RULING (Case Number 1/2007, IMQ)

Plenary

Mr. Juan Luis Crucelegui Gárate

Mr. Javier Berasategi Torices

In Vitoria-Gasteiz, on 20th February 2008

The Basque Competition Court, with the aforementioned composition and Spokesperson, **Mr. JAVIER BERASATEGI TORICES**, pronounced the following Ruling in Case Number 1/2007 lodged against IGUALATORIO MEDICO QUIRÚRGICO, S.A. DE SEGUROS Y REASEGUROS, for an alleged breach of Article 1 of the Competition Act 16/1989, in line with the adoption of anti-competitive agreements in the field of insurance and dental services.

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1 FINDINGS OF FACT

1.1 INSTRUCTING PHASE

(1) On 30th March 2006, the Basque Competition Defence Service ("SVDC") received notification from the National Competition Defence Service[1] ("SDC"), in accordance with the stipulations of Article 2.2 of Law 1/2002, of 21st February, on the Coordination of State and Autonomous Community Competencies regarding Fair Competition, reporting on signs of conduct by the IGUALATORIO MEDICO QUIRÚRGICO, S.A. DE SEGUROS ("IMQ") that is forbidden by the Competition Act 16/89 ("LDC").

(2) The notification indicated that a document regarding the DENTISTS AND STOMATOLOGISTS ASSOCIATION OF VIZCAYA ("COEV") had been received from the Competition Court[2] ("TDC") on 15th December 2004, detailing the claim by the DENTAL ASSOCIATION OF VIZCAYA ("ADEBI") regarding a Dental Policy that IMQ planned to launch on the market. The aforementioned document comprised of

[1] The SDC has become the Research Division of the National Competition Commission (CNC), by virtue of the new Law 15/2007, of 3rd July, on Competition Defence.

[2] The TDC has become the Council of the CNC, by virtue of Law 15/2007, of 3rd July, on Competition Defence.

a "*Complaint from the Dentists and Stomatologists Association of Vizcaya*", sent to COEV by ADEBI, and COEV's reply to ADEBI. In view of this document, the SDC initiated preliminary action, including a request for rectification to ADEBI and to COEV, as well as a request for information to IMQ, which led to Termination Proceedings dated 28th November 2005 ("Termination Proceedings").

(3) However, within the framework of these actions, the SDC became aware of the "*Availability of Professional Health and Dental Services Contract*" between IMQ and dentistry professionals on its medical lists, and considered that Clause 3.5.b) of the aforementioned contract, stipulating that dentists working with the IMQ must apply to insured parties the same or lower rates than those charged to private clients, may represent a breach of Article 1 of the Competition Act.

(4) Following the mandatory 15 days without any opposition from the SVDC to the SDC's competition attribution proposal, the latter passed all of the documentation related to the notification to the SVDC on 27th April 2006.

(5) On 11th May 2006, in accordance with the stipulations of sections 1 and 4 of Article 36 of the Competition Act, the SVDC agreed to the initiation of disciplinary proceedings (3/2006 Z) against IMQ for restrictive competition practices and to notify the company under investigation.

(6) During the instruction, the SVDC issued requests for information to the party under investigation (23rd May 2006); to UNIÓN ESPAÑOLA DE ENTIDADES INSURANCE COMPANIES Y REINSURANCE COMPANIES (UNESPA) (9th June 2006); to the GENERAL REGISTER OF ASSOCIATIONS IN THE BASQUE AUTONOMOUS COMMUNITY (24th May 2006); to the GENERAL DIVISION OF INSURANCE AND PENSION FUNDS (12th June 2006); to the IGUALATORIO DE PREVISIÓN SANITARIA, ALLIANZ, AXA AURORA IBÉRICA, SANITAS, ARESA, ADESLAS, IQUIMESA, MAPFRE CAJA SALUD, AEGÓN SALUD, FIATC, MUTUA DE SEGUROS (14th July 2006); and, once again, to the party under investigation on 4th October 2006. All of the requests for information were answered by the recipients.

(7) On 30th October 2006, the SVDC notified the IMQ of a Statement of Facts, receiving a reply to this document on 1st December 2006.

(8) On 20th March 2007, the SVDC elevated its proposal report to this Court. In the section of the Proposal-Report dedicated to "Legal Classification", the SVDC confirmed the following: "the conduct examined in this disciplinary proceeding stems from the forbidden practice defined in Article 1.1.a) of the Competition Act […]. In this case, the party under investigation has indirectly fixed the prices that dentists who have subscribed to the *Availability of Professional Health and Dental Services Contract – IMQ General Policy + IMQ Dental Policy* may charge clients who are not insured with the IMQ, through the restriction to freely offer discounts"[3].

[3] Proposal-Report, *Page* 839 of the SVDC Investigation

(9) Therefore, it is put to the TVDC:

"FIRST: To declare the existence of restrictive competition practices forbidden by Article 1.1 of the Competition Act, consistent with having carried out two practices regarded as *"a joint recommendation which aims to produce or may produce the prevention, restriction or distortion of competition in the whole or part of the national market and, particularly, those that consist of: a) the direct or indirect fixing of prices or other commercial or service conditions (…)*".

SECOND: To find IGUALATORIO MEDICO QUIRÚRGICO, S.A. DE SEGUROS Y REASEGUROS (IMQ), with Tax Code: A95321386, and registered office at Máximo Aguirre, 18 bis, in Bilbao (Postal Code: 48011) guilty of these forbidden practices.

THIRD: To adopt the rest of the declarations referred to in Article 46 of the Competition Act."[4]

1.2 RESOLUTORY PHASE

(10) On 30th March 2007, the TVDC notified IMQ and the SVDC of the acceptance of the Investigation proceedings (1/2007), the appointment of Mr. BIKANDI ARANA as Spokesperson and the notification of the investigation to IMQ, stipulating a period of 15 days in which the hearing may be requested and the appropriate evidence may be presented.

