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Attorney General Pam Bondi
Office of Attorney General
State of Florida
The Capitol PL-01
Tallahassee, FL 32399-1050

Re: Pending Merger of Aetna with Humana

Dear Attorney General Bondi:

On behalf of the American Medical Association (AMA), Florida Medical Association (FMA) and the Florida Osteopathic Medical Association (FOMA), and our respective physician and student members, we are writing to express our thoughts and serious concerns regarding the Florida Office of Insurance Regulation (OIR) Report and Consent Order issued in its review and approval, subject to certain remedies, of the Aetna/Humana merger. We think that the OIR's findings on market concentration and increases in concentration caused by the merger are largely helpful and can inform your own investigation, although the OIR erred in finding that Medicare Advantage (MA) is not a relevant product market. Unfortunately, in shaping its remedies, the OIR erroneously deferred to the role of regulation in health insurance as a substitute for lost competition. Accordingly, we respectfully request that your office protect competition by blocking the merger.

The OIR determined "that the majority of geographic and product markets affected by the proposed acquisition would be characterized as either moderately or highly concentrated before consideration of the proposed acquisition."[1] It also found that in numerous markets, the merger would increase market concentrations by amounts that under the 2010 Federal Trade Commission and U.S. Department of Justice (DOJ) Horizontal Merger Guidelines (Horizontal Merger Guidelines) would be either presumed likely to enhance market power or potentially raise significant competitive concerns, particularly in more populous regions.

However, the OIR refused to block the merger, substituting an inadequate conduct remedy that it deemed "necessary" to ameliorate the increases in market concentration.[2] Merely a weak remedy was required, the OIR reasoned, because of the role of state and federal regulation in health insurance. Specifically, Medical Loss Ratio (MLR) requirements "effectively limit" the ability of the merged insurer to exercise market power."[3] Similarly, the OIR found that state and federal staffing requirements for both HMOs and

[1] The OIR of Insurance Regulation, Report on the Review of Aetna Inc.'s Acquisition of Humana and Affiliates (February 12, 2016) at 3. (Report) (Exhibit 1)
[2] The OIR of Insurance Regulation Consent Order in the matter of the Indirect Acquisition of Human Health Insurance Company of Florida, et al. by Aetna Inc. (February 15, 2016) at 8. (Consent Order) (Exhibit 2)
[3] Report at 20.

exclusive provider organizations as well as network adequacy requirements limit the merged entity's ability to exercise monopsony power in the purchase of physician services.[4] Finally, the OIR erroneously concluded that MA is not a relevant product market because the federal government's traditional Medicare (TM) program is in "direct competition" with MA.[5] Moreover, "regulatory changes to Medicare…are likely to create additional competition in the near future."[6]

None of the regulations or role of the federal government in Medicare cited by the OIR mitigate concerns over the anticompetitive consequences of the merger in health insurance and physician markets and the resulting harm to consumers. Fortunately, the order recites that any approval granted by the order cannot be acted upon until the U.S. Department of Justice and Florida Office of the Attorney General conclude their independent investigations of the proposed transaction under the standards applicable to their respective reviews.[7]

THE OIR FINDINGS CORROBORATE AMA-FMA-FOMA's OBSERVATIONS OF THE MERGER'S SUBSTANTIAL ANTICOMPETITIVE EFFECTS

The OIR's analysis of the competitive effects of the proposed Aetna/Humana merger within Florida metropolitan statistical areas (MSAs) agrees with AMA-FMA-FOMA public comments: that the merger would be presumed likely, under the Horizontal Merger Guidelines, to enhance market power in commercial health insurance within numerous metropolitan statistical areas.[8] Also, to use the language of the OIR, the "impact generally is more noticeable in the more populous regions."[9] For example, in Miami-Fort Lauderdale-Pompano Beach and in Tampa-St. Petersburg-Clearwater, each and every segment of the commercial market - small group, medium group, large group, and individual - as shown in OIR's Table 4[10] are highly concentrated. Moreover, the increase in concentration caused by the merger as also shown in OIR's Table 4 exceeds the threshold of "presumed likely to enhance market power" under the Horizontal Merger Guidelines.[11]

Commercial Markets

In OIR's own words, here is a summary of the findings:

- For the small group market, "19 out of the 20 defined MSAs are characterized as highly concentrated prior to the merger. Following the proposed merger, based on the data, the calculations show all 20 defined MSAs as highly concentrated."[12]

[4] Id at 20.
[5] Report at 15.
[6] Report at 19.
[7] Report at 13.
[8] Statement of the American Medical Association, Florida Medical Association Inc. and the Florida Osteopathic Medical Association to the Office of Insurance Regulation, Florida Department of Financial Services regarding Aetna Application for the Proposed Acquisition of Humana (December 17, 2015) (AMA-FMA-FOMA Statement) (Exhibit 3) pp. 3-7 with Report at 14-15, including Table 4.
[9] Report at page 3.
[10] Table 4, Report at 14.
[11] Id.
[12] Report at 14.

- "For the medium group market, all 20 defined MSAs are measured as highly concentrated before the proposed merger, and remain so afterward with no substantial increases in concentration beyond what was already evident." In making this statement, the OIR overlooks the increase of more than 200 points in the post-merger Herfendahl-Hischman Index (HHI) of market concentration occurring in Miami-Fort Lauderdale-Pompano Beach and in Tampa-St. Petersburg-Clearwater reported in its Table 4 and that renders the merger presumed likely to enhance market power in those markets under the Horizontal Merger Guidelines.[13]

- "For the large group market, 17 of the 20 defined MSAs were measured as highly concentrated prior to the merger. Following the proposed merger, the analysis indicates 19 MSAs are highly concentrated, with substantial increases in concentration in the Tampa-St. Petersburg-Clearwater and Miami-Fort Lauderdale-Pompano Beach MSAs."[14]

- "In the individual market, every MSA had a measured HHI that would be considered highly concentrated [meaning HHI more than 2500], though the range varied from 2645 in the Miami-Fort Lauderdale-Pompano Beach MSA to 9119 in the Panama City-Lynnhaven-Panama City Beach MSA. When calculated on a post-merger basis, the most significant increases in market concentration were found in the Palm Bay-Melbourne-Titusville, Lakeland-Winter Haven, and Miami-Fort Lauderdale-Pompano Beach MSAs."[15]

<u>Market Shares Have Been Durable Over Time</u>

While the OIR acknowledges that "more weight is given to market concentration analysis when market shares have been stable over time."[16] OIR omits applying this consideration to its analysis. The AMA has studied this important issue. The AMA's analysis shows that in the numerous large MSAs where the merger would be anticompetitive in commercial markets, the market shares, ranking of market leaders, and number of competitors, have been durable and little changed from 2010 through 2013, the most recent timeframe for which the AMA has data.[17]

Medicare Advantage

The competitive ramifications of the Aetna/Humana merger within MA markets appear to be even more troubling than in the commercial health insurance markets studied by AMA and OIR.[18] Within MA MSA markets, the OIR finds HHIs in five MSAs to be moderately concentrated, *and the remainder were in the highly concentrated range*. Moreover, "when the post-merger HHIs were calculated, only one MSA

[13] Report at 15.
[14] Id.
[15] Id.
[16] Id at 6.
[17] AMA-FMA-FOMA Statement at 8.
[18] In a statewide private MA market, the OIR reports "the moderately competitive market observed prior to the proposed merger, moved slightly into the highly concentrated range and the combined Aetna/Humana entity has a market share of 45.6%."

continued to be considered moderately concentrated. The remaining four that were previously moderately concentrated migrated into the highly concentrated range, in most cases substantially so."[19]

Faced with this structural damage to competition in MA, the OIR devotes many pages to its conclusion that MA competes directly with TM. Once TM and MA are seen to be in one Medicare market, the OIR argues, "the impact of the proposed acquisition affects the highly concentrated Medicare market by only a minimal amount."[20]

While the damage to the commercial market provides an ample reason for blocking the merger, we now turn to a discussion of why MA and TM are not in the same product market such that the competitive harm shown to be occurring in the MA market is yet one more reason for blocking the merger.

Medicare Advantage Is A Relevant Product Market

The OIR erroneously accepted Aetna's argument that MA is not a relevant product market because MA consumers have the option of switching between MA and TM operated by the government. In OIR's view, there is a larger relevant market composed of MA and TM wherein Aetna faces the government as a competitor.

