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Gambling Disorder, Vulnerability, and the Law: Mapping the Field

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GAMBLING DISORDER, VULNERABILITY, AND THE LAW: MAPPING THE FIELD

Stacey A. Tovino, J.D., Ph.D.

TABLE OF CONTENTS

INTRODUCTION	102
I. HEALTH INSURANCE COVERAGE.....	107
II. DISABILITY INCOME BENEFIT ELIGIBILITY	111
III. DISABILITY DISCRIMINATION PROTECTIONS	114
IV. PUBLIC HEALTH LAW ISSUES	116
V. TORT LAW IMPLICATIONS	118
VI. PROFESSIONAL DISCIPLINE.....	121
VII. CRIMINAL LAW ISSUES	124
CONCLUSION.....	127

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INTRODUCTION

First recognized by the American Psychiatric Association (“APA”) in 1980,¹ gambling disorder is a disease of the brain characterized by persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress.³ A mental health professional may diagnose an individual with gambling disorder if the individual exhibits four or more of nine diagnostic criteria in a twelve-month period and the individual’s gambling behavior is not better explained by a manic episode.⁴ The

¹ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 291 (3d ed. 1980) [hereinafter DSM-III] (listing the diagnostic criteria for pathological gambling and classifying it as an impulse control disorder).

² See, e.g., Cynthia Lee, *Doctors Treat Gambling Addiction as a Brain Disease*, UCLA NEWSROOM (Jan. 10, 2011), <http://newsroom.ucla.edu/stories/gambling-addicts-suffer-from-brain-190668> (“The losses from gambling addiction—defined by mental health professionals as a brain disease at its most elemental form—have become so troubling that the state [of California] recently dedicated a total of \$15 million for three years to fund treatment programs for any California resident who has the addiction or has been hurt by it, including family members of compulsive gamblers.”); Liz Benston, *Illness Theory Gaining Ground for Gambling Addiction: Similar Disorders Found in Alcoholics, Those with a Compulsion to Gamble*, L.V. SUN (Nov. 23, 2009), <http://lasvegassun.com/news/2009/nov/23/illness-theory-gaining-ground/> (“A growing collection of research has found that the most afflicted have the kinds of biological brain disorders that are found among drug and alcohol abusers.”).

³ AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 585 (5th ed. 2013) [hereinafter DSM-5].

⁴ Gambling disorder’s nine diagnostic criteria include: (1) “Needs to gamble with increasing amounts of money in order to achieve the desired excitement”; (2) “Is restless or irritable when attempting to cut down or stop gambling”; (3) “Has made repeated unsuccessful efforts to control, cut back, or stop gambling”; (4) “Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)”; (5) “Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed)”; (6) “After losing money gambling, often returns another day to get even (‘chasing’ one’s losses)”; (7) “Lies to conceal the extent of involvement with gambling”; (8) “Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling”; and (9) “Relies on others to provide money to relieve desperate financial situations caused by gambling.” *Id.* at 585. If an individual exhibits four or more of the nine criteria in a twelve-month period, a mental health professional may diagnose the individual with gambling disorder. *Id.* Under the DSM-5, a mental health professional may classify an individual’s gambling disorder as: (1) “mild” if only four or five diagnostic criteria are satisfied; (2) “moderate” if

APA classifies gambling disorder as a non-substance-related disorder within the larger category of the substance-related and addictive disorders, which includes alcohol use disorder and various drug use disorders.⁵ Current research shows that gambling disorder is similar to alcohol and drug addiction in clinical expression, brain origin, comorbidity, physiology, and treatment.⁶

Gambling disorder can adversely impact or result in the complete loss of family relationships, employment, and educational pursuits.⁷ Gambling disorder is also associated with poor general health and high utilization of medical services.⁸ Individuals with gambling disorder have one of the highest rates of suicide attempt among individuals with addiction.⁹ More than one in two disordered gamblers experience suicidal ideation and approximately one in five disordered gamblers attempt suicide.¹⁰

six or seven diagnostic criteria are satisfied; (3) "severe" if eight or nine diagnostic criteria are satisfied; (4) "in early remission" if none of the criteria for gambling disorder has been met for at least three months but for less than twelve months after a prior diagnosis of gambling disorder; and (5) "in sustained remission" if none of the criteria for gambling disorder has been met during a period of twelve months or longer after a prior diagnosis of gambling disorder. *Id.* at 586.

⁵ AM. PSYCHIATRIC ASS'N, SUBSTANCE-RELATED AND ADDICTIVE DISORDERS 1 (2013) [hereinafter APA FACT SHEET]. In addition to alcohol, the ten other classes of drugs that have DSM-5-recognized use disorders include caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, stimulants, tobacco, and other unknown substances. *See* DSM-5, *supra* note 3, at 483–585.

⁶ APA FACT SHEET, *supra* note 5, at 1.

⁷ DSM-5, *supra* note 3, at 586, 589.

⁸ *Id.*

⁹ *See, e.g., Connecticut Council on Problem Gambling, Gambling and Suicide*, CCPG.ORG, <http://www.ccp.org/problem-gambling/more/gambling-and-suicide/> (last visited Feb. 2, 2016) ("The National Council on Problem Gambling, citing various studies, reports that one in five pathological gamblers attempts suicide, a rate higher than for any other addictive disorder."). Also, the results of a 2005 joint study, conducted by researchers at Yale University and the Connecticut Council on Problem Gambling (CCPG), found that of 986 individuals who called the CCPG Helpline, 252 acknowledged gambling-related suicidality (25.6%) and, of those, 53 (21.5%) reported gambling-related suicide attempts. *Id.*

¹⁰ *See* DSM-5, *supra* note 3, at 587 (referencing these statistics); *see also* Benston, *supra* note 2 (reporting the results of a group-therapy session at the Problem Gambling Center in Las Vegas, including three patients with gambling disorder who said they had thought about suicide, including one man who had his arm in a sling after a failed suicide attempt involving a fake rock-climbing accident); *see generally* Bea Aikens, *Gambling Addiction Suicide*, LANIE'S HOPE, <http://lanieshope.org/gambling-addiction-suicide> (last visited June

This Article seeks to descriptively map the sub-field of gambling disorder and the law and ask whether individuals with gambling disorder are vulnerable under the law. As background regarding the topic of, and approach taken in, this Article, the Author is on faculty at the William S. Boyd School of Law (“Boyd”) at the University of Nevada, Las Vegas (“UNLV”).¹¹ Boyd is the first law school in the United States to offer an LL.M. in Gaming Law,¹² and UNLV is home to the International Gaming Institute (“IGI”), the global leader in gaming research, innovation, and executive education.¹³ UNLV is also home to The Partnership for Research, Assessment, Counseling, Therapy and Innovative Clinical Education (“PRACTICE”),¹⁴ a community mental health training clinic that offers the Problem Gambling Treatment Program, a specialty gambling clinic founded and directed by Professor Oscar Sida.¹⁵ Eight miles northwest of UNLV is The Problem Gambling Center, a nationally and internationally recognized gambling disorder evaluation and treatment clinic.¹⁶ The Author is not only surrounded by leading gambling disorder researchers and practitioners, but she also works alongside individuals in recovery from gambling in a variety of

3, 2016) (discussing the prevalence of suicide ideation among compulsive gamblers).

¹¹ See *Stacey A. Tovino*, UNIV. OF NEV., L.V., WILLIAM S. BOYD SCH. OF LAW, <http://law.unlv.edu/faculty/stacey-tovino> (last visited Feb. 2, 2016).

¹² *LLM Programs in United States – Nevada*, LLM GUIDE, <http://www.llm-guide.com/Nevada> (last visited Feb. 5, 2016).

¹³ See *International Gaming Institute*, UNIV. OF NEV., L.V., <http://www.unlv.edu/igi> (“Welcome to the UNLV International Gaming Institute (IGI)—a world-leader in gaming research, innovation, and executive education. We provide cutting edge insights to global gaming leaders in the public, private, and non-profit sectors. IGI is the global intellectual capital of gaming—providing research and programs to more than 50 jurisdictions across the globe.”).

¹⁴ See *The PRACTICE*, UNIV. OF NEV., L.V., <https://www.unlv.edu/thepractice> (last visited Feb. 5, 2016) (stating, “The Partnership for Research, Assessment, Counseling, Therapy and Innovative Clinical Education—The PRACTICE—is a UNLV community mental health training clinic.”).