(11) On 3rd May 2007, the TVDC received a reply from IMQ requesting that the aforementioned period should not start to run as long as the SVDC Proposal-Report was not passed on to the company or secondly, a further 7-day extension of the period.

(12) On 4th May 2007, IMQ accessed the SVDC Proposal-Report along with all of the documentation included in the Investigation at the head office of this Court.

(13) On 7th May 2007, the TVDC agreed to the IMQ request and set a period of 15 days to propose the date of the hearing and the appropriate evidence as of the date of access to the File.

[4] Proposal-Report, *Page* 838 of the SVDC Investigation. Mention of "two practices considered to be a joint recommendation" is a typographic error with no practical effects as IMQ has verified that it is aware of the facts involved in the Investigation and the legal accusation of SVDC (*vid.,* First Conclusion of the IMQ Conclusions: *"Case Discussion: The Factum of the Investigation and the Accusation*").

(14) On 21st May 2007, the Spokesperson, Mr. BIKANDI ARANA, requested that the TVDC accept his abstention from the resolution of this Investigation due to the existence of a family relationship with a member of the IMQ Board of Directors and a previous lawsuit against this company.

(15) On 23rd May 2007, the TVDC agreed to accept the abstention of Mr. BIKANDI ARANA from this Investigation and appointed Mr. BERASATEGI TORICES as Spokesperson.

(16) On 6th June 2007, the TVDC received a document from the IMQ pointing out that the "factual element that concerns us has been perfectly defined in the Statement of Facts… so that no further evidential investigation is required… without detriment to the inquiries or surveys that the TVDC…may consider opportune"[5]. IMQ does not consider this hearing to be necessary.

(17) On 29th September 2007, the TVDC notified IMQ of the commencement of the period to formulate Conclusions, received by this Court on 29th October 2007.

(18) On 6th October 2007, the TVDC agreed to ask IMQ for some clarifications, which were answered in a document dated 19th November 2007.

1.3 INTERESTED PARTIES

(19) The IGUALATORIO MÉDICO QUIRÚRGICO, S.A. DE SEGUROS Y REASEGUROS (IMQ) is an interested party.

2 FACTS OF THE INVESTIGATION

2.1 IMQ

(20) IMQ, with different registered names, has been performing its activities for more than 70 years. The "Asociación del Igualatorio Médico Quirúrgico y de Especialidades" was set up as a professional medical company in 1934, providing medical care services in Vizcaya. In compliance with the Private Insurance Regulation Act, of 16th December 1954, requiring the constitution of a limited liability company for all medical healthcare companies, the IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS was set up in 1959.

(21) Although the IGUALATORIO MEDICO QUIRÚRGICO, S.A. DE SEGUROS, figures as the signatory of the Contract under investigation, this company was later divided into two companies as a result of the ADESLAS/IGUALMEQUISA[6] merger:

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[5] IMQ Document received on 6th June 2007.

[6] TDC Report on the Economic Concentration Investigation C89/05 *Igualatorios Médicos,* of 26th September 2005 ("ADESLAS/IGUALMEQUISA Report").

1. IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS Y REASEGUROS, which was assigned the medical and healthcare insurance activity in the province of Vizcaya and neighbouring areas; and
2. SOCIEDAD DE SERVICES DEL IGUALATORIO MÉDICO QUIRÚRGICO S.A., a non-insurance company that was assigned the clinics, medical centres and other healthcare services.

(22) Therefore, IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS Y REASEGUROS is the successor to IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS in terms of the insurance activity, and is therefore the recipient of this Ruling[7].

2.2 THE PROVISION OF DENTAL SERVICES CONTRACT

(23) IMQ sells, among other products, a General Healthcare Policy (General Policy), with different models, which incorporate dental cover, and a specific dental policy called "Dental Policy".

(24) In order to provide the medical and healthcare included in the risks covered by its health insurance policies, the IMQ contracts the availability of health professionals to provide the professional services within their specialised field. In relation to Dentists and Stomatologists ("dentists"), IMQ offers the professionals elected by the company the possibility of adhering to the *Contract for the provision of dental services as a liberal professional* ("the Contract"), in favour of the insured parties demanding their services within the cover of their Health Policy and Dental Policy. The Clauses of the Contract have been unilaterally drawn up by the IMQ and the elected dentists may only accept or reject them in their entirety (contract of adhesion).

(25) In relation to dentistry services requested within the General Policy, the IMQ directly pays the professional's fees in accordance with a price scale established in the Contract[8].

(26) In relation to professional services requested within the Dental Policy, the Contract differs between "Services without Excess" and "Services with Excess", subject to different remuneration rules:

1. Services without Excess: The cost of certain health services identified in the Contract are fully covered by the Dental Policy, so that IMQ directly pays the professional his/her fees for each medical act, in accordance with a price scale established in the Contract [9].

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7 In this Ruling, both IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS Y REASEGUROS and IGUALATORIO MÉDICO QUIRÚRGICO S.A. DE SEGUROS are identified as "IMQ".

8 Sections 3.2 and 4.2 of the Contract (*pages 38, 39* and *42* of the SVDC Investigation). Fees for dentistry services are established in Appendix II (*page 34*).

9 *Ibid*. Fees for Services without Excess are established in Appendix III (*pages 32-33*).

2. Services with Excess: The cost of the majority of the health services identified in the Contract are subject to an "excess", the value of which is paid directly to the Professional by the insured party and/or beneficiaries of the IMQ, in accordance with a scale of excesses (prices) established in the Contract[10].

(27) Within the framework of Services with Excess, the professionals have the option of joining a certain level of prices. The Contract includes three levels: an upper price level (A); a middle price level (B); and a lower price level (C)[11].

