PROBLEM GAMBLING in the 21ST CENTURY HEALTHCARE SYSTEM

IMPLICATIONS OF THE DSM-5, ACA, AND PARITY FOR PROBLEM GAMBLING TREATMENT & ADVOCACY

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INTRODUCTION

Symbolized by its reclassification within the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM), the scientific and clinical community clearly accepts problem gambling as a clinically diagnosable behavioral health condition with proven, effective treatments. With the behavioral health landscape shifting under the Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (M2HPAEA), the changing environment offers an opportunity to further embed problem gambling within mainstream healthcare. This report examines the opportunities under these new laws and offers recommendations for effective problem gambling advocacy in the 21st century healthcare system.

WHAT IS PROBLEM GAMBLING?

Problem gambling is gambling behavior that causes disruptions in any major area of life: psychological, physical, social, or vocational. The term "problem gambling" includes but is not limited to the condition previously known as "pathological" or "compulsive" gambling (now "gambling disorder"), which is a progressive addiction characterized by increasing preoccupation with gambling, a need to bet more money more frequently, restlessness or irritability when attempting to stop, "chasing" losses, and loss of control manifested by continuation of the gambling behavior in spite of mounting, serious, negative consequences.

As used in this report, the term "problem gambling" includes behavior that does not meet the clinical definition of gambling disorder (or previous diagnoses) but exceeds the limits of social or professional gambling, causing major life disruptions. Importantly, a single incident of problems associated with gambling (e.g. short-term chasing behavior) may not constitute problem gambling unless it causes major life disruptions. Though not meaning to limit our discussion to clinically diagnosed problem gambling, the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) has long been recognized as the standard classification of mental disorders for mental health professionals in the United States, so this report will consider the history of the DSM's classification of problem-gambling-related conditions.

THE CHANGING DSM DIAGNOSIS: GAMBLING DISORDER

Published in 2013, the APA's fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) recognizes "gambling disorder" as a diagnosable condition under the category "Substance-Related and Addictive Disorders" (American Psychiatric Association, 2013). According to the DSM-5, gambling disorder is "persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress," as indicated by an individual exhibiting four (or more) of nine (9) symptoms in a 12-month period. But this characterization represents a departure from previous editions of the DSM, which continually revisits its classifications in light of new scientific evidence.

Under the DSM-IV, which governed the APA diagnoses from 1994 to 2013, "pathological gambling" was characterized by "persistent and recurrent maladaptive gambling behavior," grouped under "Impulse-Control Disorder Not Elsewhere Classified," along with kleptomania, pyromania, trichotillomania, and intermittent explosive disorder (American Psychiatric Association, 1994). But with the publication of the DSM-5, clinically diagnosable problem gambling (gambling disorder) has been reclassified in light of new scientific evidence, recognizing the link between problem gambling and substance use disorders (SUDs). The reclassification came as the APA sought to clarify the diagnosis and treatment of gambling disorder, increase its recognition, and improve research (O'Brien, 2011; Petry, Blanoc, & Stinchfield, 2013; Rennert, 2014).

> "Although some behavioral conditions that do not involve the ingestion of substances have similarities to substance-related disorders, only one disorder—gambling disorder—has sufficient data to be included in this [Addictive Disorders] section." – DSM-5

The APA makes the case for characterizing gambling disorder as an addictive disorder, noting explicitly that, "although some behavioral conditions that do not involve the ingestion of substances have similarities to substance-related disorders, only one disorder—gambling disorder—has sufficient data to be included in this [Addictive Disorders] section." Furthermore, the DSM-5 justified the inclusion by noting "this [Addictive Disorders] chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce

some behavioral symptoms that appear comparable to those produced by the substance use disorders." The DSM-5 goes on to explain that other conditions, (like "sex addiction") are "not included because at this time there is insufficient peer-reviewed evidence to established the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders."

Of course, a change to the DSM only marks the canonization of a scientific shift that preceded it. Recognition by the DSM requires a body of clinical and scientific evidence. Not surprisingly, a plethora of research has documented the similarities between SUDs and gambling disorder (Frascella, Potenza, & Brown, 2010). After examining clinical and phenomenological similarities, genetic features, personality and neurocognitive features, neural features, and the body of treatments, in 2010, one researcher concluded that, "existing data suggest a particularly close relationship between pathological gambling and substance dependence" (Frascella, Potenza, & Brown, 2010).