¹⁵ See *Problem Gambling Treatment Program*, UNIV. OF NEV., L.V., <https://www.unlv.edu/content/problem-gambling-treatment-program> (last visited Feb. 5, 2016) (stating, “We offer services for individuals suffering with problem gambling.”).

¹⁶ See *The Problem Gambling Center’s Clinical Staff*, PROBLEM GAMBLING CTR., <http://www.gamblingproblems.com/pgc-staff.html> (last visited Feb. 5, 2016).

teaching, research, and service contexts.¹⁷ These individuals include, but are not limited to, distinguished members of the Nevada Bar,¹⁸ government scientists,¹⁹ and directors of state councils on problem gambling.²⁰

When giving talks in Nevada, at Boyd, as part of a continuing education program sponsored by the IGI, or in Reno or Las Vegas at the invitation of the Nevada Council on Problem Gambling, the Author is frequently asked to review the treatment of individuals with gambling disorder in a variety of legal contexts. The audience often responds with not only interest, but also compassion and sympathy for the estimated 6% of Nevadans—approximately 180,000 people—who struggle with gambling disorder.²¹ In Nevada, it seems, everyone knows someone who has lost or jeopardized his or her life due to gambling disorder, and no one questions the seriousness of

¹⁷ See, e.g., Carol O'Hare & Ted Hartwell, Lecture on HIPAA Privacy Law, Guest Lecture at Univ. of Nev., L.V., William S. Boyd Sch. of Law (Mar. 9, 2016) (taking place during Professor Stacey Tovino's HIPAA Privacy Law class); Oscar Sida & Stacey Tovino, Eighteenth Annual Southern Association for the History of Medicine & Science Conference, Panel Discussion at Univ. of Nev., L.V., William S. Boyd Sch. of Law (Mar. 18, 2016) (featuring talks sponsored by Boyd's Health Law Program); Carol O'Hare et al., Guest Lecture at the Nevada State Conference on Problem Gambling (May 5–6, 2016) (featuring talks by Carol O'Hare, Ted Hartwell, and Stacey Tovino).

¹⁸ See, e.g., David Ferrara, *Treatment for Problem Gamblers a Long Shot in Las Vegas Courts*, L.V. REV. J. (Aug. 1, 2015), <http://www.reviewjournal.com/news/crime-courts/treatment-problem-gamblers-long-shot-las-vegas-courts> (referencing the case of Douglas Crawford, a Nevada attorney who had his license to practice law suspended, due to behavior associated with gambling disorder, but was ultimately reinstated).

¹⁹ See, e.g., *Staff and Volunteers*, NEV. COUNCIL ON PROBLEM GAMBLING, <http://www.nevadacouncil.org/who-we-are/staff-volunteers/> (last visited Feb. 5, 2016) (stating that Hartwell is in recovery from gambling disorder); *Ted T. Hartwell*, DESERT RES. INST., <http://www.dri.edu/directory/4812-ted-hartwell> (last visited Feb. 5, 2016) (listing Hartwell as an associate research scientist).

²⁰ See, e.g., *About Carol O'Hare*, NEV. COUNCIL ON PROBLEM GAMBLING, <http://www.nevadacouncil.org/author/carol/> (last visited Jan. 24, 2016) ("Carol O'Hare is the Executive Director of the Nevada Council (since 1996) and a person in long term recovery since January 1991.").

²¹ See Casey Morell & Chris Sieroty, *New Technology Hopes to Help Gambling Addiction*, NEV. PUB. RADIO (Feb. 18, 2015), <http://knpr.org/knpr/2015-02/new-technology-hopes-help-gambling-addiction> ("Gambling addiction affects roughly six percent of Nevadans—or about 180,000 people—according to the Nevada Council on Problem Gaming.").

the disorder or the need to understand the ways in which the law does or does not accommodate individuals with the disorder.²²

The Author is also a member of the national academic health law community. When she speaks at health law conferences or symposia outside Nevada, her presentations are often met with suspicion, skepticism, or disbelief regarding the existence of gambling disorder, its understanding as a disease of the brain, and the need for scholarly attention to the legal issues raised by the disease. Indeed, the Author is frequently asked by non-Nevadans whether individuals with gambling disorder are “faking” their conditions, whether mental health professionals who treat these individuals are “medicalizing” poor behavior, and whether time spent producing gambling disorder-related scholarship would be better spent on “real” physical and mental illnesses.

Although the legal academy prefers normative scholarship,²³ descriptive work, including literature reviews, are valuable in contexts in which important legal questions are not addressed, or are under-addressed, due to a lack of awareness or understanding of an underlying concept, condition, or problem.²⁴ Like other scholarship that descriptively maps ethical, legal, and social implications of lesser known conditions and developments,²⁵ this Article seeks to describe the treatment of individuals with gambling disorder in a variety of illustrative, but not exhaustive, legal contexts, to identify the limited

²² See *Gambling Addiction Suicides*, CASINO WATCH, <http://www.casinowatch.org/suicides/suicides.html> (last visited Feb. 2, 2016) (reporting dozens of suicides believed to be associated with gambling disorder).

²³ See, e.g., Robin West & Danielle Citron, *On Legal Scholarship*, ASS'N OF AM. LAW SCHS., www.aals.org/current-issues-in-legal-education/legal-scholarship/ (last visited Feb. 1, 2016) (“Normative legal scholarship aims to influence judges, lawyers, legislators or regulators to reform, interpret, or preserve existing law to make the world more just.”).

²⁴ See generally Jean Sternlight, *Psychology and Lawyering: Coalescing the Field*, 15 NEV. L.J. 431 (2015) (reviewing conference proceedings and scholarship at the intersection of psychology and lawyering); *NEUROETHICS MAPPING THE FIELD* (Steven J. Marcus ed. 2002) (identifying basic issues and raising initial ethical, legal, and social questions associated with the implications of advances in brain science); *NEUROETHICS: AN INTRODUCTION WITH READINGS* (Martha J. Farah ed. 2010) (introducing key issues in neuroethics and placing them in scientific and cultural context).

²⁵ See generally Sternlight, *supra* note 24; *NEUROETHICS MAPPING THE FIELD*, *supra* note 24; *NEUROETHICS: AN INTRODUCTION WITH READINGS*, *supra* note 24.

scholarship assessing the application of the law to individuals with gambling disorder, and to invite members of the health law academy to bring their significant expertise to bear on these issues through traditional normative scholarship. Such work would require members of the health law academy to familiarize themselves with gambling disorder, including its prevalence, evaluation, diagnosis, and treatment, as well as advances in the neuroscientific understanding of the disorder. This is intentional; that is, one of the goals of this Article is to increase awareness of gambling disorder and to encourage compassion and sympathy for affected individuals. A second goal of this Article is to revisit age-old questions about what it means to be ill and whether and how the law should accommodate individuals with particular physical and mental health conditions, including gambling disorders.

I. HEALTH INSURANCE COVERAGE

One important legal issue that requires further academic analysis relates to health insurance coverage of treatments and services for gambling disorder. In prior works, the Author thoroughly examined the application of then-current mental health parity law and mandatory mental health and substance use disorder benefit law to individuals with gambling disorder.²⁶ In those works, the Author showed how, historically, many private health plans excluded gambling disorder treatments and services from health insurance coverage²⁷ and how some state laws continue to expressly exclude

²⁶ See, e.g., Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191, 213–24 (2014) [hereinafter, Tovino, *Lost in the Shuffle*] (titled, “Health Insurance Coverage of Gambling Disorder”); Stacey A. Tovino, *The DSM-5: Implications for Health Law*, 2015 UTAH L. REV. 767, at Part III [hereinafter Tovino, *DSM-5*] (titled, “Health Insurance Coverage”).