(28) Section 3.5 of the Contract and particularly paragraph 3b) are particularly relevant:

"Election of the "Price Scale" with respect to Services with Excess

a) The Professional undertakes to apply to the insured parties and / or beneficiaries that request any of the Services with Excess under the Dental Policy, the excess values to be paid by them in the concept of professional, which are set out in Appendix IV, in accordance with the "Price Level" that the Professional has previously elected.

b) In this act, the Professional declares to have opted for Level _, which shall irrevocably be maintained until [end of the year]. The chosen Price Level shall be understood to be automatically extended for annual periods throughout the validity of the Contract, in accordance with Clause 5. However, at least two months in advance of the termination of the initial period or each extended period, the Professional may request a modification of the Level, which will not come into effect until the beginning of the following period.

   The Professional declares in this act that the prices recorded in his/her chosen Price Level are the same or lower than those applied to private patients, without citing the condition of insured party and/or beneficiary of the IMQ. Likewise, this condition must be withheld in the future, expressly renouncing the possibility of lowering private prices if such an action breaches the previous obligation. (underlined by the Court)

c) The Professional authorises the IMQ to publish its Rates.

d) At any time, the IMQ may request the Professional to provide documental proof justifying the strict compliance with the obligations established in this section 3.5 of the Contract. Refusal to do so will enable the IMQ to immediately terminate the contract".

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[10] Section 4.3 of the Contract (*pages 39* and *41* of the SVDC Investigation). Services without Excess and the general price scales are established in Appendix IV (*pages 29-31*) of the Contract. Appendix VI (*pages 23-27*) establishes a scale of special prices for employees of IBERDOLA.

[11] Explanatory Preamble (*page 43*) and Section 3.5 (*page 39*) of the Contract

(29) The Contract does not mention the updating of the fixed prices in each level, although Section 4.3 establishes that the IMQ may not lower the amounts of the excesses without the consent of the Professional[12]. In response to the request for information from the SVDC dated 23rd May 2006, IMQ declared that "bearing in mind that the sale of the Dental Policy began in January 2005, and therefore no more than 17 months have passed, prices or fees have not yet been subject to any modification".

(30) This Court considers it to be proven that the nature of the Contract (contract of adhesion) and its articles do not include any legal mechanism that allows this Clause to be applied individually to each dentist, although paragraph 3 of Section 3.5 b) ("the Clause") formally constitutes a "Most Favoured Customer Clause"[13]. Therefore, the ban on "lowering private rates" produces the effects of a minimum price obligation or a ban on discounts, imposed by the IMQ on its dentists[14].

3 LEGAL BASIS

(31) In this Investigation, compatibility between Article 1.1.a) of the Competition Act, and paragraph 3 of section 5.3.b) of the IMQ Contract with dentists wishing to form part of the medical list in its Dental Policy is clarified.

(32) The legal analysis of the Court has followed the methodology established by the European Commission in its *Guidelines on the application of Article 81(3) of the Treaty*[15], concluding that the Contract may prevent or restrict competition through its purpose or, at least, by its effects. In order to specifically analyse the restrictive effects of the Contract, this Court has previously defined the relevant markets (*Guidelines, Epigraph 27*). Then, the Court has evaluated whether the Contract contributes to the creation, maintenance or strengthening of market power or allows the parties to make use of it, bearing in mind that the degree of market power that is normally required for the finding of an infringement in the case of agreements that restrict competition is less than the degree of market power required for a finding of dominance (*Epigraph 26*).

(33) This Section of the Ruling begins by summarising the IMQ allegations (*Ruling, Section 4.1*); defines the markets affected by the practice (*Section 4.2*) and its competitive structure (*Section 4.*3); refers to the rulings of Spanish competition authorities in terms of insurance company-professional relationships and the decisions of European and American authorities in relation to the Most Favoured Customer Clauses (*Section 4.4*); as well as the economic theory related to the anti-competitive effects of the ban on "discriminatory" prices in economic terminology (*Section 4.5*); and concludes by analysing the compatibility of IMQ practices with the Competition Act (*Section 4.6*).

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12 Section 4.3 of the Contract (*page 37*)

13 The terminology "most favoured customer" (MFC) is a variation on the term *"most favoured nation*" (MFN), an international trading law clause that obliges one State to offer another State the same preferences (commercial) that are offered to any other State. In Section 3.4 of this Ruling, the decisions of European and American Authorities in relation to the "most favoured customer clause are analysed.

14 *Vid*., *infra* Section 3.6.1 of this Ruling.

15 Communication from the Commission— Guidelines on the application of Article 81(3) of the Treaty, Official Journal C 101 dated 27/04/2004.

3.1 IMQ ALLEGATIONS

(34) IMQ has had the opportunity to state its allegations in relation to the matter in its documents in response to (1) Statement of Facts; (2) Providence of the TVDC notifying IMQ of the Investigation; and (3) Conclusions.

(35) The IMQ allegations may be divided into four categories:

Interpretation of the Clause

(36) IMQ confirms that the Clause refers exclusively to the prices that dentists apply to private patients "and not those that may be offered to IMQ competitors, or in other words, to other companies that sell Dental Policies" (response to the Statement of Facts, *Page 808*). IMQ clarifies that "according to technical vocabulary in the sector…"private" means "a patient that is not insured by any company and pays the fees for the care received at his/her own expense" (response to the SVDC Proposal-Report, page 2). IMQ also considers that the verification by SVDC in its Proposal-Report that "the excesses offered by IMQ…may be above those offered by other insurance companies" (Proposal-Report, *page 840*) and that "professionals apply the rates agreed with different insurance companies regardless of whether they are lower than those fixed by the IMQ" (Proposal-Report, *page 839*) confirms the interpretation of the Clause defended by the IMQ, "representing a fact admitted by the S[V]DC which the TVDC may not now question" (response to the SVDC Proposal-Report, page 2). The Conclusions insist on this question (pages 3-4).