Aetna and the OIR have mischaracterized the federal government's role. The federal government is not an Aetna competitor attempting to compete for Medicare business. Instead the government is a purchaser procuring competitive bids from private health insurers competing to offer MA plans to Medicare beneficiaries.[21] Congress's goal in establishing the MA program was "that vigorous competition among private MA insurers…would lead those insurers to offer seniors a wider array of health insurance choices and richer and more affordable benefits than TM does, and be more responsive to seniors."[22] In the event Aetna were to acquire Humana, and competition for the government contract and MA beneficiaries were lessened, the government would actually be harmed, not advantaged, as would be the case if it were a competitor, by the higher prices and/or poorer service offered by a combined Aetna/Humana in MA.[23] Accordingly, once the government is understood as a purchaser, there is a relevant MA market in which the proposed acquisition clearly lessens competition substantially.

If for the sake of argument the government could plausibly be characterized as a competitor to health insurers offering MA, then whether in a given case the government's TM and the private insurer's MA plans are separate products would require a demand substitutability test, a well-established way of

[19] Report at 15.
[20] Consent Order at ¶ 19
[21] For an explanation of the competitive bidding process See Song, Landrum and Chernew, "Competitive Bidding and Medicare Advantage: Effect of Benchmark Changes Unplanned Bids", Journal of Health Economics 32 (2013) 1301-1312. http://www.ncbi.nlm.nih.gov/pubmed/24308881
[22] See, United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download)
[23] A Center for American Progress Study has concluded that Medicare program spending would increase as a result of the merger. Spiro, Calsyn, O'Toole, "Bigger is not Better: Proposed Insurer Mergers are Likely to Harm Consumers and Taxpayers," Center for American Progress (Jan. 21, 2016)

determining whether markets are separate.[24] The test asks whether customers have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of the product.

When applying the demand substitutability test to MA in merger cases, the DOJ has concluded that seniors are not likely to switch away from MA plans to TM in sufficient numbers to make an anticompetitive price increase or reduction in quality unprofitable to a MA insurer.[25] In consent decrees that the DOJ has entered into with Humana and Arcadian Management and with UnitedHealth Group and Sierra Health Services (Consent Decrees) rightly observe that TM is not an adequate substitute for MA because MA plans offer substantially richer benefits at lower costs than TM,[26] including lower copayments, lower coinsurance, caps on total yearly out-of-pocket costs, prescription drug coverage, and supplemental benefits that TM does not cover, such as dental and vision coverage, and health club memberships. Even the OIR concedes that MA offers a superior "value proposition."[27] Moreover, in MA plans, seniors can receive a single plan covering a variety of benefits that seniors in TM must assemble themselves. The combination of richer benefits and one stop shopping accounts for the strong preference by many seniors for MA plans. Consequently, the closest competition to one MA insurer's plan is another insurer's MA plan and the presence of many competing MA insurers is what keeps quality and price competitive. This conclusion is buttressed by a recent study finding that when Humana offers a Medicare Advantage plan in the same county as Aetna, Aetna's premium is lower than in counties where Humana does not offer a plan.[28]

The OIR neither distinguishes the DOJ consent decree findings that MA is a separate product market nor cites any case law or scholarship concluding that MA is not a product market. Instead, the OIR references a study finding that annually "approximately 5% switch into MA from TM."[29] Ironically rather than support the contention that MA and TM patients have an ability and willingness to substitute away from one product to another in response to a small but significant and non-transitory increase in the quality adjusted price of the product, the cited study's authors refer to an "MA market" and conclude that the observed 5% switching number is troublesomely low.[30]

The OIR cites data supplied by Thomas McCarthy, PhD, Aetna's expert at the hearing, indicating that annually 21% -25 % of persons terminating Aetna or Humana's MA turn to TM.[31] If accurate, this Aetna/Humana reported rate of switching from MA to TM is many times the national rate reported in a