²⁷ See, e.g., WELLMARK S.D., BLUE PRIORITY HSA HEALTH PLANS FOR INDIVIDUALS AND FAMILIES 9 (2012), http://www.wellmark.com/SouthDakotaPlans/OOC/BluePriorityHSA_M31118_10_12.pdf (excluding coverage for certain mental health and chemical dependency services, including “[i]mpulse-control disorders (such as pathological gambling)”); UNITED HEALTHCARE INS. CO., 2013–2014 STUDENT INJURY & SICKNESS INSURANCE PLAN 16 (2013), <https://www.uhcsr.com/uhrBrochures/Public/ClientBrochures/2013-735-2-3%20Brochure-v3.pdf> (excluding coverage for treatments, services, or supplies for “addiction,” including nicotine addiction, caffeine addiction, non-chemical addictions, such

gambling disorder from mental health parity mandates.²⁸ The Author also revealed how developments in health insurance law over the past two decades, including the federal Mental Health Parity Act of 1996 (“MHPA”),²⁹ the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”),³⁰ and the Affordable Care Act of 2010 (“ACA”),³¹ have eliminated most, but not all mental health benefit disparities.³² In particular, the Author focused on the ACA’s essential health benefit (“EHB”) provisions, which require individual and small group health plans,³³ exchange-offered qualified health plans,³⁴ state basic health plans,³⁵ and Medicaid benchmark plans and Medicaid benchmark equivalent plans³⁶ (collectively, “Covered Plans”), to offer mental health and substance use disorder services, including behavioral health

as “gambling, sexual, spending, shopping, working and religious[,]” and codependency”); UNIV. OF PITTSBURGH MED. CTR., UPMC HEALTH PLAN EXCLUSIONS 1, <http://www.upmchealthplan.com/pdf/Exclusions.pdf> (excluding “[t]welve step model programs as sole therapy for . . . addictive gambling” from insurance coverage).

²⁸ See, e.g., N.M. STAT. ANN. § 59A-23E-18(A) (West 2015) (“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.”); *id.* § 59A-23E-18(F) (“[M]ental health benefits’ means mental health benefits as described in the group health plan, or group health insurance offered in connection with the plan; but does not include benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction.”).

²⁹ Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701–703, 110 Stat. 2944 (1996) (codified as amended at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26 (2012)).

³⁰ Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765 (2008) (codified as amended at 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-26 (2012)).

³¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 145 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

³² Tovino, *Lost in the Shuffle*, *supra* note 26, at 215–23 (referencing portions of the Author’s prior works examining these issues in detail).

³³ 42 U.S.C. § 300gg-6(a) (2012).

³⁴ *Id.* § 18021(a)(1)(B).

³⁵ *Id.* § 18051(e) (providing that 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).

³⁶ *Id.* § 1396u-7(b).

treatments³⁷ in addition to nine other categories of EHBs.³⁸ The Author further explained how the ACA did not address whether Covered Plans were required to provide particular mental health benefits, such as gambling disorder treatments and services, and how the federal Department of Health and Human Services (“HHS”), in February 2013, required states to select (or be defaulted into) a 2012-sold benchmark plan that would serve as a reference plan for the required content of each state’s Covered Plans in plan years 2014, 2015, and 2016.³⁹ Finally, the Author reviewed the 2012-sold benchmark plan selected by Nevada,⁴⁰ and certain other states where gambling is legal, and showed how it did not require coverage for gambling disorder treatments and services, at least for plan years 2014, 2015, and 2016.⁴¹

Since the Author’s prior works, the HHS has updated its EHB regulations by requiring states to select new, sold-in-2014 benchmark plans that will be effective for the 2017 plan year.⁴² For example, in

³⁷ *Id.* § 18022(b)(1)(E).

³⁸ *Id.* § 18022(b)(1).

³⁹ 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. 144, 147, 153, 154, 155, 156, 158).

⁴⁰ See CTR. FOR MEDICARE & MEDICAID SERVS., NEVADA EHB BENCHMARK PLAN, <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nevada-ehb-benchmark-plan.pdf> (last visited Feb. 1, 2016); Letter from Scott J. Kipper, Comm’r of Insurance, St. of Nev., to Secretary Kathleen Sebelius, U.S. Dep’t of Health & Human Servs. (Dec. 14, 2012) (on file with author), http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/12.14.12_kipper_letter_re_ehb.pdf (identifying Nevada’s sold-in-2012 benchmark plan selection for plan years 2014 through 2016).

⁴¹ See Tovino, *DSM-5*, *supra* note 26, at 784–85 (“[O]n March 31, 2012, the Nevada Benchmark Plan . . . excluded coverage for a class of mental health conditions known as the ‘impulse control disorders.’ 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 for gambling disorders, at least for years 2014, 2015, and 2016. That is, in years 2014, 2015, and 2016, Nevada residents and residents of other states with similar benchmark plan limitations will not benefit from any mandatory gambling disorder benefits and will only have them to the extent their health plans voluntarily provide gambling disorder benefits or they access state-funded gambling disorder benefits.”).

⁴² Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) (to be codified at 45 C.F.R. pt. 156) (“[W]e are finalizing . . . our proposal to allow issuers to design a plan that is

June 2015, the State of Nevada selected the Health Plan of Nevada (“HPN”) Solutions HMO Platinum 15/0/90% Plan.⁴³ Unlike Nevada’s previous benchmark plan, Nevada’s new benchmark plan does not expressly or impliedly exclude health insurance coverage for gambling disorder treatments and services.⁴⁴

States’ new benchmark plans raise a number of important issues that require academic analysis. As an empirical matter, how many states have selected benchmark plans effective for the 2017 plan year that expressly or impliedly include or exclude gambling disorder treatments and services? In states that have benchmark plans that expressly or impliedly exclude coverage, how many Covered Plans in those jurisdictions voluntarily cover gambling disorder services? For insured and self-insured plans that continue to exclude gambling disorder treatments and services, why do they do so? Do these plans believe the disorder does not exist or, perhaps, that the disorder exists but is difficult to diagnose? Or, perhaps even, that the disorder is too expensive to cover? Does stigma against mental illness in general, or against gambling or gambling disorder in particular, play a role? Is the religious affiliation of the employer or other group that offers the plan relevant? How can gambling disorder treatments and services exclusions be reconciled with the clinical literature showing that gambling disorder is diagnosable and treatable?⁴⁵ How can gambling disorder treatments and services exclusions be reconciled

substantially equal to the newly selected 2014 benchmark plan for the 2017 plan year.”).

⁴³ See *Essential Health Benefits*, NEV. DIV. OF INS., <http://doi.nv.gov/Healthcare-Reform/Individuals-Families/Essential-Health-Benefits/> (last visited Feb. 12, 2016) (“After receipt of public input the Division has now confirmed our selection of Health Plan of Nevada’s HPN Solutions HMO Platinum small group plan as the 2017 EHB Benchmark plan for Nevada. The federal authorities were properly notified of the selection in late June 2015 as required.”).

⁴⁴ See CTRS. FOR MEDICARE & MEDICAID SERVS., NEVADA 2017 EHB BENCHMARK PLAN, http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/HHS%20Final%202017%20NV%20EHB%20Benchmark%20Plan.pdf (last visited Feb. 19, 2016) (covering mental, behavioral, and substance-related health services, but excluding counseling and therapy for marital issues, family problems, learning disabilities, mental “retardation[.]” any social, occupational, or religious maladjustments, and any behavior, impulse control, personality, or attention deficit disorders).

⁴⁵ Leena M. Sumitra & Shannon C. Miller, *Pathologic Gambling Disorder: How to Help Patients Curb Risky Behavior When the Future Is at Stake*, 118 POSTGRADUATE MED. S1, S36 (July 2015) (“[Gambling disorder] is highly treatable . . .”).

with the health plan cost literature and the mental health parity economics literature showing that coverage of inpatient and outpatient services for mental health conditions may not raise total health care costs and, in some plan contexts, may actually lower total costs?⁴⁶ As a normative matter, should gambling disorder treatments and services be an essential health benefit in the United States? Or, perhaps, only in jurisdictions like Nevada where gambling is common and gambling disorder is prevalent?⁴⁷ More broadly, are individuals with gambling disorder vulnerable in the context of health insurance? Should they be? Do they deserve to be?

II. DISABILITY INCOME BENEFIT ELIGIBILITY

A second legal issue that requires further academic analysis relates to disability income benefit eligibility for individuals with gambling disorder. As background, disability benefits can be public, such as the cash disability benefits provided by the Social Security Administration (“Administration”) to individuals who meet the Social Security Act’s (“SSA”) definition of disability.⁴⁸ 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.⁴⁹ In prior works, the Author reviewed the SSA

⁴⁶ Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEG. 1, 9, 22 (2012) (reviewing the health plan cost literature showing that untreated mental illness is associated with increases in total health care costs while treatment of mental illness is associated with decreases in total health care costs; further reviewing the mental health economics literature showing that implementing mental health parity does not increase total health care costs).