Beyond the implications for treatment and insurance coverage, the codification of gambling disorder as an addictive disorder within the DSM-5 is also important for its cultural significance. Like substance abuse, problem gambling has long faced the social stigma of being a "moral failing" rather than a medical condition—a condition thought to stem from lack of will power. Years of addiction science have battled this stigma, and the inclusion and placement of gambling disorder within the DSM-5 should serve as yet more authoritative determination that problem gambling is a diagnosable disorder and not and not a weakness of will or a failure of character.

HOW COMMON IS PROBLEM GAMBLING?

There is no single consensus figure for the prevalence of problem gambling, in part because the terms used to describe the condition (and the tools used to screen for it and asses it) are continually evolving. Prevalence estimates for the DSM-IV's "pathological gambling" diagnosis range from 0.4% to 3.4% among U.S. adults (Shaffer, Hall, & Vander Bilt, 1999; Stea & Hodgins, 2011; Toce-Gerstein, Gerstein, & Volberg, 2009). Estimates for problem gambling—which has a less restrictive definition clinically and colloquially—may be higher. In fact, examining global prevalence, one meta-analysis found that prevalence may range from 0.5% to 7.6%, with an average of 2.3% (Williams & Volberg, 2012). Notably, though the DSM-5 cites a prevalence rate of 0.2% to 0.3% for its diagnosis of "disordered gambling," most research indicates that prevalence is much higher. Assuming conservative rates of 1.1% for gambling disorder and 2% for cumulative problem gambling, the U.S. is home to more than 3.4 million adults with gambling disorder and 6.2 million problem gamblers.

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Research also shows that problem gamblers—and particularly individuals with gambling disorder—are more likely to have other health problems (American Psychiatric Association, 2013). In particular, problem gamblers are more likely to be dependent on alcohol; abuse other drugs; suffer from depression, bipolar disorder, and anxiety disorder; and experience certain somatic illnesses (Petry N. , 2008). Though few thorough social cost studies exist, based on the National Gambling Impact Study Commission, the NCPG estimates that the social cost of gambling programs was $7 billion in 2011, including job loss, bankruptcy, and criminal justice costs (Whyte, 2011). Given that problem gambling has such a profound effect not only on the gamblers and their families but on the entire country, we face both a moral and financial obligation to offer treatment for problem gamblers.

PROBLEM GAMBLING TREATMENT: IT WORKS!

The body of evidence is sufficiently robust to declare that problem gambling treatment works. Findings from randomized control trials published in peer-reviewed journals support the larger body of evidence from state-sponsored treatment programs, showing that specific treatments lead to improved outcomes among problem gamblers (Gooding & Tarrier, 2009; Pallessen, Mistem, Kvale, Johnsen, & Molde, 2005).

State-funded treatment in Oregon, Arizona, and Nevada have all shown significant improvements among problem gamblers that complete treatment. In Arizona, 97 percent of those who completed treatment reported reduced participation in gambling activity (Bernhard, 2009). Meanwhile, Oregon's treatment program reported a 40 percent drop in suicidal ideation, a 75 percent decrease in illegal acts, a 73.6 percent rate of abstinence from gambling one year after treatment, and statistically significant improvements on numerous quality of life indicators, including physical health and emotional well-being (Moore, 2013). Similarly, 91 percent of study participants in Nevada's state-sponsored program reported reduced gambling frequency during treatment and 66 percent reported abstinence from gambling (Brenhard, Crossman, & Cross, 2007).

Yet not all treatment is equal and randomized control trials present the best opportunity to improve treatment and outcomes. A critical review of treatment for gambling disorder by Stea and Hodgins evaluated each of seven specific treatment approaches, (1) psychoanalytic/psychodynamic; (2) Gamblers Anonymous; (3) behavioral treatments; (4) cognitive and cognitive behavioral therapies; (5) brief, motivational, and self-directed interventions; (6) pharmacotherapies; and (7) family therapy. Despite numerous methodological difficulties, the authors used a modified application of the APA's Division 12 clinical psychology guidelines to determine that the strongest evidence based exists for CBT; particular behavioral treatments; particular brief, motivational, and self-directed treatments; pharmacotherapies; and select family therapies (Stea & Hodgins, 2011).

In spite of the ever-growing body of scientific evidence, while most states fund limited treatment programs for problem gamblers, most health insurers have not "embraced" gambling disorder treatment as a covered benefit. With the newly restructured DSM-5, the growing body of research supporting formal treatment for problem gambling, and the wave of new behavioral health legislation, the tide may be shifting toward inclusion of problem gambling treatment within the cannon of accepted behavioral health treatments.

