When it comes to cholesterol management, managed care organizations (MCOs) really have no choice—people want their cholesterol managed. It is clear that the baby boomers are concerned about cholesterol and are doing everything they can to reduce their risk of heart disease. Currently, MCOs have 2 separate roles in the management of high cholesterol. First, they must make sure that high cholesterol is treated as cost-effectively as possible, which usually means using a formulary to steer patients toward the most cost-effective agents. Second, they must improve quality by detecting patients whose treatment is inadequate or who are not compliant and, ultimately, making sure their target levels are actually achieved. Achieving targets requires sustained treatment over time. This is different from MCOs trying to eliminate unnecessary medical care like unnecessary MRIs of the back. Rather, they are trying to improve care that patients want and that is supported by evidence.

There's no question that cholesterol management is cost-effective, meaning that MCOs are paying less than $50,000 for every year of life saved. As such, the "bang for the buck" is very competitive compared with other efforts in health care, particularly when patients with known coronary artery disease or other conditions due to atherosclerosis are targeted. On the other hand, one may not be able to argue with confidence that MCOs are actually saving money by spending money on cholesterol treatment, except in the highest-risk patients.

Of all the cardiac risk factors, high cholesterol is the easiest to treat. It is not like giving up smoking, losing weight, controlling diabetes, or even controlling blood pressure, which can be difficult to do without having side effects. Most patients have no side effects from statins. Patients generally take a pill, sometimes the dose must be increased, and then they and their doctor get to declare victory. However, 6 months after victory is declared, patients forget to fill prescriptions. Up to 50% of older patients stop taking their medication 6 months to a year after lowering their cholesterol. Identifying persons who have stopped taking their medication by sifting through pharmacy claims is one way MCOs can improve compliance.

The HEDIS measure for evaluating MCO performance in secondary prevention of coronary disease uses chart review to profile the MCO on the percentage of patients whose low-density lipoprotein (LDL) cholesterol level is under 130 mg/dL. There is currently a proposal to reduce that level to 100 mg/dL, which is the target proposed in the National Institutes of Health guidelines. As chair of the National Committee for Quality Assurance (NCQA) Cardiovascular Measurement Advisory Panel, I supported lowering the target, and I think there is an excellent chance that it will be lowered.

Beyond a lower target, however, it is possible that within a few years measurement of MCO performance will involve claims review to identify patients with diabetes or other syndromes associated with atherosclerosis and coronary disease. The measure will simply be the percentage of these high-risk patients who are on a statin. This strategy is based on good research showing that cholesterol is only one factor affected by statins and that vascular inflammation is just as important. Achieving the cholesterol goal itself does not tell the whole story, and patients with high-risk conditions may benefit just by being on a statin. The Heart Protection Study published in the *Lancet* last July showed that people benefited from a statin if they had certain conditions, like diabetes, regardless of their LDL levels. This kind of measure might be more actionable for MCOs because they can search claims, find patients in the denominator, and then determine which are not on a statin and send alerts to their doctors, the way they let me know when I haven't done a mammogram on a patient.

On the other hand, the NCQA is far along in the development of a program that will recognize doctors as being excellent in heart disease/stroke prevention if chart review shows that they are hitting certain performance targets. One of the most important targets will be actual control of LDL cholesterol levels—the percentage of patients treated who are below 100 mg/dL. So I think we're going to see the control targets moving from being a health plan accountability issue to being a doctor accountability issue.

An important question for the future is, who should be on cholesterol-lowering therapy? This issue will be thoroughly explored in the next several years, and it could well be that three quarters of the population might benefit from statins, as preposterous as that might sound at first. If this proves to be true, it will be important for there to be more competitive pricing on generic statin preparations. Right now there is only one generic statin, and with no competition its price is really quite high. I'm hoping that in the future statins will become much less expensive.

Finally, I think that a global approach to coronary risk factor management is the right approach because there is clustering of risk factors. Obesity is often the common link, as it leads to hypertension, diabetes, and high cholesterol. Focusing on cholesterol does some good but not nearly as much as trying to address some of the root factors. I will not be surprised if some MCOs start to take on the tough issue of obesity over the next 5 to 10 years.

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