⁴⁷ See, e.g., Richie Bernardo, *2016’s Most Gambling-Addicted States*, WALLETHUB, <https://wallethub.com/edu/states-most-addicted-to-gambling/20846/> (last visited July 14, 2016) (reporting that Nevada has the highest rate of problem gamblers in the country); Karen Frazier, *Gambling Addiction Statistics*, LOVETOKNOW, http://addiction.lovetoknow.com/wiki/Gambling_Addiction_Statistics (last visited July 14, 2016) (“Nevada has the highest prevalence of problem gambling in the country, at about 6.4 percent.”).

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

⁴⁹ DISABILITY INSURANCE OVERVIEW, METLIFE, <https://www.metlife.com/individual>

provisions providing for the payment of federal Social Security Disability Insurance (“SSDI”) benefits to certain individuals with physical and mental disabilities, including the five-step sequential evaluation the Commissioner of Social Security (“Commissioner”) established to determine whether an individual has a disability that qualifies for SSDI benefits.⁵⁰ The Author further explained how neither Congress, in the SSA, nor the HHS, in the SSA’s implementing regulations, expressly excluded individuals with gambling disorder from qualifying for SSDI benefits.⁵¹ Instead, SSDI claimants with gambling disorder, like most SSDI claimants, are assessed using the case-by-case, five-step sequential evaluation process.⁵² The same is true with respect to most private short and long-term disability benefit plans; that is, these plans typically do not expressly exclude individuals with gambling disorder from benefit eligibility.⁵³ Finally, the Author showed that most disability income benefit cases involving individuals with gambling disorder, regardless of whether they are public or private disability benefit disputes, focus on one of two issues: (1) whether the individual’s

/insurance/disability-insurance/index.html (last visited July 31, 2016). Metlife provides that if one is “unable to work due to a sickness or injury, disability insurance can help you meet expenses and maintain your standard of living. It can help you pay bills like your mortgage, tuition and car payments, and help cover expenses for food, clothing and utilities. By replacing a portion of your income, disability insurance can help provide financial security until you get back on your feet and return to work.” *Id.*

⁵⁰ See 20 C.F.R. § 404.1520(a)(4) (2015) (listing the five-step sequential evaluation process); *Id.* § 416.920(a)(4) (explaining the five-step sequential evaluation process); *Bowen v. Yuckert*, 482 U.S. 137, 140–42 (1987) (United States Supreme Court opinion explaining the five-step sequential evaluation process in the context of a particular claimant); *Tovino, Lost in the Shuffle*, *supra* note 26, at Part V (reviewing disability income benefit cases involving individuals with gambling disorder); *Tovino, DSM-5*, *supra* note 26, at Part IV (reviewing the impact of the DSM-5 on disordered gamblers’ eligibility for disability income benefits).

⁵¹ Compare 42 U.S.C. § 423(d)(2)(C) (2012) (“An 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.”), with *Johansen v. Astrue*, 2011 WL 4583828, at *1 n.1 (D. Minn. 2011) (referencing the exclusion for individuals with alcoholism).

⁵² See *Lost in the Shuffle*, *supra* note 26, at Part V; *Tovino, DSM-5*, *supra* note 26, at Part IV.

⁵³ See *McClagherty v. Unum Life Ins. Co.*, 2010 WL 2787632 at *2 (S.D.W. Va. 2010) (unpublished opinion) (finding that an individual with gambling disorder and other co-occurring disorders could be disabled for purposes of his private disability income policy if he could prove his disabilities with medical records or other evidence).

gambling disorder is of such severity that the individual cannot do his or her previous work and cannot perform other substantial gainful work; or (2) whether the individual's loss of employment resulted from the performance of an illegal act.⁵⁴

The Author's prior works do not address many important disability income benefit questions. As an empirical matter, how many individuals with gambling disorder apply for and receive public and private disability income benefits? For those individuals who are denied benefits, what is the reason for the denial? Is the denial due to lack of proof of disability, the applicant's continued ability to work, or the applicant's performance of an illegal act, such as the theft of work-related funds? As a normative matter, are disability income benefits ever appropriate for individuals with gambling disorder? Would individuals with gambling disorder spend income benefits on gambling instead of expenses associated with daily living, including food, clothing, or shelter? Could disability benefits assist individuals who are attempting to recover from gambling disorder while burdened with the expenses associated with obtaining gambling disorder treatments and services, given that many of these individuals lost their health insurance when they lost their jobs? As a practical matter, could disability income benefits be limited to only those individuals in recovery from gambling disorder? If so, how would recovery be tested? And, for how long must the individual be in recovery? If for an extended period of time, would the individual not, at that point, be eligible to return to work, thus obviating the need for cash income benefits? Should case law assessing disability benefit eligibility in the context of individuals with alcohol use disorder, or one or more of the drug use disorders, be used as a guide for disability benefit disputes involving individuals with gambling disorder?

⁵⁴ See *Reilly v. Northwestern Mut. Life. Ins. Co.*, 2007 WL 1485103 (S.D. Iowa 2007) (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 due to the insured's misappropriation of client trust fund accounts, is not a disability; ruling that the plaintiff "was not disabled by the gambling, only by the license revocation," and pointing to the fact that the plaintiff would still be practicing law with his full income, notwithstanding his excessive gambling, except for his wrongful conversion of client funds).

III. DISABILITY DISCRIMINATION PROTECTIONS

A third legal issue that requires academic attention relates to disability discrimination protections for individuals with gambling disorder. In prior works, the Author reviewed the anti-discrimination protections and accommodations available to qualified individuals with physical and mental disabilities under a variety of federal and state laws,⁵⁵ including Section 504 of the Rehabilitation Act,⁵⁶ the original Americans with Disabilities Act of 1990 (“ADA”),⁵⁷ the ADA Amendments Act of 2008 (“ADAAA”),⁵⁸ and analogous state laws.⁵⁹ The Author also explained that most of these laws expressly excluded individuals with gambling disorder from protection.⁶⁰ Both the original ADA and the ADAAA, for example, expressly exclude individuals with “compulsive gambling” from the definition of disability,⁶¹ while the California Fair Employment and Housing Act,⁶² like many state disability discrimination laws, similarly excludes “compulsive gambling” from the definition of both “mental disability”⁶³ and “physical disability.”⁶⁴ Finally, the Author showed

⁵⁵ Tovino, *Lost in the Shuffle*, *supra* note 26, at Part VI.

⁵⁶ Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 394 (1973) (codified at 29 U.S.C. § 701 (2012)) (“No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his or her disability, 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.”).

⁵⁷ Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified as amended at 42 U.S.C. §§ 12101–12213 (2012)).

⁵⁸ ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) (amending Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327).

⁵⁹ CAL. GOV'T CODE §§ 12940(a)(1), (e)(1) (West 2015).

⁶⁰ See Tovino, *Lost in the Shuffle*, *supra* note 26, at Part VI; Tovino, *DSM-5*, *supra* note 26, at Part V.

⁶¹ See 42 U.S.C. § 12211(b)(2) (2012).

⁶² CAL. GOV'T CODE § 12900.

⁶³ *Id.* § 12926(j)(5) (“‘Mental disability’ does not include sexual behavior disorders, compulsive gambling, kleptomania, pyromania, or psychoactive substance use disorders resulting from the current unlawful use of controlled substances or other drugs.”).

⁶⁴ *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.”).

how courts across the country have upheld these exclusions in cases in which they have been challenged.⁶⁵

However, once again, the Author's prior works did not address several important questions. As an empirical matter, how many individuals with gambling disorder seek protection from disability discrimination? In which contexts (*e.g.*, employment, housing, etc.) are those protections sought? As a normative matter, most federal and state laws that exclude gambling disorder from disability discrimination protection do so in a single clause that also excludes kleptomania and pyromania.⁶⁶ Both of these disorders are classified by the APA as impulse control disorders, not substance-related or addictive disorders.⁶⁷ In May 2013 (after the enactment of the original ADA in 1990 and the ADAAA in 2008), the APA removed gambling disorder from the impulse-control disorders section of the DSM-5 and reclassified it as a substance-related and addictive disorder.⁶⁸ Should Congress amend the ADA again to reflect this change? Stated another way, should gambling disorder be treated like alcohol use disorder under the ADA and analogous state laws? Is the analogy between gambling disorder and alcohol use disorder apt given that adult drinking and adult gambling are not illegal in some jurisdictions?⁶⁹ If so, should the result be that employers may legally prohibit gambling at work and may legally discipline, discharge, or

⁶⁵ See, *e.g.*, Trammell v. Raytheon Missile Sys., 721 F.Supp.2d 876, 878 (D. Ariz. 2010) ("Congress expressly excluded compulsive gambling . . . from the ADA's definition of disability.").