Economic Justification of the Clause

(37) According to IMQ, the fact that the excess amount to be paid by the insured party for assistance is less than what it would cost privately responds to the most elementary economic logic (response to the Statement of Facts, *page 809*; Conclusion 2.1 (i) and 2.2.a, pages 4-5).

Breach of Article 1 of the COMPETITION ACT

(38) IMQ confirms that "an agreement that regulates a supply price between a supplier and its client may never be contrary to Article 1 of the Competition Act. There is no precedent in this respect in Spain or in any of the community bodies" (response to the Statement of Facts, *page 806*).

(39) Likewise, IMQ declares that "by no means does the Clause constitute a fixed or minimum price agreement" and moreover "such clauses… are not prohibited when imposed on the supplier by the purchaser, according to the literal tenor of Article 4.a, in relation to Article 2 of Regulation 2790/1999,…incorporated into internal Law by RD 368/2003" (response to the Statement of Facts, *pages 805-806*), considerations that are reiterated in the response to the SVDC Proposal-Report, page 3; and in the Conclusion 2.2 (d).

(40) IMQ also rejects that the Clause is "the typical most favoured customer, bearing in mind that…these types of Clauses are only restrictive to competition if (a) they are applied to suppliers by dominant companies or those with market power and (b) whenever they are appropriate to exclude third competitors from the market" (response to the Statement of Facts, *page 805*; Conclusion 2.2 (c)). Along the same lines, IMQ does not consider that "we are faced with a supposed price discrimination, which may only be considered if imposed by a dominant company, establishing different prices between different clients" (response to the Statement of Facts, *page 805*; Conclusion 2.2 (c)).

(41) IMQ considers that the Clause does not restrict competition between contractual parties, nor between the IMQ and third parties, particularly insurance companies (response to the SVDC Proposal-Report, page 3; Conclusion 2.2 (a)).

(42) Neither does IMQ consider that competition between dentists to attract patients without insurance is affected because the dentist is free to reduce his/her prices to such clients, provided that the same applies to IMQ clients. Likewise, IMQ rules out the application of Article 6 of the Competition Act for not having been raised during the instruction and because the IMQ does not predominate the dental policy market (response to the SVDC Proposal-Report, page 3; Conclusions 1.2 (b) and 2.2 (b)).

"*De minimis*" Effects

IMQ confirms that "the number of insured parties of any of the companies which are beneficiaries of dental policies and, in particular, the number of insured parties with IMQ…is negligible with respect to the potential clients for dental care services, or in other words, a scarce 0.20% of the universe of potential plaintiffs" (response to the Statement of Facts, *page 810*). "The professionals that have signed the Contract…total 127, whereby the total of registered dentists in Vizcaya alone exceeds 750, to which the stomatologists registered in the Medical Association must be added" (response to the Statement of Facts, *page 809*). This leads the IMQ to conclude that even in the hypothesis that the Clause may be considered contrary to Article 1 of the Competition Act, "its limited economic relevance does not make it "significantly affect competition" (response to the Statement of Facts, *page 809*). IMQ reiterates this argument in its Conclusion 1.2 (a).

3.2 RELEVANT MARKETS

(43) The Contract between IMQ and dentists in its Dental Policy affects the dental insurance and dental service markets. Due to the close relationship between dental insurance and general healthcare insurance, it is also necessary to analyse the competitive structure of the latter market.

3.2.1 PRIVATE HEALTH INSURANCE IN BIZKAIA

(44) Although this Investigation focuses on insurance and dental services, the close relationship between dental insurance and healthcare insurance and the dominant position of IMQ in the latter market means that it must be considered.

(45) The TDC has analysed the healthcare insurance market in diverse disciplinary investigations and concentration reports, two of which are directly related to the IMQ.

(46) In the Ruling of 6th July 2000[16], the TDC sanctioned the IMQ for an abuse of its leading position consistent with the exclusivity requirement applied to health professionals included in its medical list, hence presenting an obstacle to the implementation and growth of the competition's insurance companies in Vizcaya. The TDC considered that the reference product market was medical and healthcare services – contracted through the system of voluntary private insurance – provided by different private insurance companies (*F.J. 2, p. 15*). As for the geographical market, the TDC confined it to the province of Vizcaya, the region in which IMQ mainly operates and where all of the health professionals and clinics included on its medical list are located (*F.J. 2, p. 15*).

(47) In the recent ADESLAS/IGUALMEQUISA Report, the TDC yet again identified the private health insurance market that offers the insured party and his/her beneficiaries medical, hospital or surgical care in the event of illness or accident, either at centres associated to the insurance company in which the insured party does not incur any charges (healthcare model), or at centres freely chosen by the insured party, in which case the cost of medical services incurred is either fully or partially refunded (cost refund model)[17].

(48) The TDC differentiated between a freely chosen private healthcare insurance market and another associated private healthcare insurance market (aimed at public groups). Within the first market, the TDC identified two different demand segments, namely individuals and non-public groups, whereby it was not considered necessary to identify them as separate markets for the purpose of the analysis of the concentration (*page 39*).

(49) In relation to the geographical market, the TDC verified the weight of insurance companies that exclusively cover the provincial market in the different provinces in which they are present; the orientation of the demand of insured parties towards nearby health care, with the lowest possible travelling costs and time; the price difference of premiums between provinces; and the provincial physical presence of the insurance companies as an important factor in client service and attracting new clients. The TDC also verified that Vizcaya, Araba and Gipuzkoa are three different Health Areas for the effects of the General Health Law[18].

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16 Case Number 464/99, Aseguradoras Médicos Vizcaya.