THE ACA & PROBLEM GAMBLING TREATMENT: AN INTUITIVE CASE

As treatment for problem gambling continues to establish a foothold within both "behavioral health" and the broader U.S. healthcare system, changes enacted under the Patient Protection and Affordable Care Act (the ACA) offer intuitive inroad into the mainstream. Signed into law in 2010 and colloquially known as "ObamaCare," the ACA enacted numerous provisions designed to reduce healthcare costs, improve the quality of care, and expand coverage. The ACA's provisions attempt to expand coverage in two major ways: by covering the uninsured and by ensuring that covered benefits meet certain minimum standards. Through these efforts, the ACA intends to secure broad coverage for millions of individuals—including behavioral health coverage. And though the ACA does not enumerate a complete set of covered conditions, gambling disorder clearly falls within the law's behavioral health benefit.

The ACA seeks to cover more people through a combination of public and private coverage, and the Congressional Budget Office (CBO) estimates that the law will cover 26 million previously uninsured individuals by 2024 (CBO, 2014). To accomplish this, the ACA employs three principle mechanisms: (1) the "individual mandate," (2) insurance marketplaces and accompanying federal insurance subsidies, and (3) an optional Medicaid expansion.[1] In addition, to ensure that this new coverage provides a minimum level of benefits, the ACA established 10 mandatory "essential health benefits" (EHBs), which include, "mental health and substance use disorder services, including behavioral health treatment."

When combined with the marketplace plans and Medicaid expansion, EHB provisions are designed to ensure that newly covered Americans receive a certain set of benefits—deemed "essential" by the Congress. That these "essential" benefits include behavioral health coverage is emblematic of the nation's continuing shift toward embracing behavioral health as part of an integrated notion of healthcare. However, the exact nature of covered benefits is vague and many details are left to states. These details will be crucial in determining how the ACA affects problem gambling treatment.

How the ACA Covers More People

The "individual mandate" requires most Americans to obtain health insurance or pay a penalty. Coupled with that mandate, the ACA has created Affordable Insurance Marketplaces (also known as Health Exchanges) and subsidizes private coverage purchased through those marketplaces for people earning up to 400 percent of the federal poverty level (FPL). In addition, the ACA's changes to the Medicaid

1 The law includes numerous other relevant provisions, including the employer mandate.

system further expand public coverage for the neediest Americans. While many believe that Medicaid already provided healthcare for all low-income Americans, states are only required to cover low-income individuals in certain groups (e.g., pregnant women, parents with young children, etc.). Under the optional expansion, states may cover residents up to 138 percent of the FPL.

With the ACA set to bring insurance coverage to millions of new people, the implementation of this landmark legislation presents the perfect opportunity to ensure that affected plans cover all legitimate health conditions. If newly insured individuals can access the full range of behavioral health benefits, the ACA will truly have altered the behavioral health financing landscape forever. And if those 26 million previously uninsured people can access treatment for problem gambling, the ACA will have played a tremendous role in bringing problem gambling into the mainstream of the American healthcare system.

How the ACA Enhances Benefits: What are Essential Health Benefits?

To ensure that the law provides good coverage, the ACA enacted measures to ensure that newly covered individuals—and many others—have a sufficient scope of coverage under both public and private plans. Beginning in 2014, the ACA established 10 mandatory "essential health benefits" (EHBs) for newly eligible Medicaid enrollees and most individual and small group health plans. The mere existence of EHBs ensures that millions of Americans will be assured access to a basic set of health benefits that incorporates "mental health and substance use disorder services, including behavioral health treatment."[2] However, much of EHB implementation rests with states and the exact nature of covered services remains imprecise.

As a transitional policy until 2016, states must select a pre-existing health insurance plan to serve as a benchmark, dictating the minimum coverage for affected private plans and Medicaid expansion enrollees.[3] States are required to choose from 1 of 10 plans[4] to serve as their benchmarks; however, 26 states elected not to make a selection, thereby defaulting to a Federally selected plan (Corlette, 2013). In addition, states have the flexibility to specify individual services within EHB categories, or include additional services outside the scope of the EHBs in their benchmark.[5] Under these transitional regulations, states may include state-required mandates in their benchmark selection. Many states have taken this opportunity to mandate coverage for specific behavioral health conditions or treatments; however, the transitional policy requires states to defray the cost of any coverage requirements that were not in effect under state law prior to December 31, 2011. Whether this will change under final EHB policy is unclear.