⁶⁶ See 42 U.S.C. § 12211(b)(2) (2012) ("[T]he term 'disability' shall not include . . . compulsive gambling, kleptomania, or pyromania[.]").

⁶⁷ DSM-5, *supra* note 3 (classifying kleptomania and pyromania as impulse-control disorders).

⁶⁸ See, *e.g.*, Tovino, *Lost in the Shuffle*, *supra* note 26, at Part II (providing a detailed history of the diagnostic classification of gambling disorder).

⁶⁹ My colleagues in UNLV's Department of Sociology would say "yes" to this question and the prior question. See Christian E. Hardigree et al., *Sicknesses and Sanctions: The Exclusion of Pathological Gambling under the Americans with Disabilities Act*, 1 ELEC. J. HOSPITALITY L., SAFETY & SECURITY RES. (2010) ("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.").

deny employment to an individual with gambling disorder, if the disorder adversely affects job performance or conduct, but that employers must otherwise provide reasonable accommodations to individuals with gambling disorder?⁷⁰

IV. PUBLIC HEALTH LAW ISSUES

A growing literature assesses gambling disorder from a public health perspective. Existing public health research investigates the prevalence of gambling disorder in different jurisdictions, the prevalence of co-occurring disorders in individuals with gambling disorder, the limitations of gambling disorder prevalence research, the need for improved gambling disorder diagnostic tools, and the need for more effective legal strategies for preventing and reducing gambling-related harms.⁷¹ As an example, Howard Shaffer and David Korn use a public health lens to understand gambling disorders within populations and assess the factors that influence individuals to change from healthy to unhealthy gambling.⁷² Shaffer and Korn also assess the social, cultural, and economic factors that influence the spread and patterns of gambling disorder.⁷³

⁷⁰ Cf. Disability Rights Sec., Civil Rights Div., U.S. Dep't of Justice, *Questions and Answers: The Americans with Disabilities Act and Hiring Police Officers*, ADA.ORG (Apr. 4, 2006), <http://www.ada.gov/copsq7a.htm> ("12. Q: Are alcoholics covered by the ADA? A. Yes. While a current illegal user of drugs is not protected by the ADA if an employer acts on the basis of such use, a person who currently uses alcohol is not automatically denied protection. An alcoholic is a person with a disability and is protected by the ADA if he or she is qualified to perform the essential functions of the job. An employer may be required to provide an accommodation to an alcoholic. However, an employer can discipline, discharge or deny employment to an alcoholic whose use of alcohol adversely affects job performance or conduct. An employer also may prohibit the use of alcohol in the workplace and can require that employees not be under the influence of alcohol.").

⁷¹ NAT'L CTR. FOR RESPONSIBLE GAMING, GAMBLING & THE PUBLIC HEALTH, PART 1 (2009) (reviewing public health research assessing gambling disorder).

⁷² See, e.g., David A. Korn & Howard J. Shaffer, *Gambling and the Health of the Public: Adopting a Public Health Perspective*, 15 J. GAMBLING STUD. 289, 289 (1999); David A. Korn, *Examining Gambling Issues from a Public Health Perspective*, 4 J. GAMBLING ISSUES 289, 289-90 (2001); Howard J. Shaffer & David A. Korn, *Gambling and Related Mental Disorders: A Public Health Analysis*, 23 ANN. REV. PUB. HEALTH 171, 171-212 (2002).

⁷³ See *id.*

However, additional public health research is required. New gaming technologies and newer means of gambling, including online gaming, gambling via social networking sites, mobile gambling, video lottery terminals, electronic gaming machines, and unregulated fantasy sports, raise novel public health issues.⁷⁴ Can technological interventions, such as stop-play features, be used to curb or avoid problem gambling?⁷⁵ As an empirical matter, how effective are voluntary self-exclusion programs in preventing or treating gambling disorder?⁷⁶ As a technological matter, how can casino operators improve identification of self-excluders who try to enter gaming establishments? Are computerized facial recognition programs effective and/or do they invade privacy?⁷⁷ Should penalties be imposed on disordered gamblers who breach their self-exclusion contracts?⁷⁸ What is the optimum length of a self-exclusion period, and who (*e.g.*, the gaming operator, an independent authority, or a government regulator) should be in charge of creating and enforcing self-exclusion programs?⁷⁹ How effective are Problem Gambling Helplines,⁸⁰ responsible gaming and problem gambling signage and warnings,⁸¹ gambling advertising limitations,⁸² automated teller

⁷⁴ See, *e.g.*, Robert W. Stocker II & Peter J. Kulich, *Welcome to Legalized I-Gaming in North America*, CASINO LAWYER, Autumn 2013, at 21 (discussing developments in online gaming); Susan Hensel, *Regulator and Industry Collaboration: Challenging the Dynamic*, CASINO LAWYER, Autumn 2013, at 6 (noting that globalization and technological change have put the gaming industry “in an accelerated state of evolution”; referencing the advent of “mobile phones, tablets, and social media” as sources of new questions).

⁷⁵ See, *e.g.*, NAT’L CTR. FOR RESPONSIBLE GAMING, GAMBLING AND THE PUBLIC HEALTH, PART 2 (2009) (identifying these and other public health issues).

⁷⁶ See, *e.g.*, Keith Miller, *The Utility and Limits of Self-Exclusion Programs*, 6 UNLV GAMING L. J. 29 (2015) (reviewing the benefits and limitations of self-exclusion programs).

⁷⁷ See Robert Ladouceur et al., *Self-Exclusion Program: A Longitudinal Evaluation Study*, 23 J. GAMBLING STUD. 85, 92 (2007) (asking this question).

⁷⁸ See *id.* at 93 (asking this question).

⁷⁹ See *id.* (asking these questions).

⁸⁰ See, *e.g.*, Luca Bastiani et al., *National Helpline for Problem Gambling: A Profile of Its Users’ Characteristics*, J. ADDICTION (2015), <http://www.hindawi.com/journals/jad/2015/659731/> (assessing the types of individuals who use Italy’s problem gambling Helpline).

⁸¹ See, *e.g.*, JOHN COPPOLA, N.Y. ASS’N OF ALCOHOLISM & SUBSTANCE ABUSE PROVIDERS, NEW YORK STATE GAMING COMMISSION PUBLIC FORUM: ADDRESSING PROBLEM GAMBLING IN THE ERA OF EXPANDED GAMING (2014) (providing examples of responsible gaming, problem

machine (ATM) casino location restrictions,⁸³ and credit restrictions in curbing or eliminating gambling disorder?⁸⁴ More broadly, what lessons can the gaming industry learn from the experience of other industries with respect to government-imposed health warnings, including the food, beverage, and tobacco industries?⁸⁵ Can public health law experts apply interventions used in the contexts of tobacco, alcohol, and obesity to gaming?

V. TORT LAW IMPLICATIONS

Over the past two decades, individuals with gambling disorder have brought dozens of lawsuits against gaming establishments, alleging tort theories of liability, including intentional infliction of emotional distress (“IIED”), negligence, and strict liability.⁸⁶ Although

gambling, and Helpline casino signage).

⁸² See, e.g., PER BINDE, GAMBLING ADVERTISING: A CRITICAL RESEARCH REVIEW 18–20 (2014) (providing an in-depth review of research on gambling advertising with particular attention to studies that assess the impact of advertising on gambling participation and problem gambling).

⁸³ See, e.g., Sean P. Murphy, *State Casino Regulators Put Limits on Gamblers’ ATM Access*, BOSTON GLOBE, Apr. 3, 2015, <https://www.bostonglobe.com/metro/2015/04/02/state-casino-regulators-put-limits-gamblers-access-atm/FxTZKtXikMQiMdojkDfahO/story.html> (discussing whether restrictions on the location of ATMs in casinos could curb problem gambling).