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[24] See Horizontal Merger Guidelines, Section 4.
[25] United States v. Humana and Arcadian Management, No. 12-cv-00464 (D.D.C. Mar. 27, 2012) (complaint ¶¶ 20-21) (*avail. at* http://www.justice.gov/atr/case-document/file/499076/download); United States v. UnitedHealth Grp. Inc. & Sierra Health Servs., Inc., No. 08-cv-00322 (D.D.C. Feb. 25, 2008) (complaint ¶¶ 15-18) (*avail. at* http://www.justice.gov/atr/case-document/file/514126/download). Paragraph 2
[26] Id.
[27] Consent Order at paragraph 20(c).
[28] Spiro et al, supra n. 23
[29] Report at 18, citing Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259
[30] Sinaiko, Afendulis, & Frank, Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?, 50 Inquiry 202 (2013), available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4108259
[31] Report at 18.

recent peer reviewed article.[32] The authors of that article found that nationally between 2006 and 2011 on average annually "[f]ewer than 5% of TM beneficiaries switched to MA and a similar percentage of MA enrollees switch to TM. These results suggest that initial coverage decisions have long-lasting effects."[33]

We do not know from Dr. McCarthy's testimony why patients left the Aetna/Humana MA offerings and turned to TM at a rate roughly five times the national average. At the extreme, the patients leaving Aetna and opting for TM may have been forced to turn to TM by for example, Aetna's terminating service. Moreover, Dr. McCarthy does not explain why the overwhelming portion of Aetna's MA enrollees, apparently stay with MA. One explanation is that TM is not an adequate substitute for MA, absent extreme circumstances that may account for those who switch from Aetna/Humana to TM.

The OIR advances a final speculative argument under the heading of "The future of Medicare." It claims that there will be future regulatory changes that will narrow the differences between MA and TM that will "likely" "create additional competition" between them "in the near future."[34] Predicting the future of Medicare should never be the basis of approving a merger. In any event, the government's interest will continue to be that of a consumer on behalf of Medicare beneficiaries promoting choice and innovation through a MA program that, as compared with TM, offers lower costs and richer benefits as a trade-off for a more limited healthcare provider network than TM.[35] Consequently, MA is, and will likely remain into the foreseeable future, a product market that is separate and distinct from TM.

THE OIR RELIES ENTIRELY ON WHOLLY INADEQUATE FORMS OF ADMINISTRATIVE REGULATION FOR PROTECTING THE QUALITY AND QUANTITY OF PHYSICIAN SERVICES

The AMA-FMA-FOMA advised the OIR that consumers do best when there is a competitive market for purchasing physician services.[36] The AMA-FMA-FOMA also asked that the OIR not approve Aetna's acquisition of Humana because it would eviscerate physician ability to contract with alternative insurers in the face of unfavorable contract terms and would:[37]

- Result in weaker provider networks for consumers, reducing patient access to physicians and effectively curtailing their services;

- Hinder physician ability to invest in new equipment, technology, training, staff and other practice infrastructure that could improve access to, and quality of, patient care—investment critical for enabling physicians to successfully transition into new value-based payment and delivery models;

- Force physicians to spend less time with patients to meet practice expenses;

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[32] Gretchen A. Jacobson, Patricia Neuman, Anthony Damico, "At Least Half Of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006–11," 34 *Health Affairs* (Millwood) 48, 51 (Jan. 2015), *available at*: http://content.healthaffairs.org/content/34/1/48.full.pdf;
[33] Id at 1.
[34] Consent Order paragraph 20(d).
[35] See paragraph 17 of Consent Order in *United States v. Humana and Arcadian Management Services*. *Supra.*
[36] AMA Statement at 14.
[37] Id at 14-16.

- Pressure physicians not to engage in aggressive patient advocacy, a crucial safeguard of patient care; and

- Motivate physicians to retire early or seek opportunities outside of medicine that are more rewarding, financially or otherwise.

All of the above anticompetitive effects in Florida physician markets were identified as likely to occur by very large percentages of Florida physicians responding to a 2016 FMA survey:[38]

- 85% of respondents believed that the Aetna/Humana merger would be very or somewhat likely to lead to narrower physician networks which will in turn reduce patient access to care, with 73% reporting that they will be very or somewhat likely pressured not to engage in aggressive patient advocacy as a result of the mergers;

- 90% of respondents believed that the Aetna/Humana merger would be very or somewhat likely to decrease reimbursement rates for physicians such that there would be a reduction in the quality and quantity of the services that physicians are able to offer their patients; and

- If Aetna and Humana merged and the reporting physicians did not continue to have a contract with the merged health plan, the following consequences were reported:

    - 9% of responding physicians would retire from active practice;
    - 9% would need to close their practice;
    - 5% would move their practice to a more competitive reimbursement market;
    - 27% would cut investments in practice infrastructure;
    - 34% would cut or reduce staff salaries;
    - 27% would have to spend less time with patients; and
    - 18% would cut quality initiatives or patient services.