Given the process by which EHB benchmarks are currently established, the place for disordered gambling treatment remains murky. However, the spirit of the EHB language—if not the policy—appears to require problem gambling coverage regardless of whether states specifically mandate it. In addition, there are several avenues through which the place for gambling disorder treatment can be established and clarified in the coming years. At the state level, changes to the EHB benchmarks for 2015 could stipulate coverage. While, though HHS has not yet announced a policy, the 2016 EHB rules will provide an opportunity to implement a Federal change that would affect all states.

2 Though some other EHBs are condition-specific (e.g., "maternity and newborn care") most are broader benefit categories (e.g., "emergency services," "prescription drugs," and "laboratory services" etc.).

3 States are not required to select the same benchmark for both private plans and the Medicaid expansion, and the list of eligible options differs for each.

4 For private plans, states could choose from: any of the three largest small group plans, by enrollment; any of the three largest state employee plans, by enrollment; any of the three largest national Federal Employees Health Benefits Program (FEHBP) plans, by enrollment; or the HMO plan with the largest non-Medicaid enrollment in the state. For the Medicaid expansion, states could choose from the largest national FEHBP plan, by enrollment; the largest state employee plan, by enrollment; the HMO plan with the largest non-Medicaid enrollment in the state; or any other pre-existing plan approved by HHS.

5 Many states may require legislative action to establish these mandates.

The Place for Problem Gambling Under the ACA

An overwhelming body of evidence—spanning the scientific and clinical communities—now recognizes some form of problem gambling as an addictive disorder, falling under the umbrella of either "mental health" or "behavioral health." Given that the ACA's EHB language takes care to include both "mental health and substance use disorders" as well as "behavioral health treatment," the law's intention is clear. Within that category, the ACA was designed to ensure that affected plans cover conditions that have been recognized by the appropriate clinical and scientific authorities. But the ACA's process for implementing EHBs strays from that legislative intent, leaving practical ambiguity.

The behavioral health authorities are unified in their conclusion that gambling disorder is so closely related to substance use disorders that they categorize them under the single category of "addictive disorders." In the newly published DSM-5, the APA makes the case that the clinically diagnosable condition of "gambling disorder"—is not only a scientifically recognized "mental disorder" but also an "addictive disorder" akin to substance use disorders (American Psychiatric Association, 2013). Furthermore, the American Society of Addiction Medicine (ASAM) includes gambling disorder under "emerging understanding of addiction" within its published treatment placement criteria and crosswalks the existing SUD criteria for application to gambling disorder (American Society of Addiciton Medicine, 2013). The inclusion of gambling disorder in both the DSM-5 and the 2013 edition of the ASAM criteria provides seemingly irrefutable evidence that the clinical community fully accepts the legitimacy of both the condition and its treatment.

Yet the current structure of the ACA's EHBs creates a disconnect between the law's apparent intentions and its practical application. Though one primary aim of the ACA was to ensure that that Americans' coverage met certain minimally acceptable standards that Congress deemed "essential," the ACA currently sets those standards by referring to states' to pre-existing "benchmark" plans"—that is, by using existing insurance plans as the standard for future plans. This process, in turn, appears to allow new plans to avoid coverage for gambling disorder—not because of the legitimacy the condition or because the law intended to exclude gambling disorder, but simply because the practical implementation relies on previously existing plans. While upcoming policy changes under the 2016 Federal EHB regulations may affect this reality, HHS has not yet provided any information on those regulations or the process for determining them.

At this writing, state EHB packages do not explicitly include or exclude gambling disorder, leaving the matter open to interpretation. As late as 2011, HHS noted that the implications of EHBs on behavioral health were ambiguous. The department found that, "the extent to which plans and products cover behavioral health treatment, a component of the mental health and substance use disorder EHB category, is unclear. In general, plans do not mention behavioral health treatment as a category of services in summary plan documents" (Centers for Medicare & Medicaid Services, 2011). But states may choose to update their benchmark plans for 2015, which may offer an early opportunity to clarify or buttress coverage. And HHS (as well as states) must revisit EHBs for 2016, presenting a major opportunity to clarify coverage for future plan years at the Federal level—potentially listing gambling disorder as an explicitly covered condition. In addition, despite the ambiguity surrounding the application of EHBs to behavioral health coverage, the ACA is not the only legislation that aims to enhance behavioral health benefits. Other legislative actions that expand behavioral health coverage may also have implications for problem gambling treatment.