17 ADESLAS/IGUALMEQUISA Report, *supra 6,* p. 35.

18 ADESLAS/IGUALMEQUISA Report, *supra 6,* p. 48, note 79: "Article 56.2 of the General Health Act 14/1986, of 25th April, introduces the Areas of Health as essential structures of the health system, whilst Article 56.4 indicates that "The areas of health shall be defined bearing in mind geographical, socio-economic, demographic, labour, epidemiological, cultural, climatological,

3.2.2 PRIVATE DENTAL INSURANCE IN VIZCAYA

(50) In the ADESLAS/IGUALMEQUISA Report, the TDC identified the "dental insurance model" within private medical insurance and cost refund[19] although it did not consider it necessary to "analyse this model in greater detail as dental insurance only represented 1.5% of the premiums and almost all insurance corresponded to medical act models (97%)"[20].

(51) General health insurance only offers limited coverage for dental care[21], similar to the national health service[22], so dental policies have emerged as a differentiated product which adds to and extends the cover provided by general health insurance, with the added value that it allows the risk of dental incidents that are not covered by the national health service to be covered.

(52) The existence or otherwise of a separate market for a complementary product to another product has been the object of various sentences of community legal authorities. In the *Microsoft sentence*, the European Court of First Instance, in line with previous community jurisprudence[23], established that the "differentiability" of the products must be examined from the point of view of consumer demand: if there is autonomous demand for a product, it is possible to talk of a differentiated product or market[24].

(53) In this case, although insurance companies preferably target their health care insurance clients for dental insurance, they also sell it to third parties (clients of other insurance companies and uninsured people), so there is a separate demand for dental insurance[25].

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factors and provision of channels and communication, as well as the health facilities in the area".[…].In this concentration operation, the three Health Areas in the Basque Country coincide with each of the three provinces: Álava, Guipúzcoa and Vizcaya."

19 *Ibid*., p. 35.

20 *Ibid*., p. 36, note 45.

21 In response to the SDC, IMQ confirms that in terms of dentistry, the cover of general healthcare policies is minimum (*page 62*).

22 Section 9 of the Appendix II of Royal Decree 1030/2006, of 15th September, establishing the portfolio of common services of the National Health Service and their updating procedure, determines the dental services offered by the National Heath Service. Article 9.5 lists all of the treatments that are excluded from basic dental care.

23 Case C-333/94 P *Tetra Pak II*, Epigraph 36; Case T-30/89 *Hilti*, Epigraph 67; and Case T-83/91 *Tetra Pak II*, Epigraph 82

24 Sentence of 17th September 2007, Case T-201/04, *Microsoft c. European Commission*, Epigraphs 917 and 918

25 IMQ Reply dated 17th May 2005 to the request for information from the SDC: "although the IMQ Dental Policy does not have a formal limit in terms of potential clients, IMQ marketing is essentially aimed at existing IMQ clients by virtue of general healthcare insurance policies, as a complementary product as such policies only have limited dental coverage" (*page 62*).

(54) Therefore, this Court, in line with the considerations of the SVDC Proposal-Report[26], which in turn coincides with those of the SDC[27], concludes that dental insurance constitutes a separate market although closely related to the private health insurance market.

(55) Dental insurance may be classified into three categories according to the method of payment:

1. Excess Model: The insured party pays a monthly premium which guarantees free cover for certain basic services (check-ups, dental cleaning, etc.), and pre-established prices (excesses) for other treatments. The service is provided by the professionals that appear in the company's brochure and are freely chosen by the insured party.

2. Reimbursement Model: The insured parties pay a regular premium which entitles them to be refunded a certain percentage of the expenses incurred. The service will be provided by any dentist on the market (not necessarily included in the brochure) and is freely chosen.

3. Mixed Model: This is a combination between the excess and reimbursement model. The insured parties may opt to visit professionals on the company's dental list but they may also visit other doctors and part of the cost will be refunded.

(56) In relation to dental insurance demand, the SVDC Proposal-Report has focused its analysis on the relevant market in individual (not group) private dental insurance. This Court considers the market definition provided by the SVDC to be appropriate, in view of the fact that (a) there are sensitive differences between individual and group private insurance, as indicated in the ADESLAS/IGUALMEQUISA Report (*pages 37-38*); (b) individual insurance is also taken out through the open group insurance model: an organization negotiates certain conditions to which its members may or may not subscribe (ADESLAS/IGUALMEQUISA Report, *page 39, note 55*); and (c) is the market that best reflects free competition (prices and conditions) in insurance and dental services[28].

(57) In relation to the geographical area, the considerations regarding general healthcare services are fully applicable to dental services, so the relevant market in this case shall be private dental services offered in Vizcaya.

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26 The SVDC Proposal-Report: "if we add that dental insurance is usually complementary yet differentiated from healthcare policies and cover services that are not covered by the National Health Service, which is practically limited to extractions, following the thesis of the protection of national competition, it may be concluded that the relevant markets for the product are private insurance dental care and dental services provided by dentists and stomatologists" (page 11, *page 841*).

27 *Vid.*, SDC Termination Proceedings in the Investigation 2586/05 (*page 59*).

28 However, "the different tax procedure and the possibility of deducting premiums from corporate tax are influential today in group private insurance, particularly in this case" (ADESLAS/IGUALMEQUISA Report, *supra 6,* p.38).

(58) In the document on Conclusions, IMQ agrees with this definition of the market[29].

3.2.3 PRIVATE DENTAL SERVICES IN BIZKAIA

(59) Dental services represent a differentiated market as only registered Dentists and Stomatologists are legally authorised to diagnose and treat dental health problems[30]. Due to the limited cover of dental services by the national health system, in this case, the potential replacement of private dental services for national health dental services (almost non-existent) is not raised.

(60) In relation to the geographical area of the dental services market, in the ADESLAS/IGUALMEQUISA Report, the TDC observed that consumers preferred healthcare close to home, with the least possible travelling time and costs (except in specific, serious cases), giving rise to sensitive price differences between provinces (*pages 48-49*).

(61) This Court considers that dental services share the same characteristics as other health services and, therefore, the geographical market is provincial. IMQ agrees with this definition of the geographical market[31].