⁸⁴ See generally S. AUSTL. CTR. FOR ECON. STUDIES, DEP’T OF FAMILIES, HOUS., CMTY. SERVS. & INDIGENOUS AFFAIRS, NO. 33, PROBLEM GAMBLERS AND THE ROLE OF THE FINANCIAL SECTOR (2011) (assessing the behavior of disordered gamblers with respect to accessing funds from joint bank accounts and home equity loans; consulting with the financial sector, relevant government agencies, financial counselors, and gambling counselors to identify measures that will reduce disordered gamblers’ ability to withdraw funds from these accounts for gambling purposes).

⁸⁵ Patrick Basham & John Luik, *Tobacco’s Graphic Warning for the Gambling Industry*, CALVIN AYRE (July 15, 2011), <http://calvinayre.com/2011/07/15/business/patrick-basham-tobaccos-graphic-warning-for-gambling-industry/>.

⁸⁶ See, e.g., *Merill v. Trump Indiana, Inc.*, 320 F.3d 729, 732 (7th Cir. 2003) (holding that Indiana law did not impose a duty on casinos to eject individuals with gambling disorder or to prevent them from gambling); *Caesars Riverboat Casino, LLC v. Kephart*, 934 N.E.2d 1120, 1124 (Ind. 2010) (holding that Indiana law governing riverboat gambling abrogated any duty on the defendant casino’s part to refrain from attempting to entice or contact individuals with gambling disorder); *Taveras v. Resorts Int’l Hotel, Inc.*, 2008 WL 4372791 at 1 (D. N.J. Sept. 19, 2008) (finding plaintiff’s argument, that gambling is an “abnormally dangerous activity” and facilitating casinos should therefore be held strictly liable for

the courts have held that individuals with gambling disorder have no legal recourse against casinos based in tort for their emotional, financial, and other injuries, scholars who write at the intersection of tort law and gambling disorder have identified potential avenues of change in favor of individuals with gambling disorder.⁸⁷

Beginning with the intentional torts, such as IIED, could or should a casino's intentional marketing to an individual with gambling disorder be extreme and outrageous conduct, as required by one of the elements of IIED?⁸⁸ Could or should the extreme mental suffering of an individual with gambling disorder, especially in cases involving suicide, constitute severe, not just mere, emotional distress as required by a second element of IIED?⁸⁹

As for negligence, could negligence lawsuits filed by individuals with gambling disorder follow dram shop lawsuits filed by individuals with alcohol use disorder where, for example, courts have identified a duty of care by taverns to patrons?⁹⁰ As a normative matter, should casinos have a duty of care to individuals with

gambling debts, to have "no merit" (internal references and citations omitted); *see generally* Joseph M. Kelley & Alex Igelman, *Compulsive Gambling Litigation: Casinos and the Duty of Care*, 13 GAMING L. REV. & ECON. 386 (2009) (reviewing the outcomes of lawsuits filed by casino patrons against casinos in a number of international jurisdictions); Emir A. Crowne-Mohammed & Meredith A. Harper, *Rewarding Trespass & Other Enigmas: The Strange World of Self-Exclusion & Casino Liability*, 1 UNLV GAMING L.J. 99 (2010) (discussing tort and contract law issues faced by casinos).

⁸⁷ *See, e.g.*, CASINO LIABILITY POLICY GRP., HARVARD LAW SCH., COMPULSIVE GAMBLING: DO CASINOS SHARE RESPONSIBILITY? 23–24 (2013) [hereinafter HARVARD WHITE PAPER], <http://learning.law.harvard.edu/frontiertorts/wp-content/uploads/2014/02/Casino%20Liability%20Whitepaper%20Final.pdf> (identifying avenues of change in favor of individuals with gambling disorder).

⁸⁸ *See, e.g.*, *Taveras*, 2008 WL 4372791 (applying the elements of IIED to a casino patron's lawsuit against a casino; stating, "[T]o establish a claim for intentional infliction of emotional distress, the plaintiff must establish intentional and outrageous conduct by the defendant, proximate cause, and distress that is severe.").

⁸⁹ *See, e.g.*, Ferrara, *supra* note 18, at 8 (detailing the severe emotional anguish, suffering, and suicidal ideation of Douglas Crawford, a Nevada attorney with gambling disorder).

⁹⁰ *See, e.g.*, HARVARD WHITE PAPER, *supra* note 87, at 24–25 ("Dram shop laws and the associated common law remedies were primarily motivated by the need to curb drunk driving and to provide a remedy to third-parties injured by drunk patrons. Similarly, courts could hold casino owners accountable for the harms caused by their addicted or otherwise incapacitated patrons to third-parties, such as family members or others injured by their excessive gambling.").

gambling disorder? If so, what would be the contours of that duty and what would constitute a breach of that duty? As a practical matter, could casinos use their elaborate player monitoring⁹¹ and advertising systems⁹² together with their electronic surveillance equipment to identify and exclude individuals with gambling disorder?⁹³ If so, would failure by a casino to do so constitute a breach?⁹⁴

With regard to strict liability, could an individual with gambling disorder successfully sue a gaming establishment or a gaming machine manufacturer based on strict liability and/or products liability; that is, on the theory that gambling, or highly addictive gaming machines, are abnormally dangerous activities or defectively designed or warranted products?⁹⁵ Thus far, courts have disagreed with respect to strict liability, finding that gambling is unlike toxic waste dumping, building demolition, and the transportation of highly flammable substances in that gambling is common and can be done safely, and that state-regulated casinos are not inappropriate

⁹¹ See, e.g., *Gaming & Casinos*, VIDEOSURVEILLANCE.COM, <https://www.videosurveillance.com/gaming-casinos.asp> (last visited July 14, 2016) (advertising player video surveillance systems).

⁹² See, e.g., *Casino Advertising*, MARKETING RESULTS, <http://www.marketingresults.net/services/agency-services-detail.php?Casino-Advertising-4> (last visited July 14, 2016) (“[C]asino advertising must be strategically planned and meticulously managed from start to finish, including . . . [d]atabase research to help target audiences[.]”).

⁹³ See HARVARD WHITE PAPER, *supra* note 87, at 25 (posing this possibility).

⁹⁴ See, e.g., *Duty of Care Paper Distributed to Victorian MPs*, VICTORIAN INTER-CHURCH GAMBLING TASKFORCE (Nov. 28, 2012) <http://churchgamblingtaskforce.com/2012/11/28/duty-of-care-paper-distributed-to-victorian-mps/> (“In the view of the Victorian Inter-Church Gambling Taskforce all gambling providers owe a duty to their customers to do all they reasonably can to reduce any harm that may arise from the product they are selling. . . . [I]n the view of the Taskforce, the gambling industry fails to fulfill[.] this ‘duty of care’ to their customers. Instead many in the gambling industry seek to do the minimum they can get away with in terms of consumer protection measures.”).

⁹⁵ See, e.g., NATASHA DOW SCHÜLL, *ADDICTION BY DESIGN: MACHINE GAMBLING IN LAS VEGAS* (2014) (drawing on fifteen years of field research in Las Vegas and extensive interviews with both designers and disordered gamblers to show how the “duty to extract as much money” as possible from individuals who gamble and the desire to play for as long as possible combine to produce a recipe for potential gambling disorder).

locations for gambling.⁹⁶ However, in the future, could a creative plaintiff's lawyer make a case for strict products liability based on the highly addictive design of many gaming machines?⁹⁷

VI. PROFESSIONAL DISCIPLINE

The application of state administrative law to professionals with gambling disorder also requires academic attention. This section will use attorneys with gambling disorder and the law of attorney professional responsibility to illustrate these issues, although other professionals, including but not limited to nurses, physicians, accountants, and architects also struggle with gambling disorder⁹⁸ and their professional practice acts and ethical obligations must be examined as well.

In a prior work, the Author reviewed how the law of professional responsibility requires attorneys to deposit any funds received or held for the benefit of a client, including advances for costs and expenses, in one or more identifiable bank accounts designated as a client trust account.⁹⁹ The Author further reviewed rules prohibiting attorneys from withdrawing funds from a client trust account, unless the attorney is withdrawing earned legal fees or incurred legal expenses or is delivering funds owed or due by the client.¹⁰⁰ The Author explained how an attorney who fails to safeguard

⁹⁶ See, e.g., *Ratcliff v. Rainbow Casino-Vicksburg P'ship*, 914 So.2d 762, 765 (Miss. Ct. App. 2005) ("We decline to apply a new standard of strict liability to casinos. Ratcliff has provided no authority to support her argument that strict liability should be applied to casinos. No Mississippi case has ever applied strict liability to a casino.").