Problem Gambling & Behavioral Health Parity Legislation

Though the ACA's EHBs present one promising inroad for problem gambling treatment, other legislative avenues offer opportunities as they seek to level the playing field between "general" healthcare and behavioral health. Recent federal legislation (and a tremendous amount of state legislation) has sought to ensure equality of coverage—or parity—for behavioral health conditions. The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA or the "Parity Act") does not require plans to offer behavioral health benefits. Instead, for nearly all individual and large-group plans that offer behavioral health coverage, MHPAEA requires that they offer those benefits "at parity" with general health coverage. But despite the law's clear intent, the definition of "parity" is far from straightforward.

As with the ACA's EHBs, the true ramifications of MHPAEA are determined by its implementation, and the actualization of coverage "at parity" has proven challenging. MHPAEA does not stipulate a set of covered conditions or treatments. Under its current implementation, for applicable plans, MHPAEA requires parity between behavioral health benefits and medical/surgical benefits (e.g., inpatient in network and inpatient, out-of-network) as well as general equivalence of annual and lifetime dollar limits, financial requirements, and treatment limitations (Centers for Medicare & Medicaid Services, 2013). While there is a synergistic effect between ACA (and state-level) coverage requirements and MHPAEA's parity requirements, neither outlines specific covered conditions or settles the issue of coverage for gambling disorder. Yet, like the ACA's EHBs, the spirit of MHAPEA goes beyond the current state of implementation.

An intuitive reading of a parity requirement would not permit insurers to exclude behavioral health conditions without a clinical justification, just as they are not permitted to deny coverage for "general health" conditions without a medical justification. The inclusion of gambling disorder within the DSM-5 and the continually evolving definition of behavioral health parity may provide yet another avenue for establishing broad insurance coverage for gambling disorder treatment. If advocacy efforts can shape the implementation of parity laws to include treatment for gambling disorder, when taken together, the additive effect of the ACA and MHPAEA could ensure that 62.5 million American's receiving expanded behavioral health coverage also receive access to problem gambling benefits (Beronio, 2013).

A ROADMAP FOR PROBLEM GAMBLING ADVOCACY IN THE NEW FINANCING ENVIRONMENT

Like substance use before it, the problem gambling field has come a long way. Problem gambling advocates must think strategically about how to position the field within the new financing environment created by the ACA and MHPAEA. The recommendations in this section seek to provide a roadmap for gambling advocates to navigate the 21st century healthcare environment in four broad advocacy areas:

- Prepare for the EHBs Using the Intuitive Case and a Multi-Pronged Approach
- Strengthen the Case for Problem Gambling Treatment
- Establish Concrete Prevalence Data and Support Research
- Focus on Special Populations

Prepare for the EHBs Using the "Intuitive Case" and a Multi-Pronged Approach

The implementation of the ACA's EHBs renders the next several years both crucial and complex for problem gambling treatment. While a considerable amount of control may rest with states, the Federal government retains preemptive authority over EHB implementation. In addition, multiple waves of EHB deadlines over the next several years further complicate the advocacy agenda. A multi-pronged approach will likely prove most effective for navigating the sea of changes to come, focusing on (1) state-level policymakers and legislators, (2) Federal policymakers, and (3) legal action.