3.3 THE COMPETITIVE STRUCTURE IN THE RELEVANT MARKETS

3.3.1 COMPETITION IN HEALTH AND DENTAL INSURANCE

(62) Competition in dental insurance presents two notable characteristics.

(63) First of all, dental insurance is a relatively small market and subject to the health insurance market.

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[29] Conclusions Document, page 2. IMQ also considered the individual private healthcare insurance market to be differentiated in its notification of the merger with ADESLAS (ADESLAS/IGUALMEQUISA Report, *supra 6,* p. 37, note 46).

[30] Vid., Dental Act 10/1986, of 17th March, on dentists and other professionals related to dental health, First Article: 1. The dentistry profession is regulated, requiring a university degree which will be established by the Government, upon the recommendation of the Universities Council. 2. Dentists have the professional capacity to perform activities regarding the prevention, diagnosis and relative treatment of anomalies and disease in teeth, the mouth, the jawbone and surrounding tissue. 3. Dentists may prescribe medication, dentures and health products corresponding to the field of their professional practice. This Article is developed in Article 1 of the Royal Decree 1594/1994, of 15th July, which develops the stipulations of Law 10/1986, which regulates the Dental Technician and Dental Hygienist Profession. Similarly, the Additional Provision of Law 10/1986 and the Second Additional Provision of Royal Decree 1594/1994 indicate that doctors specialised in Stomatology and Maxillo-facial Surgery may perform the functions carried out to date in addition to those set out in both regulatory texts for dentists.

[31] SDC Termination Proceeding, Investigation 2586/05 (*page 62*).

(64) Looking at the data from ICEA (Cooperative Research between Insurance Companies and Pension Funds), dental insurance only represents 1.5% of the premiums and, are almost entirely insurance policies that correspond to medical models (97%)[32].

(65) General healthcare insurance, like the National Health Service, only offers limited dental care cover, which is why dental policies have emerged as a differentiated product that complements and extends the cover offered by general healthcare insurance, with the added value of covering dental risks that are not covered by the National Health Service.

(66) A Study commissioned by the Catalonia Dentists and Stomatologists Association ("COEC") revealed that the incremental cost of offering dental insurance is relatively low in relation to the cost of offering health insurance: "The details regarding who assumes the risk in this type of product is what has enabled the insurance companies to avoid modifying dental insurance premiums in the past eight years. The only cost incurred by companies offering dental insurance derives essentially from the administration of the insured parties (receipt of premiums) and product advertising. Many companies even offer dental insurance free of charge with the contracting of general health insurance"[33].

(67) The COEC I Study provides an analysis of the average, minimum and maximum premiums for dental insurance in Catalonia and Spain. It can be observed that the dental insurance premium is considerably lower when it is taken out as a supplement to healthcare insurance:

Table 3.2 Premiums offered for Individual Dental Insurance

Individual Model	Catalonia (euros)	Spain (euros)
Extension to Health Insurance	64,59 (30,48 – 88,80)	67,26 (30,80 – 105,60)
Independent Insurance	81,30 (60,30 – 100,80)	89,52 (60,03 – 122,40)

Source: Self-compiled, base don the prices Publisher on the web pages of twelve leading companies in the dental insurance market in Catalonia.

(68) Another study into the dental services market, commissioned by the Spanish Dentists and Stomatologists Association ("COE"), also concluded that dental insurance has limited independence, whereby it is demanded as a supplement to health insurance: "37% of the Spanish people interviewed replied that they had *medical insurance*. Of

32 ADESLAS/IGUALMEQUISA Report, *supra 6,* page 36, note 45.

33 PINILLA and PETROVA, *The dental services market in Catalonia: Analysis of new business methods with special attention to franchises and dental insurance*, Catalonia Dentists and Stomatologists Association, 2006 (COEC I Study), page 45. http://www.coec.cat/pdf/blanc_mercat_serveis_cast.pdf

these, 27% admitted to having had a *Dental Policy* and 22% replied that they had one at present. Of the 63% that admitted to not having medical insurance, 4% replied that they had had dental insurance and only 1% had it now. In other words, Dental Policy has greater penetration with individuals with medical insurance"[34].

(69) Secondly, dental insurance, like any insurance, offers the insured party the possibility of contracting dental services from a list of dentists, at a cost and with the quality guarantees that are pre-established by the insurance company. A priori, this service involves important cost savings in relation to the individual search, evaluation and selection of a dentist.

(70) Although the insurance companies appear to have emphasized the discounts of their excesses as a commercial tactic, dental insurance also competes in other parameters, such as the range of the medical list and the quality of service offered, as revealed in another study by the COEC: "The advantages presented included the free choice of specialists (non-existent in the NHS), 24 hour emergency service, 365 days a year, immediate access to all services, family advantages (some do not charge for minors), home service, guarantees of the materials used, no age limits and compensation for hospitalization for any reason"[35].

(71) In the dental insurance market, like in the dental services market, quality in its multiple parameters (easily accessible information on professionals and their location; emergency service; guarantee of materials; additional services such as compensation for hospitalization; reimbursement of costs instead of a closed medical list, etc.) is an equally important variable as price when choosing a professional, so dental insurance is an untouched field in terms of "price-quality" ("value for money") of its products, which do not have to adhere exclusively to the cost of each treatment.

(72) As for dental insurance with a medical list (dental insurance model offered by IMQ), the insurance company must have a wide list of dentists, attracted by the expected client flow.