The OIR acknowledged the presence of monopsony power acquired in the merger while at the same time erroneously speculating that regulation supplies a cure, albeit partial: "[n]etwork adequacy requirements limit, to some extent, the ability to exercise monopsony power, independent of concentration."[39] Moreover, the OIR found that "monopsony power is limited by state and federal laws requiring health maintenance organizations and exclusive provider organizations to have a minimum number of healthcare providers and facilities available in a specific market."[40] The OIR does not, and cannot, explain how provider staffing regulations imposed on exclusive provider organizations and HMOs would cure the anticompetitive effects of physicians retiring from practice, cutting staff or spending less time with patients to meet practice expenses, and other harms to the physician market. Provider organizations are victims, not the solution, to this monopsony injury that would be caused by the merger.

[38] This survey was administered to members of the Florida Medical Association. In total, 126 physicians completed the survey, although specific questions only polled a subset of physicians depending on whether they were decision makers in the practice.
[39] Report at 3. See also Report at 20.
[40] Report at 20.

Similarly, network adequacy requirements/standards are no panacea for the weaker provider networks likely to result from the merger. Generally speaking, the standards focus simply on vague notions of whether "enough" providers and facilities are included in the network. They address "adequacy" as a floor and not as prescription for optimal physician availability. Moreover, Florida's network adequacy requirements lack objective measurements of network adequacy and do not address the issue of providers changing their minds on whether to accept new patients, common limitations in network adequacy regulation.[41] Indeed, the standards are wholly inadequate even for the task of providing a floor protecting consumers. Thirty-seven percent of respondents to the Florida Medical Association survey said they had difficulty finding available in-network physicians who accepted new patients for referrals with Aetna and Humana; while 59% encountered formulary limitations which prevented a patient's optimal treatment.

Also in Florida, as elsewhere, the state regulations do not address whether in-network providers are high-quality.[42] Consequently, the regulations allow health plans to cherry pick physicians based on costs (not quality) in order to have the lowest cost patients. Therefore, rather than increasingly relying on network adequacy requirements, regulators need to foster health insurer competition promising broader high quality networks responsive to patients' access needs.

Importantly, network standards cannot cure the fundamental problem requiring that the merger be blocked – that health insurer monopsonists typically are also monopolists. Facing little if any competition in the market for health plans, the merged entity would lack the incentive to refrain from imposing upon physicians take it or leave it contracts resulting in anticompetitive reimbursement levels that hinder physician investment in practice infrastructure, force them to spend less time with patients to meet practice expenses or motivate them to leave the physician workplace. No amount of speculation about the future coverage of network adequacy requirements[43] – a program not even intended to address the most profound monopsony injuries to the physician marketplace – can justify the merger.

MEDICAL LOSS RATIO

The OIR relies on the notion that Florida and federal MLR requirements compensate for competition lost as a result of the merger. While we and others have exhaustively explained MLR's myriad of limitations in protecting consumers from anticompetitive premium increases,[44] the OIR offers no counterargument. Instead it simply declares:

> [f]or several decades Florida law, and more recently federal laws, have included MLR requirements. For the markets considered in this report, the MLRs range from 80% to 85%.

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[41] See Network Adequacy and Exchanges, The National Committee for Quality Assurance, (2013)
[42] Id.
[43] See Report at page 20
[44] James L. Madara, MD, Executive Vice President, American Medical Association letter to the Hon. William Baer, Assistant Attorney General, United States Department of Justice, Antitrust Division, (November 11, 2015) at page 12 (Exhibit 4), Melinda Hatton, Senior Vice President and General Counsel, American Hospital Association letter to Ted Nichel, Wisconsin Insurance Commissioner and Katherine Wade, Connecticut Insurance Commissioner (February 23, 2016) (Exhibit 5); Leemore Dafny, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?", Testimony before the Senate Committee on the Judiciary, (September 22, 2015) (Exhibit6), at 10.