⁹⁷ See, e.g., HARVARD WHITE PAPER, *supra* note 87, at 25 (using game theory to analyze the relative efficiency of various alternative rules for casino liability, and finding the imposition of strict liability on casinos, for the losses of compulsive gamblers, to be the "most efficient solution").

⁹⁸ See, e.g., *Anyone Else With Gambling Problem?*, ALLNURSES.COM, <http://allnurses.com/nurses-recovery/anyone-else-with-504708.html> (last visited July 14, 2016) (a critical care nurse with twenty years' experience requesting help for her gambling addiction).

⁹⁹ See Stacey A. Tovino, *The House Edge: On Gambling and Professional Discipline*, WASH. L. REV. (forthcoming 2016) [hereinafter *Tovino, On Gambling*]; LA. RULES OF PROF'L CONDUCT R. 1.15; NEV. RULES OF PROF'L CONDUCT R. 1.15(a).

¹⁰⁰ See, e.g., NEV. RULES OF PROF'L CONDUCT R. 1.15(c).

client trust funds in accordance with the law of professional responsibility may be sanctioned.¹⁰¹ Depending on the jurisdiction, sanctions may include admonition, censure, restitution, diversion, probation, interim suspension, suspension for a fixed period of time, and/or disbarment.¹⁰² The Author further described how regional and state disciplinary boards and, on appeal, state supreme courts consider a range of factors when recommending and ordering attorney sanctions: including, but certainly not limited to, whether the attorney has violated a duty owed to a client, the public, the legal system, or the profession; whether the attorney acted intentionally, knowingly, or negligently; the amount of the actual or potential injury caused by the attorney's misconduct; and the existence of any aggravating or mitigating factors.¹⁰³ Following certain license suspensions, an attorney must petition the state supreme court for reinstatement and typically must prove by clear and convincing evidence that the attorney has the "moral qualifications, competency, and learning" required for reinstatement, and that reinstatement will not be "detrimental to the integrity and standing of the bar, to the administration of justice, or to the public interest."¹⁰⁴

Analyzing case law involving attorneys with gambling disorder who were subjected to professional disciplinary proceedings due to the misappropriation of client trust funds, the Author noted in a prior work that some state and regional disciplinary boards and state supreme courts fail to recognize addiction to gambling as a disease of

¹⁰¹ *Tovino, On Gambling, supra* note 99.

¹⁰² *See, e.g.*, LA. SUP. CT. R. XIX, § 10(A) (stating that attorney misconduct in Louisiana may result in one or more of the following sanctions: (1) permanent disbarment; (2) suspension for a fixed period of time not in excess of three years; (3) probation not in excess of two years; (4) public reprimand; (5) private admonition; (6) restitution to persons financially injured by the attorney's actions or omissions; (7) limitation on the nature or extent of the attorney's future practice; and (8) diversion); NEV. SUP. CT. R. 102 (stating that attorney misconduct in Nevada may result in one or more of the following sanctions: (1) permanent, irrevocable disbarment; (2) suspension for a fixed period of time; (3) temporary restraining order regarding funds; (4) temporary suspension precluding the attorney from accepting new cases but allowing the attorney to continue to represent existing clients for fifteen days; (5) public or private reprimand, with or without conditions; and (6) a letter cautioning the attorney against specific conduct).

¹⁰³ *See, e.g.*, LA. SUP. CT. R. XIX, § 10(C) (listing aggravating factors); NEV. SUP. CT. R. 102.5(2)(a)-(n) (listing mitigating factors).

¹⁰⁴ *See, e.g.*, NEV. SUP. CT. R. 116.

the brain, instead, referring to it as a “bad habit,” “character weakness,” or “personal demon.”¹⁰⁵ The Author further reported that some disciplinary boards and state supreme courts refer to individuals with gambling disorder as “terrible,” “despicable,” and “black stains,” suggesting a strong moral stigma against gambling and, in particular, individuals with gambling disorder.¹⁰⁶

The Author also noted that some disciplinary boards and state supreme courts fail to understand the treatable, but non-curable, nature of gambling disorder. For instance, these boards and courts require an attorney to be “cured” or the attorney’s gambling disorder to be “removed” before reinstatement, even though “cure” and “removal” of other mental health conditions, including alcohol use disorder and drug use disorders, are not required for reinstatement.¹⁰⁷ The Author further identified state laws that offer express, clear, and surmountable reinstatement guidelines for attorneys with substance-related disorders, but not attorneys with gambling disorder.¹⁰⁸ Moreover, the Author realized that some disciplinary boards and state supreme courts have recommended or required attendance at Gamblers Anonymous (“GA”) and other twelve-step meetings as a condition of license reinstatement. A requirement to attend GA is concerning because some attorneys do not believe in God or a Higher Power, concepts that are formally recognized and promoted through the second, third, seventh, and eleventh steps of GA.¹⁰⁹ Finally, the Author identified challenges posed by co-occurring disorders to legal scholarship, designed to assess the legal treatment of individuals with only one disorder, such as gambling disorder.¹¹⁰

The Author’s prior work does not address many important questions, however. For example, as an empirical matter, how many attorneys and other professionals with gambling disorder are subject to license suspension or revocation proceedings due to behavior associated with the disorder? What are the rates of license

¹⁰⁵ Tovino, *On Gambling*, *supra* note 99, at 20.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

suspension, revocation, and reinstatement for professionals with gambling disorder? Are professionals with gambling disorder treated like professionals with other physical and mental health conditions in disciplinary proceedings? Do the opinions of regional and state disciplinary boards and state supreme courts reflect an accurate understanding of gambling disorder? If not, how can we better educate disciplinary boards and courts regarding gambling disorder?

Because many disciplinary boards and state supreme courts require attendance at GA as a condition of license reinstatement, do we know whether GA is an effective treatment intervention? If other treatments are as effective as GA, or more effective than GA, should disciplinary boards and courts offer a range of treatment options for professionals with gambling disorder? As a matter of constitutional law, are disciplinary boards and state supreme courts impermissibly mixing Church and State when they require professionals to attend GA meetings as a condition of reinstatement? As a normative matter, should professional disciplinary law continue to expressly accommodate professionals with alcohol use disorder and one or more of the drug use disorders, but not other disorders, such as gambling disorder?

VII. CRIMINAL LAW ISSUES

A final illustrative set of issues that require academic attention lies at the intersection of gambling disorder and criminal law. Some individuals with gambling disorder do commit crimes, such as wire fraud, theft by conversion, embezzlement, and check kiting, to finance their gambling.ⁱⁱⁱ One question relates to whether individuals

ⁱⁱⁱ See, e.g., Trish Mehaffey, *Disbarred Cedar Rapids Attorney Pleads Guilty in Federal Court*, GAZETTE (Oct. 21, 2014), <http://www.thegazette.com/subject/news/public-safety/crime/fraud/disbarred-cedar-rapids-lawyer-pleads-guilty-to-wire-fraud-in-federal-court-20141020> ("A Cedar Rapids disbarred attorney who stole more than \$800,000 from clients pleaded guilty to one count of wire fraud Monday in U.S. District Court. Susan Hense, 54, faces up to 20 years in federal prison and agreed in the plea deal to pay \$837,011 in restitution to 15 former clients."); Connie P. Henry, *Discipline Summaries*, 19 GA. B.J. 1, 54 (2014) (noting that Georgia attorney Richard Wesley Kelley was arrested for theft by conversion). See generally Krzysztof Labuzek et al., *The Latest Achievements in the Pharmacotherapy of Gambling Disorder*, 66 PHARMACOLOGY REP. 811, 811 (2014) ("Gambling ... can still lead to serious social and personal consequences, including criminal

with gambling disorder should be able to complete a treatment program in lieu of criminal sentencing. Nevada, for example, has legislation that authorizes: (1) postponement of criminal sentencing of individuals with problem gambling who commit crimes in furtherance or as a result of problem gambling; and (2) diversion of such individuals to treatment.¹¹² This law raises a number of important sub-questions. For example, which individuals with gambling problems should be eligible for diversion? Nevada law currently allows a “problem gambler who has been convicted of a crime and who committed the crime in furtherance [of] or as a result of problem gambling” to be eligible for diversion, unless, for example, the crime committed is (1) a crime against the person punishable as a felony or gross misdemeanor, (2) a crime against a child, (3) a sexual offense, or (4) an act that constitutes domestic violence.¹¹³ Are these and other eligibility exceptions listed in the Nevada law appropriate? Or, are they too broad? Because the APA has stated that words such as “problem” and “pathological” are pejorative,¹¹⁴ should Nevada’s legislation be amended to incorporate the phrases “gambling disorder” or “disordered gambler?” In addition, which mental health professionals should be eligible to assess an individual-for-diversion eligibility?¹¹⁵ Which mental health

behavior[.]”).