(73) Although the initial relationship between the insurance company-dentist appeared to be mutually beneficial, the Professional Bodies or Associations of dentists have been condemning the enormous "negotiating power" of the insurance companies and the low prices imposed on dentists: "In light of this weak situation of a large number of professionals, it has been relatively easy for insurance companies and friendly societies to enter the dental services market, proposing private insurance systems aimed at the middle income bracket and supported by the need of many dentists for patients. In this way, the insurance companies and friendly societies contract the

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34 GALLUCI and TEJERINA, *The Demand for Dental Services in Spain*, General Board of Spanish Dentists and Stomatologists Associations, 2003 (COE Study), page 39. http://www.consejodentists.org/demanda_services.pdf

35 HEALTH OUTCOMES RESEARCH EUROPE, *The Future of the Dentistry Profession in Catalonia: Evolution Scenarios*, Catalonia Dentists and Stomatologists Association, 2006 (COEC II Study), page 64 http://www.coec.cat/pdf/llibre_blanc_castella.pdf

services of individual dentists, lured by the promise of their insured parties based on a scale of low prices imposed by the insurance company, thanks to their negotiating power, which is what counts with patients" (COEC I Study [36]).

(74) In general, Professional Bodies or Associations have carried out various actions against insurance companies: (a) complaints against insurance companies for imposing excessively low prices in their excesses; (b) attempts to negotiate or impose group prices, accompanied by pressure tactics; and (c) complaints as a result of public opinion regarding the supposedly harmful effects of insurance companies. Without looking further, this Investigation was instigated as a result of a complaint against IMQ by COEV and ADEBI.

(75) In any case, it appears to be unquestionable that insurance companies, to a greater or lesser extent have enjoyed important negotiating power compared to dentists. For example, the COEC I Study has analysed the price discounts for dental insurance in relation to the fees recommended by the COEC: "Table 3.3 represents the significant price difference between the COECV price guide and the process offered for a sample of seven treatments, for clients in Catalonia, by four insurance companies, including three of the companies with the largest volume of premiums. In all of the treatments, the prices published by the insurance companies are much lower, between 50%, 60% and 90% lower than those recommended by the COEC, and some treatments were even offered free of charge by certain companies"[37].

Table 3.3 Difference between the COEC price guidelines and the list offered by the leading (by volume of premiums) insurance companies in Catalonia. 2006

	COEC	Company 1	Company 2	Company 3	Company 4
Extraction of dental piece included	243 €	Free	Free	€90	Free
Simle Filling (amalgam or composite)	€54	€27,5-35,5	€29-24	€19-25	€41,70
Multi-radicular cast post	€145	€76	€31	€37,5	€73,70
Uni-radicular cast post	€209	€89	€46	€43,8	€90,70
Provisional resin crown	€66	€20,5	€15	€76	€51,60
Metal-ceramic crown	€364	€180	€165	€157	€243,20
Ceramic crown on implant	€481	€208	€228	€208	€310-400

[36] *Vid., supra 33,* p. 30. The TDC reached the same conclusion regarding the negotiating power of life insurance companies compared with funeral parlours, in Investigation C-85/05 *Intur/Euro Stewart*, page 35.

[37] *Ibid,* p.50.

Source: COEC I Study, page 51

(76) Curiously, both dentists and insurance companies appear to attribute the condition of “market prices” to price scales[38]. This situation shows the anti-competitive effects of the price guidelines, which will be considered in another section of this Ruling[39].

(77) On the other hand, the negotiating power of insurance companies, defined even as an “oligopsony” in the COEC I Study, does not seem to affect prices and the demand for private dental services: “…enabling us to define the current market model for dental services in Catalonia as an oligopsony on the demand side, although with limited power over prices and the amount of the product offered, due to the special characteristics of this type of services: particularly the high search and information asymmetry costs. This situation has encouraged the increasing presence of powerful groups which are gradually controlling prices in the sector (we refer to the large mutual insurance companies or health insurance companies, dental excesses, and companies that manage large portfolios of potential clients), assuming the control of the oligopolistic power of the plaintiffs”[40].

(78) In short, insurance companies unilaterally establish the prices of excesses and other conditions of Contracts for the provision of dental services, and dentists are only able to accept or reject them[41]. However, this negotiating power of the insurance companies contrasts with the situation of uninsured consumers, the immense majority of whom are victims of legal restrictions and inadequate competition in the dental services market.

3.3.2 COMPETITION IN THE DENTAL SERVICES MARKET

(79) Dental services in Spain and other European countries have traditionally been protected from free competition by legal and regulatory restrictions. Although successive legal reforms have introduced a gradual liberalization in this sector, in accordance with the market economy model, a comparative analysis of the competitive structure in different countries shows that dental services are still far from being a competitive market.

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[38] *Vid.,* in relation to dentists, COEC II Study, *supra 35*, page 64: “The price with excess depends on the amount defined by the insurance company. The patient benefits from approximately a 30% to 50% discount on the market price”. In relation to insurance companies, the following may be cited as an example, Sanitas: “Save up to 50% on the average market price” http://www.sanitas.es/sanitas/seguros/seguros_medicos/particulares/sanitas_dental; and, without mentioning specific percentages, IMQ : “you can benefit from extremely favourable prices below those of the market in coverage with excess”, https://www.imq.es/grupo_imq/dental/acceso.htm.

[39] *Vid., infra Section* 4.1.1.3 of this Ruling.

[40] *Vid. supra 33,* pages 32-33.

[41] The COEC I Study, *supra 33*, describes the cost of excess as unilateral decisions of the insurance companies. For example: “the prices offered in the catalogues of insurance companies delimit the lowest band of the market” (p. 30); and “the comparison of prices and services is extremely complex, insurance companies establish their rates according to cover that is not easily comparable” (p. 46).

3.3.2.1 The Dental Services Markets in Europe

(80) The Competition Defence authorities in Ireland, the United Kingdom and Sweden, as well as the Danish consumer authority, have carried out studies on the competitive structure of this market, pointing out important shortcomings.

3.3.2.1.1 Sweden

(81) The Swedish Competition Authority observed that prices had increased by an average of 55% since the abolition of price controls in 1999, compared with a 7% increase in the CPI in its "*Report on the Dental Care Market in Sweden*"[42], published in 2004. According to this Authority, the evolution of prices depended on the competitiveness of the market, which presented important problems, some of which were regulatory. One of the problems identified was the lack of information for consumers to make informed choices on the dentist and appropriate types of treatment and the proposals presented by the Swedish Consumer Agency in 2003 to rectify this information asymmetry were cited.