> These requirements guarantee that consumers will receive eighty to eighty-five cents in healthcare services for every dollar of premium paid and they effectively limit any entity's ability to exercise market power, independent of concentration.[45]

In relying on MLR to protect consumers from an exercise of market power, the OIR stays true to its theme running through its entire analysis of this merger – that regulations, intended as a floor on the value of health insurance products, can substitute for competition.

In the case of the Affordable Care Act's MLR standard, even if a majority of privately-insured enrollees were affected by the MLR (which they are not),[46] and it addressed the level of premium increases (and not solely the percentage used for claims and quality activities), there is no basis for the OIR to assume that the floors are higher than what a competitive market would supply. Industry aggregate MLR generally have exceeded the required percentages.[47] Also, Medicare administrative expenses for 2014 were merely 1.4% of total expenditures, suggesting that the MLR value floor should not be aspirational and should not be treated as displacing competition.

Finally, MLR requirements do not address non-price dimensions of health insurer competition. Only competition will force insurers to enhance customer service, improve provider networks, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs.

ABSENCE OF EFFICIENCIES

The AMA-FMA-FOMA has previously explained that Aetna's merger efficiency claims are unsupported and speculative.[48] Tellingly, neither the OIR's Consent Order nor its Report even mention a single claimed efficiency as a justification for approving the merger. The only mention paid to Aetna's claimed efficiencies is within the remedy portion of the Consent Order reciting that the health insurers have "represented" that "certain efficiencies will be achieved as a result of the proposed transaction."[49] Without identifying the efficiencies, the Order merely requires the merged entity to annually submit for the first three years following the merger, documentation detailing the realization of estimated efficiencies.[50] The Order contains no benchmarks for measuring expected efficiencies, nor remedies for failure to obtain them. The vagueness and lack of enforcement teeth in the Order's "efficiencies" reporting requirement is a testament to how efficiencies played no real role in justifying the merger.

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[45] Report at 20.
[46] Dafny testimony, supra n.44 at 14 ("More than half of privately-insured enrollees are in self-insured plans, and the minimum MLR do not pertain to these plans.")
[47] http://inq.sagepub.com/content/50/1/9.full.pdf
[48] See AMA Statement to the Office of Insurance Regulation at 16-18.
[49] Consent Order at paragraph 25.
[50] Consent Order at paragraph 25.

REMEDY

The AMA-FMA-FOMA have advocated that the merger be blocked. The OIR's Consent Order, by contrast and as explained above, ineffectually requires the merged entity to report on unidentified efficiencies. It also requires Aetna to "develop a plan" to enter into Florida individual health insurance exchanges in five counties not currently covered. Nowhere does the Consent Order explain how Aetna/Humana entering into new markets would remedy the substantial lessening of competition in the numerous populous markets identified by AMA and the OIR's own study. Moreover, the agreement to enter these underserved markets is as a practical matter nonbinding and illusory. The merged entity only needs to enter if it finds the move practical and profitable, specifically that it can "secure a competitive position based upon adequate premium rates; enter into satisfactory contracts with a sufficient number of providers to meet network adequacy standards in each county reviewed; and other competitive factors some of which may be related to federal exchange policies."[51]

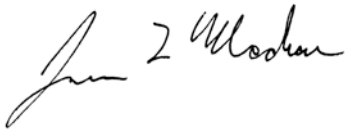
CONCLUSION

Apart from its erroneous finding that MA is not a relevant product market, the OIR should be commended for thoroughly investigating and determining the extensive anticompetitive market structural damage that would be caused by Aetna's proposed merger with Humana. The OIR also wisely rejected divestiture as a remedy too disruptive to existing physician-patient relationships.

However the OIR appears to have been captured by Aetna's faulty arguments that existing state and federal regulation - MLR and staffing requirements - mostly solve the competitive concerns and justify very limited remedies that are largely illusory. Both forms of regulation have only partial applications to the value and quality concerns raised by the merger. They also are designed as performance floors, and they are not intended to displace competition and the additional benefits that blocking this merger would achieve.

We, therefore, respectfully request that you block the merger to preserve competition and protect Florida patients and other consumers.

Sincerely,



James L. Madara, MD

cc: Florida Medical Association
Florida Osteopathic Medical Association

[51] Consent Order at paragraph 24(b)