incorporated in solutions remain poorly understood. What is clear is the need for action based on both careful thinking and painstaking science.

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In Reply: Everyone agrees that potentially violent individuals should not have ready access to firearms. But who is potentially violent? Dr Howsepiann and Drs Swanson and Gilbert concur that predictions of violence among persons with mental illness are fraught with difficulty, pointing to recent evidence that some serious mental disorders may predispose even sober individuals to violence. Howsepiann goes further to note that individuals who are left untreated are at greatest risk. We agree. Yet firearm restrictions do not differentiate between diagnoses and are not applicable to individuals prior to adjudication or involuntary commitment. In other words, the law does not reach the untreated mentally ill, regardless of severity of disease.

Does sensible gun control necessitate diluting the civil liberties of persons with mental illness? Howsepiann implies that one cannot advocate for both. We disagree. It is vital for society to respect the rights of vulnerable individuals while still enacting strong firearms laws. Statutes that perpetuate the ostracism of persons with mental illness are fundamentally unacceptable; all individuals, regardless of their medical diagnoses, share the same rights to dignity, privacy, and nondiscrimination. Effectiveness aside, firearm restrictions based on mental illness must afford all individuals these rights, requiring health care professionals, firearms sellers, and law enforcement to avoid unwarranted disclosure of sensitive medical information.

Can government regulate guns, not people, as Swanson and Gilbert suggest? Universally applicable firearm regulations are both ethical and efficacious, but removing dangerous arms from the civilian market is not an option. The Supreme Court has made clear that the Second Amendment protects a robust individual right to bear arms, absent adjudication or involuntary commitment. This right does not extend to unusual weapons (eg, hand grenades, automatic firearms, sawed-off shotguns) but it does encompass arms that kill; self-defense is the cornerstone of this protected right.1 Conditions and qualifications on sales (eg, waiting periods, background checks) and limits on possession (eg, at schools or government buildings, of concealed weapons) are not sufficient to keep handguns out of the hands of dangerous civilians.1 Regulating based on mental illness is not ideal but is currently a reality.

Restricting access to dangerous firearms based on predictions of dangerousness will always prove inaccurate and less effective than restricting dangerous arms themselves. One of the greatest challenges in law is closing the chasm between its intent and practical effect. A system of scattered background checks and waiting periods has prevented some deaths, but gun violence in the United States remains a leading cause of avoidable death,2 which need not be the case. Strengthening the law to better protect the public’s health while also upholding the civil liberties of persons with mental illness is a critically important, albeit complicated, task.

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US Medical Students’ Health Insurance Coverage for Mental Health and Substance Abuse Treatment

To the Editor: Medical students experience high levels of distress, including burnout, depression, and suicidal ideation.1,2 They use alcohol and tranquilizers at rates comparable with those of their peers.3 This distress has serious consequences, negatively affecting student empathy and altruism and contributing to postgraduate medical error.3,4 However, few students seek help. Limited data suggest cost is one reason students avoid seeking care.4 As no previous study has documented health insurance coverage offered to US medical students by their schools for mental health treatment (MHT) and substance abuse treatment (SAT), we set out to determine coverage standards.

Methods. Between June and December 2010, data on health insurance offered by all US medical schools were obtained from each school’s Web site, sending a questionnaire to the dean of students for schools without insurance information online. For schools with more than 1 plan available, we recorded data from the least expensive plan.

For each plan, we recorded the following for both inpatient and outpatient MHT and SAT: annual maximum...
dollar limit; annual maximum visit limit; co-payment amounts; and coinsurance (defined as the percentage of total costs paid by the patient). If maximum visit or dollar limits were not specified, we assumed no limit. When maximum dollar limits were specified only for all medical care, we used that value to represent the maximum limits for MHT and SAT.

The Cambridge Health Alliance institutional review board approved the study.

**Results.** Health insurance benefit data were obtained for 115 of the 129 medical schools in the United States (89%), exclusive of Puerto Rico. All schools provided some coverage for outpatient MHT, but 6 schools offered no coverage for inpatient MHT, SAT, or either.

**Table 1** shows the annual dollar and visit limits of medical student health insurance plans. A minority of schools provided unlimited coverage: 43 schools (37.4%) for outpatient MHT, 32 schools (28.6%) for outpatient SAT, 48 schools (43.2%) for inpatient MHT, and 40 schools (36.4%) for inpatient SAT. Annual dollar limits varied widely, with a range of $1000-$200 000 for outpatient MHT, $800-$200 000 for outpatient SAT, and $1000-$2 000 000 for inpatient MHT and inpatient SAT.