- **Focus on States.** Under HHS' current interpretation of the ACA, the bulk of EHB implementation decisions were designed to occur at the state level, and states have considerable authority over the insurance products sold within their jurisdiction. States are permitted to outline specific EHB coverage requirements and have the opportunity to update their EHB requirements for 2015. In addition, states will need to respond to HHS' forthcoming regulations for 2016 and onward. Advocacy campaigns directed at state legislators and policymakers offer an opportunity to establish a "foot in the door" with a particular state, establishing precedent for future action. However, while some states may be able to require EHB coverage through their Departments of Insurance, many will likely require legislative action to mandate coverage for particular conditions.
    - **Work with Insurance Commissioners and Legislators**: States that wish to modify their EHBs for 2015 must finish those regulations during 2014, leaving only a small window for advocacy prior to that deadline. Nevertheless, state insurance regulators or legislators are empowered to enforce condition-specific requirements over and above the ACA's EHB standards. Even after the 2015 EHBs have been established, insurance regulators and state legislators will likely continue to play a pivotal role in implementing EHBs after 2016. These policymakers may be the most straightforward path to universal problem gambling coverage in a particular state.
    - **Engage with Single State Agencies (SSAs) & Other Relevant Departments**: Most states (42) already provide public funding for substance abuse treatment. Given the new healthcare environment, problem gambling advocacy should seek to go beyond state insurance commissioners and legislators to involve their single state agencies (SSAs) for substance abuse or other state departments responsible for problem gambling treatment. Though states vary, the SSA is often the agency responsible for publicly funded problem gambling treatment and is likely the "expert agency" on problem gambling within the state government. States that consider adding problem gambling treatment as a mandatory benefit are likely to seek guidance from their SSAs as part of that process. In addition, states that consider expanding their own problem gambling treatment programs will surely work closely with their SSA to establish standards, best-practices, and billing procedures. By working with these entities, advocates can also help bridge the gap between programmatic experts at SSAs and states' Medicaid programs—opening up new revenue streams and further bringing problem gambling treatment into "mainstream" healthcare.
    - **Explore Coverage Through State Medicaid Programs**: While Oklahoma already providers Medicaid funding to treat individuals diagnosed with either "pathological" or "problem" gambling, most states do not. Working toward Medicaid coverage offers the chance for immediate tangible benefits—that is, problem gambling coverage for Medicaid enrollees—and a promising "foot in the door" for eventual coverage by private payers. In addition, because securing Medicaid coverage requires Federal involvement, a strategy focused on securing Medicaid funding for problem gambling treatment also expands Federal support, which can ultimately pay dividends through other HHS programs and policies. Working with the Oklahoma Health Care Authority to learn about their experience with CMS may be a valuable place to start.
    - **Seek Federal Technical Assistance**: State-based policymakers should request Federal technical assistance (TA) on problem gambling and the integration of problem gambling services into existing healthcare infrastructure. In addition to gaining valuable information from Federal authorities, these requests show Federal policymakers that problem gambling is a developing area of interest at the state level. TA requests will also make Federal authorities develop documentation on problem gambling services, carving out a space for problem gambling within the Federal healthcare policymaking apparatus. Of course, problem gambling TA can take many forms, including programmatic and best-practice requests to agencies like SAMHSA or HRSA or billing and payment information requests to agencies like CMS.
- **Target HHS & Work with SAMHSA**. Though states have considerable control over EHB implementation and local insurance regulations, the current EHB regulations are temporary, and HHS must issue new regulations prior to 2016. No information is yet available on the particulars of HHS' plans or the timetable for them, but HHS has the authority to restructure EHBs and will need to finalize a rule during 2015. While a total restructuring seems unlikely, HHS seems to have the authority to require coverage for specific conditions—or to clarify the implications of a particular EHB. As a result, targeting HHS prior to 2016 offers a chance to effect change for all states simultaneously. Advocates should respond to all relevant Requests for Information, Notices, and Proposed Rules to ensure that HHS officials are cognizant of the problem gambling issues at every stage of the EHB rule-making process. In addition, it is important to secure passage of legislation such as the Comprehensive Problem Gambling Act that provides formal authorization for HHS (and all its component agencies and offices) to address gambling addiction. Because the behavioral health EHB is particularly complicated and HHS has previously noted that its implementation will not be simple, HHS is likely to turn to SAMHSA as its in-house expert on behavioral health conditions. Working with SAMHSA to establish a position of problem gambling treatment could, in turn, help promulgate that view throughout HHS. State technical assistance requests can also help establish the need for HHS to clarify the application of EHBs to problem gambling treatment.
- **Support Legal Action**. Though future regulations may clarify the issue, existing law is probably too vague to be dispositive on problem gambling. And insurance companies are not likely to begin covering a new condition without an incentive or mandate. Though policy and regulatory

agencies may settle the issue, a lawsuit (or many) contesting a coverage denial may be required to determine the precise effects of EHBs and MHPAEA on treatment for gambling disorder.

Strengthen the Case for Problem Gambling Treatment

While the APA and ASAM have accepted gambling disorder and its treatment, much work remains. Arguments for the inclusion of problem gambling treatment within the healthcare system must convince not only behavioral health experts but also those outside the behavioral health field: insurers, regulators, providers, clients, and the general public. These recommendations focus on ways to sharpen and improve the arguments for problem gambling coverage and enhance the existing body of evidence supporting that coverage.

