical evidence presented by the plaintiff's treating clinicians.

Second, in the context of public disability benefit disputes, attorneys, ALJs, and reviewing courts should continue to apply the five-factor analysis set forth by the Social Security Commissioner for determinations regarding SSDI benefit eligibility, as discussed in Part IV(A). The DSM-5 may be helpful in the second of the five steps; that is, in identifying the criteria required for a diagnosis of a mental impairment, which may aid the plaintiff's attorney in her request for medical documentation of the impairment from the plaintiff's treating physicians. However, attorneys, ALJs, and reviewing courts must recognize that SSDI benefit eligibility depends on a number of other legal determinations that the DSM-5 cannot answer, including whether the individual is presently engaged in substantial gainful activity, whether the impairment prevents the individual from performing past relevant work and, if it gets to this point, whether the Commissioner has carried the burden of proving that the individual is able to perform other kinds of work in the national economy. An attorney, ALJ, or reviewing court would abuse the DSM-5 if the attorney, judge, or court argued or determined that the claimant would be eligible for SSDI benefits based solely on a claimant's DSM-5 diagnosis.

Third, in the context of private disability benefit disputes, some private disability plans do internally reference the DSM for purposes of identifying the conditions that constitute a qualifying disability. In these cases, it would be permissible for an attorney or judge to consult the current edition of the DSM to determine whether the insured's alleged condition constitutes a qualifying disability. However, most private disability plans also require the insured to prove that her

²¹⁷ *Id.*

disability makes her unable to work. The DSM-5 cannot provide this type of evidence and it would be inappropriate for an attorney or judge involved in a private disability benefit dispute to argue or determine that an individual is entitled to cash disability benefits based only on a DSM-5 diagnosis, or for a judge to decide herself, without medical evidence, that the individual has a particular mental disability.

Fourth, in the context of disability discrimination disputes, the EEOC and the courts have stated that the DSM is relevant for purposes of identifying conditions that constitute mental impairments.²¹⁸ However, disability discrimination law also requires the plaintiff to plead and prove a number of other factors, such as whether the individual is a qualified individual who can perform the essential functions of the job with or without reasonable accommodation. In addition, and even though this requirement has been substantially watered down by the ADAAA, the text of the ADAAA continues to require the individual to at least plead that the individual's disability substantially limits a major life activity. The DSM-5 is not determinative of any of these issues. Attorneys and judges involved in disability discrimination disputes should be mindful of these additional statutory requirements and should take care not to minimize the disability analysis to the question of whether a DSM-5 diagnosis exists.

In summary, the DSM-5 has relevance to a number of health law proceedings but is not dispositive with respect to any of them except for certain limited health insurance coverage questions. Attorneys and judges should be mindful of the ways in which the DSM-5 can impact health law proceedings as well as the limitations of the DSM-5 with respect to questions of ultimate concern to the law.

²¹⁸ See *supra* notes 178–179 and accompanying text.