¹¹² See NEV. REV. STAT. §§ 458A.010–.260, 458A.200(2)(d) (West 2015) (“If the person satisfactorily completes treatment and satisfies the conditions upon the election of treatment, as determined by the court, the conviction will be set aside, but if the person does not satisfactorily complete treatment and satisfy the conditions, the person may be sentenced and the sentence executed[.]”).

¹¹³ See, e.g., *id.* § 458A.210(1)–(5).

¹¹⁴ See CHRISTINE REILLY & NATHAN SMITH, NAT’L CTR. FOR RESPONSIBLE GAMING, THE EVOLVING DEFINITION OF PATHOLOGICAL GAMBLING IN THE DSM-5, [https://www.gaming.ny.gov/gaming/20140409forum/Reilly%20\(National%20Responsible%20Gambling%20Council\)/Supplemental%20Material/Reilly%20and%20Smith,%20Evolving%20Definition%20of%20Pathological%20Gambling%20in%20DSM-V%20\(2013\).pdf](https://www.gaming.ny.gov/gaming/20140409forum/Reilly%20(National%20Responsible%20Gambling%20Council)/Supplemental%20Material/Reilly%20and%20Smith,%20Evolving%20Definition%20of%20Pathological%20Gambling%20in%20DSM-V%20(2013).pdf) (last visited Feb. 15, 2016) (“Officially changing the name to ‘Gambling Disorder’ is a welcome revision for many researchers and clinicians who have expressed concern that the label ‘pathological’ is a pejorative term that only reinforces the social stigma of being a problem gambler.”).

¹¹⁵ See, e.g., NEV. REV. STAT. § 458A.230(1) (“If the court, after a hearing, determines that a person is entitled to accept the treatment offered...the court shall order a qualified mental health professional to conduct an examination of the person to determine whether the person is a problem gambler, whether the person committed the crime in furtherance or as a

professionals should be eligible to treat individuals with gambling disorder under a program of diversion?¹¹⁶ What should be the length of treatment?¹¹⁷

As part of the conditions that may be imposed on the individual seeking diversion,¹¹⁸ should attendance at GA be a permissible condition given the lack of belief by some individuals with gambling disorder in a "Higher Power," concepts that, as previously mentioned, are formally recognized and promoted through the second, third, seventh, and eleventh steps of GA?¹¹⁹ Would a court be impermissibly entangling Church and State by requiring an individual to attend GA meetings as a condition of diversion? Should the individual with gambling disorder be required to pay for the cost of treatment?¹²⁰ Should the individual be required to pay restitution as a condition of diversion, given that many individuals will not have the money to do so, or may never be able to earn the money to do so?¹²¹ Should community service be allowed as a substitute for

result of problem gambling, and whether the person is likely to be rehabilitated through treatment.").

¹¹⁶ See, e.g., *id.* § 458A.057 (defining "qualified mental health professional" to include certified problem gambling counselors, certified problem gambling counselor interns, physicians, nurses who are authorized to engage in the practice of counseling problem gamblers, licensed psychologists and psychologist assistants, certain clinical professional counselors and clinical professional counselor interns, marriage and family therapists who are authorized to engage in the practice of counseling problem gamblers, and clinical social workers authorized to engage in the practice of counseling problem gamblers).

¹¹⁷ See, e.g., *id.* § 458A.220(2)(b)(1) ("If the person elects to submit to treatment and is accepted, the person . . . [m]ay be placed under the supervision of the qualified mental health professional for a period of not less than 1 year and not more than 3 years[.]").

¹¹⁸ See, e.g., *id.* § 458A.220(2)(a) ("The court may impose any conditions upon the election of treatment that could be imposed as conditions of probation[.]").

¹¹⁹ *Recovery Program*, GAMBLERS ANONYMOUS, <http://www.gamblersanonymous.org/ga/content/recovery-program> (last visited Feb. 3, 2016).

¹²⁰ See, e.g., *id.* § 458A.200(3) ("Before the court assigns a person to a program for the treatment of problem gambling, the person must agree to pay the cost of the program to which he or she is assigned, to the extent of the financial resources of the person. If the person does not have the financial resources to pay all the related costs, the court shall, to the extent practicable, arrange for the person to be assigned to a program that receives a sufficient amount of federal or state funding to offset the remainder of the costs.").

¹²¹ See, e.g., *id.* § 458A.230(4) ("If the court places a person under the supervision of a qualified mental health professional for the purpose of receiving treatment . . . the person must agree to pay restitution as a condition upon the election of treatment.") (citation omitted).

payment of the cost of treatment or the cost of restitution in cases of need?¹²² Should other states adopt similar diversion legislation? If so, should that new legislation be specific to gambling disorder or, because the vast majority of individuals with gambling disorder have co-occurring disorders,¹²³ should each jurisdiction have one piece of mental health diversion legislation or, at least, one piece of substance-related and addiction diversion legislation? Are individuals with gambling disorder who are convicted and not diverted, either because they are not eligible for diversion or because they reside in a jurisdiction that does not have diversion legislation, eligible for sentencing relief? Should they be?¹²⁴

CONCLUSION

This Article has identified a number of legal issues raised by gambling disorder that would benefit from analysis and normative scholarship by the academic health law community. As a note of limitation, the issues described in this Article are simply illustrative, not exhaustive. Gambling disorder intersects with the law in a variety of other contexts including, but not limited to, family law, where gambling disorder may be relevant to the division of community property and child custody,¹²⁵ and tax law, regarding the taxable

¹²² See, e.g., *id.* § 458A.230(6)(b) (“The court may order the person to perform supervised community service in lieu of paying the remainder of the costs relating to the person’s treatment and supervision.”).

¹²³ See, e.g., Nathan Smith, *Psychological and Neurobiological Factors in the Development of Gambling Disorders*, in 7 INCREASING THE ODDS: A SERIES DEDICATED TO UNDERSTANDING GAMBLING DISORDERS 5, 8 (Nat’l. Council on Responsible Gaming ed., 2012) (“The largest study that examined the comorbidity of PG [Problem Gambling] surveyed more than 43,000 representative Americans and concluded that almost 75 percent of those diagnosed with PG had a co-occurring alcohol use disorder, while almost 40 percent had a comorbid drug use disorder.”).

¹²⁴ See generally Alan Ellis et al., *Gambling Addiction: Making the Case for Sentencing Relief*, CRIM. JUSTICE, vol. 30, Fall 2015, at 12 (explaining why gambling disorder is relevant to criminal sentencing, identifying how the courts have addressed gambling disorder in the context of sentencing, and reviewing methods for obtaining sentencing variances for individuals with gambling disorder).

¹²⁵ See generally Cheryl B. Moss, *A View from the Bench: Insight from Judge Cheryl B. Moss*, in GAMBLING AND HEALTH IN THE JUSTICE SYSTEM 17, 17–20 (Nat’l. Ctr. for Responsible Gaming ed., 2013) (discussing family law issues raised by gambling disorder).

nature of gambling winnings.¹²⁶ Using discrete examples from health insurance law, disability benefit eligibility law, disability discrimination law, public health law, tort law, professional responsibility law, and criminal law, this Article aims to bring greater awareness to the ways gambling disorder intersects with the law and the treatment of individuals with gambling disorder under those laws. Hopefully, this Article has encouraged readers to re-visit age-old health law questions about what it means to be ill, and whether and how the law should accommodate individuals with particular physical and mental health conditions, including gambling disorder.

¹²⁶ *Topic 419 – Gambling Income and Losses*, INTERNAL REV. SERV., <https://www.irs.gov/taxtopics/tc419.html> (last updated Jan. 4, 2016) (“Gambling winnings are fully taxable and you must report them on your tax return. Gambling income includes but is not limited to winnings from lotteries, raffles, horse races, and casinos. It includes cash winnings and the fair market value of prizes, such as cars and trips.”).