- **Distinguish Between Problem Gambling and Gambling Disorder**. With problem gambling treatment preparing to move into the healthcare mainstream, advocates should distinguish between "problem gambling" and the more restrictive, clinically recognized, "gambling disorder." Payers and providers—particularly private insurers—are unlikely to pay for non-diagnosable behavioral health conditions. While an advocacy organization's mission may be oriented around the broader condition, advocates should be careful with their terms, restricting certain claims or requests only to "gambling disorder"—at least for now.
- **Distinguish Between Types of Treatment**. At this writing, some forms of treatment for gambling disorder are better supported than others. With the legitimacy of gambling disorder established, advocacy should distinguish between evidence-based practices, promising practices, and treatments for which there is not yet any scientific basis. As the focus of advocacy switches to insurance coverage, this distinction will become crucially important for advocates, individuals seeking treatment, treatment providers, and prospective payers. Advocating for a limited set of treatments with a strong evidence base is the most effective way to bring gambling disorder treatment into the mainstream.
- **Support Research to Test the Efficacy of the Most Promising Treatment Models**. As a compliment to advocacy which distinguishes between types of treatment, supporting research to further establish the efficacy, cost-effectiveness, and relative-utility of different forms of treatment will further establish the legitimacy of problem gambling treatment while also ensuring a wider array of effective interventions for individuals in need. As outlined below, the National Institutes of Health (NIH) offer one promising funder for such research.
- **Expand and Enhance Certification**. Formalized and robust certification standards for clinicians providing problem gambling treatment can help demonstrate legitimacy both within and outside the behavioral health field. States and other organizations have taken an active role in provider certification for SUD treatment, offering a paradigm for gambling disorder treatment certification. This process will require an ever-progressing balance, designed to ensure that standards are sufficiently rigorous to ensure quality care while not being so onerous as to unduly limit access to treatment. In addition to enhancing certification standards for clinicians, an easily-accessible national list of certified providers should be maintained. Extensive outreach and education for existing behavioral health providers will also help ensure that the entire behavioral health field has basic knowledge on problem gambling and problem gambling treatment.

Establish Concrete Prevalence Data and Support Research

The lack of well-established data around problem gambling presents a major barrier to treatment and advocacy. However, numerous Federal and state agencies already conduct surveys, which can be leveraged to fill many of the field's knowledge gaps.

- **Embed Problem Gambling Prevalence Research within HHS's Existing Infrastructure**: The National Gambling Impact Study Commission recommended that "gambling components, where appropriate, be added to existing federal research in the substance abuse and other mental health fields" (National Gambling Impact Study Commission, 1999). For example, inclusion of a small problem gambling section within SAMHSA's National Survey on Drug Use and Health (NSDUH) would end the confusion surrounding national prevalence estimates and help to further embed problem gambling within SAMHSA's purview as the Federal mental health and substance use authority. To understand the full nature of problem gambling, prevalence studies must be regular and robust, and using the NSDUH would allow SAMHSA to examine the general population as well as special populations of interest, including youth, women, the elderly, military personnel, and veterans. The National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Indian Health Service, and the National Institute of Justice (NIJ) are also promising Federal agencies with research or data gathering components that lend themselves naturally to problem gambling. In addition, while the advocates should work with the CDC to secure global changes to the Brief Risk Factor Surveillance System (BRFSS), at the state level, a number of states have added gambling questions to their surveys and additional states should follow their example until a national standard is established (Marotta, Bahan, Reynolds, Vander Linden, & Whyte, 2014).
- **Survey Existing Programs**. With minimal effort, SAMHSA can expand existing provider surveys to address problem gambling issues, including but not limited to: scope of coverage and billing-related data. Over and above SAMHSA's surveys, states can and should survey existing programs to develop a robust understanding of the state of problem gambling treatment programs in their jurisdiction. This baseline data, which should be updated frequently, can then form the basis of efforts outlined above—including efforts to expand coverage for problem gambling treatment through EHBs and state Medicaid programs.
- **Support Broader NIH Research**. As research into brain science continues to become a more important component of health research, NIH research is perhaps the most promising method to fund research that enhances the understanding of problem gambling and helps develop and improve treatments for problem gambling and gambling disorder. While agencies like SAMHSA and CDC offer a tremendous data gathering opportunities, NIH research offers a vehicle for academic research into topics as diverse as the root causes of problem gambling behavior and the relative effectiveness of existing problem gambling treatments. In addition, working with NIH can help problem gambling further solidify its place as an addictive disorder, both through its association with NIH and through new research findings.

