appearance of persuasive data regarding important safety issues. Gatifloxacin was first marketed in 1999. Reports of dysglycemic effects appeared soon after the drug's approval, and Health Canada (the Canadian FDA) published a report about the drug in 2003. Is six years too long to wait for a high-quality, controlled epidemiologic study quantifying such important drug-related risks? The experience with gatifloxacin underscores the need for a comprehensive plan to respond appropriately and expeditiously to signals indicating potential drug-safety problems in order to reduce unnecessary complications and deaths.10

Gatifloxacin now takes its place among an ever-growing list of medications that have been associated with very serious adverse effects. The most immediate question is what should be done with gatifloxacin. It seems clear that the drug's place among broad-spectrum antibiotics available for outpatient use is tenuous at best. For every approved indication for gatifloxacin, there are safer, equally effective, and less costly alternatives. In comparison with other recent experiences regarding adverse drug effects, this choice should not be a difficult one for physicians, patients, regulators, and manufacturers.

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Better Behavioral Health Care Coverage for Everyone
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People with private health insurance who seek care for mental health conditions generally face higher coinsurance and more limits to coverage — including limits on the numbers of outpatient visits and inpatient days — than do those who require care for other health conditions. These restrictions reduce the use of mental health services and force persons who have severe mental health problems to bear crushing financial costs for necessary treatment.1

Existing insurance limitations reflect previous experience. Efforts to extend parity coverage — equality of benefits — to federal employees in the 1960s failed as the use of services soared and persons with chronic mental health needs were much more likely than the average person to select plans with more generous coverage. The RAND Health Insurance Experiment, conducted in the late 1970s, corroborated this pattern, documenting the fact that responsiveness to reductions in copayments for mental health was double that for general health services.3

The article by Goldman et al. in this issue of the Journal4 provides the first controlled study of parity in insurance for mental health in two decades. The compelling evidence presented suggests that in today’s environment, parity in health insurance coverage is both economically feasible and socially desirable.

The rise of managed behavioral health care organizations, which control costs through non-financial mechanisms, had led policymakers and advocates to revisit the question of parity. A series of case studies of experiments involving par-
ity have shown much smaller increases in parity-associated costs than expected. The study by Goldman et al. improves on these case studies in several respects. Most important, the investigators carefully matched the plans of the Federal Employees Health Benefits (FEHB) Program with a set of comparison plans outside the FEHB Program that did not involve this mandate about parity. The most striking findings in this study come from the contrast — or lack of contrast — between the experiences of persons covered under the FEHB Program plan and those covered under the comparison plans.

As previous studies had predicted, Goldman et al. found systematic increases in the proportion of the population using mental health services in the wake of the reductions in cost sharing required by parity. However, this increase in the use of services mirrored that of the control-group plans. This finding suggests that the use of mental health services is no longer exceptionally responsive to price. The contrast with older studies reflects the sea changes that have occurred in the delivery of mental health services over the past two decades. Baseline rates of use of mental health services are much higher today than in the past, and many more of these services are delivered in primary care settings, which were included in this study but were not affected by requirements for parity. Even without parity, many persons who need mental health services or medications are able to obtain them at low out-of-pocket costs through their primary care providers.

Changes in the practice of mental health care, which in part have been a response to managed care, appear to have altered the effects of cost sharing. In contrast to the situation two decades ago, when long-term psychotherapy was popular, a plurality of mental health providers today use psychotherapeutic strategies that are inherently time-limited. Similarly, providers today rarely use the inpatient setting as part of a long-term treatment plan. In today's environment, decreased cost sharing did not lead to large increases in the use of services. Moreover, the constrained rise in the use of services does not appear to stem from efforts to control the costs of caring for the most severely ill members of the population, as some analysts had feared. The government evaluation of parity in the FEHB Program, from which Goldman and colleagues derived their data, shows no evidence of reductions in the use of inpatient hospital services or stays after the introduction of parity.

Although parity did not lead to increases in the use of services relative to a comparison group, it did lead to systematic reductions in out-of-pocket spending for mental health services. Parity coverage performed just as insurance coverage should. It shifted costs from out-of-pocket payments to the insurance company (and eventually to very small increases in insurance premiums) without leading to an increase in the use of services. This shift means that, in today's mental health environment, parity coverage unambiguously improves the value of health insurance. It moves risk away from individual patients without changing the incentives that they face.

The results of this study ought to pave the way toward broader acceptance of parity on the part of employers, insurers, and legislators. Parity improves the well-being of insured people by reducing their financial risk, and it does not distort the market for mental health services. Insurance for mental health care should enter the mainstream of coverage. Legislation is the way to achieve this, because if parity coverage were offered independently through only a single plan, that plan would probably attract a disproportionate share of people with chronic mental illness.

At the same time, putting coverage for mental health care on a par with that for other conditions is far from enough to ensure that health insurance will work in the best interests of persons with mental health problems. Parity does not guarantee that the unique forms and settings of care that have been shown to benefit persons with mental illness will be covered by insurance. Assertive community-treatment teams, supportive employers, and other exceptional evidence-based services that do not have parallels in the context of general health care will not be facilitated by parity. Advocates for improved mental health care need to move beyond the question of parity to encourage the formulation of benefit packages that will provide better, more efficient care, not just equal coverage.

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