**Table 2** shows the cost sharing required from students. Few schools provided complete coverage without cost sharing (ie, no co-payments or coinsurance): 13 schools (11.3%) for outpatient MHT, 17 schools (15.2%) for outpatient SAT, 22 schools (19.8%) for inpatient MHT, and 23 schools (21.1%) for inpatient SAT. Median co-payments were $20 for the 36 schools (31.3%) requiring co-payments for outpatient MHT, $25 for the 26 schools (23.2%) requiring co-payments for outpatient SAT, and $500 for the 11 schools (9.9%) and 10 schools (9.2%) requiring co-payments for inpatient MHT and inpatient SAT, respectively. Median coinsurance was 20% for all services and was required by 46 schools (40%) for outpatient MHT, 50 schools (44.6%) for outpatient SAT, 70 schools (63.1%) for inpatient MHT, and 68 schools (61.5%) for inpatient SAT.

**Comment.** Visit and dollar limits, as well as cost sharing, are common features of medical student insurance coverage for MHT and SAT. Only around a third of schools provide unlimited dollar and visit benefits. Although plans vary widely, the maximum dollar benefits can be very low. Fewer than 22% of schools provide first-dollar coverage without cost sharing. This is worrisome because of
evidence that cost sharing discourages students from seeking both MHT and SAT. The study may have underestimated the MHT available to medical students, who may access care through student health centers or have more generous coverage through their schools or parents.

Coverage offered by US medical schools is unlikely to be worse than that available to the nonstudent population. Most private insurance plans have annual limits; for example, one study found that 90% of plans limit outpatient MHT and 93% limit outpatient SAT. This parity is not reassuring given the importance to the medical profession and patients of aggressively treating these disorders. Medical schools should consider improving student insurance coverage for mental health and substance use disorders.

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Author Contributions: Dr Nardin had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: Nardin, Day, Boyd.

Acquisition of data: Nardin, Frank.

Analysis and interpretation of data: Nardin, Zallman, Day, Boyd.

Drafting of the manuscript: Nardin, Frank, Boyd.

Critical revision of the manuscript for important intellectual content: Nardin, Zallman, Day, Boyd.

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Study supervision: Nardin, Day.

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5. Trivedi AN, Swaminathan S, Mor V. Insurance parity and the use of outpatient mental health care following a psychiatric hospitalization. JAMA. 2008;300(24):2879-2885.

CORRECTIONS

Error in Author Affiliation and in Text: In the Original Contribution entitled “Accuracy of Stated Energy Contents of Restaurant Foods,” published in the July 20, 2011, issue of JAMA (2011;306[3]:287-293), in the Author Affiliations, the second affiliation should be “Department of Nutrition and Science, Department of Psychological Sciences, and the Ingestive Behavior Research Center, Purdue University, West Lafayette, Indiana (Dr McCrory).” In the Comment section, second paragraph, the second sentence should be “However, the stated information of individual foods was variable and 19% of individually tested foods contained energy contents of at least 100 kcal/portion more than the stated energy contents, an amount that has been projected to cause 5 to 7 kg of weight gain per year if consumed daily.” This article was corrected for errors on April 8, 2011.

Incorrect Number and Percentage: In the Original Contribution entitled “Change in Prevalence of Chronic Conditions Between Childhood and Adolescence Among Extremely Low-Birth-Weight Children,” published in the July 27, 2011, issue of JAMA (2011;306[4]:394-401), in the Results section, the second sentence should read “Among the ELBW children, neonatal complications included bronchopulmonary dysplasia defined as oxygen dependence at 36 weeks corrected age in 74 children (41%) and a severely abnormal cerebral ultrasound in 44 children (24%).” This article was corrected for errors on August 5, 2011.

Omission of Name and Affiliation of a Source: In the Medical News & Perspectives article entitled “Traumatic Brain Injury a Growing Problem Among Troops Serving in Today’s Wars,” published in the August 3, 2011, issue of JAMA (2011;306[5]:477-479), in the next to last paragraph of the article, there was an omission of a name and affiliation of a source. The paragraph should read “It is likely that optimal treatment for TBI will involve tailoring various therapies to the needs of each patient at different stages after injury, said Jennifer Vasterling, PhD, chief of the VA Boston Healthcare System’s psychology service.” This article was corrected for errors on August 4, 2011.