Focus on Special Populations

Research tells us that certain populations suffer disproportionately from problem gambling or face a higher likelihood of becoming problem gamblers. While problem gambling treatment should be available for all individuals in need, "special populations" are also worthy of special consideration.

- **Military Personnel & Veterans**. When compared to the general population, a significant body of evidence shows that veterans who utilize VHA services are at greater risk for and have a higher prevalence of problem gambling. Both because of their national and importance and because military personnel and veterans have their own dedicated healthcare systems, special attention should be paid to ensure that these men and women have access to problem gambling treatment within their Federal healthcare systems. In addition to providing services for veterans in need, ensuring robust coverage for problem gambling treatment within the VHA helps to establish a Federal precedent for problem gambling coverage, thereby supporting the movement towards universal coverage for the general population.
- **Adolescents**. Research shows that adolescents are at higher risk for problem gambling and that adolescents with gambling problems are, in turn, at higher risk for binge drinking, drug use, and numerous types of violent behavior (including gang involvement). Treatment and research resources should target adolescents in need. Early interventions can help ensure that today's adolescents do not become tomorrow's adult problem gamblers. In particular, problem gambling should strive to follow the path taken by SUD treatment, creating a branch of research dedicated to determining and developing the best treatments for youth.
- **Individuals with Co-Occurring Mental Health Conditions or SUDs**. Individuals with co-occurring conditions suffer disproportionately from problem gambling, and these individuals likely require treatment for their mental health or substance use condition, as well. Because of the significant relationship between problem gambling and other behavioral health conditions, treating individuals with co-occurring conditions in a holistic way offers the best chance to ensure that they receive the quality care they need.

WHAT YOU CAN DO

The National Council on Problem Gambling's mission is to lead state and national stakeholders in the development of comprehensive policy and programs related to problem gambling. Our vision is to improve health and wellness by reducing the personal, social and economic costs of problem gambling. We prepared this report to provide NCPG members and anyone affected by gambling addiction—from individuals, families, businesses and communities—with information on the Affordable Care Act and the anticipated significant changes to the US behavioral health system. NCPG will spearhead efforts at the Federal and state levels to ensure that gambling disorder is not excluded from coverage.

JOIN NCPG

All system change starts at the individual level. Our role is to harness the power of these single voices into a national chorus. By joining NCPG you will become part of a movement stretching back more than 40 years. We serve as the national advocate for the problem gambling field, and from our office in Washington, D.C. we will be active on Capitol Hill and with Federal agencies to pursue many of the national-level recommendations above. Our model includes both top-down and bottom-up advocacy. Members will receive national legislative alerts, advocacy tools and policy materials like this brief. You will be asked to write letters, sign petitions, contact your Congressional representatives, share your story and maybe even testify. Our State affiliate chapters provide the grassroots foundation essential for any sustainable campaign. They will also address state-specific issues, which is where many of the decisions about coverage and access will be made. Affiliates will help rally support in their state for our national initiatives. More information on membership at: www.ncpgambling.org/joinnow

ADDITIONAL RECOMMENDATIONS

Review your own insurance policy and ask your employers HR or EAP coordinator if it covers gambling addiction? If gambling addiction is excluded or not mentioned, ask for it to be included using the information in this brief and though NCPG.

If you are a treatment provider or the affected individual, submit a request for reimbursement for a diagnosis of gambling disorder. We know that a significant percentage of individuals in treatment for gambling problems report having insurance but not using it. Some tried to use their insurance but were denied. Others did not use their insurance as they were concerned that this information would be used against them. One of the best ways to overcome stigma and shame, stop discrimination and receive equal treatment is to stand up.

If you are a treatment provider, problem gambler or family member who is denied coverage, speak out. Help us document these denials and the justification offered for them.

Join other healthcare, recovery and parity advocacy coalitions, and make sure they include gambling addiction. We strongly support the Recovery Oriented Systems of Care (ROSC) movement and model and believe that individuals in recovery from gambling addiction can lead a better life in a supportive community.

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The National Council on Problem Gambling has been the leader in the field of national advocacy for programs and services to assist problem gamblers and their communities since 1972.

VISION

to improve health and wellness by reducing the personal, social and economic costs of problem gambling.

MISSION

to lead state and national stakeholders in the development of comprehensive policies and programs related to problem gambling.

PURPOSE

to advocate for programs and services to assist problem gamblers and their families.

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