3.3.2.1.2 United Kingdom

(82) In the United Kingdom, the Office of Fair Trading (OFT), initiated a study into "*The private dentistry market in the UK*"[43] ("OFT Study") in 2003, in response to a "super-complaint" from the Consumer Association. The OFT Study concluded that the dental market presented certain shortcomings which were detrimental to British consumers, and offered diverse recommendations to improve competition and offer more alternatives to consumers.

(83) Three shortcomings were identified in the competitive operation of the British dental market:

1. Consumers do not generally have sufficient information, for example in terms of prices compared with the market.

2. If problems arise in the provision of professional services, the complaint, sanction and compensation channels are inadequate.

3. There are legal restrictions on the supply side which affect free competition in the provision of dental services.

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[42] A summary of the report in English ("Summary – Dental Care Market in Sweden") is available on the web site of the Swedish Competition Authority: http://www.konkurrensverket.se/upload/Filer/ENG/Publications/rap_2004-1_eng.pdf

[43] All of the information on "The private dentistry market in the UK" Study and the actions of the British Administration to put the recommendations into practice is available on the OFT web site: http://www.oft.gov.uk/advice_and_resources/resource_base/market-studies/dentistry

(84) The lack of information on prices and services was considered to be the main obstacle for market competitiveness[44]. This explains to a large extent, the predominance of subjective criteria, unrelated to price and quality, in the consumer's choice of dentist. According to a survey carried out by the OFT, in the choice of dentist, 33% of consumers opted for their family dentist, 32% prioritized the location of the dental practice, 25% were influenced by recommendations from friends, 10% had chosen the dentist at random and only 2% had taken the prices offered into account[45].

(85) According to the OFT Study, the lack of information on prices for dental services may have serious economic implications for consumers, given that there is wide range of prices for the same treatment. In spite of excluding the 5% highest and lowest prices from the sample, it was observed that the prices analysed could be quadrupled in each of the three different medical treatments (check-up, filling and extraction) analysed[46]. According to the OFT, although differences in quality may explain heterogeneity of prices in dental services, it is hard to accept that such large variations may be explained[47].

3.3.2.1.3 Ireland

(86) A Study into dental services in Ireland, published recently by the Irish Competition Authority, has revealed that prices are increasing as a result of inadequate competition[48]. This lack of competition stems from legal and regulatory restrictions that unnecessarily forbid or restrict (i) discounts, advertising and other types of competition between dentists; (ii) the direct availability of dental hygiene services from dental hygienists[49]; and (iii) the sale of dentures directly to the public from dental technicians[50]. The Irish Competition Authority recommends 13 measures to increase competition in dental services. These recommendations include the reform of the regulatory body of the Association of Dentists, allowing the entry of representatives from other groups (for example, consumers), in order to avoid conflicts of public interest (consumer protection) compared with private interests (wellbeing of the profession).

3.3.2.1.4 Denmark

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44 OFT Study, Section 1 (Summary and Conclusions), Finding 1.8.

45 OFT Study, Section 4, Epigraph 4.12.

46 OFT Study, Section 4, Epigraph 4.13.

47 OFT Study, Section 4, Epigraph 4.14.

48 Irish Competition Authority, *Competition in Professional Services: Dentists*, October 2007. All of the information on the Study is available on the web site: http://www.tca.ie/NewsPublications/NewsReleases/NewsReleases.aspx?selected_item=203

49 The Study mentions that in Sweden, Finland, Denmark, Norway, Holland and in certain regions of Canada and the United States, patients may make an appointment directly with a dental hygienist without the need for a referral from a dentist (page 39). This practice is forbidden in Spain.

50 The Study mentions countries in which this practice is authorised en Australia, Canada, Denmark, Finland, Holland, New Zealand, Sweden, the United States and, as a result of the OFT Study, also in the United Kingdom (page 34). In Spain, this practice is forbidden, in spite of the demand in this respect from Associations of dental technicians.

(87) The shortcomings in the competitive operation of the dental services market detected in Sweden, the United Kingdom and Ireland appear to spread to other European countries. Along the same lines, a report published in 2005 by the Danish Consumer Agency highlights that Danish consumers have difficulties evaluating quality and comparing prices of dental services, generating cautious patients who seldom change dentists, despite significant differences in the cost of dental services.[51]

3.3.2.2 The Spanish Dental Services Market

(88) The competitive shortcomings detected in other countries are also reflected in Spain.

3.3.2.2.1 Registered Profession

(89) The dentistry profession is legally reserved for odontology graduates, a higher level degree created in 1986 following Spain's entry into the European Union. Doctors specialised in Stomatology may also practise as dentists (both degrees share the same Official Association), although this speciality was abolished in 2001.

(90) According to the COE, there were 20,090 registered dentists in 2004, but it is estimated that about 75% of them (15,000) were active. Out of the group of active dentists, 14,450 dentists (96%) were working in the private sector whilst only 4% of them were working exclusively for the National Health Service[52]. In short, the majority of dentistry services are carried out through the private system[53].

3.3.2.2.2 Minimum State Coverage

(91) The National Health Service essentially offers dental extraction for adults and preventive and constructive dentistry for children and teenagers in some Autonomous Communities. In the Basque Country, children and teenagers aged between 6 and 15 years old, have access to a private dentist from the National Health Service (essentially) and from private clinics (mixed offer)[54].

3.3.2.2.3 Competition Restrictions

(92) The European Commission's *Report on Competition in Professional Services* identified four areas of legal/regulatory restrictions associated to liberal professions: (i)

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[51] http://www.forbrug.dk/fileadmin/Filer/FR05_-_filer/Fact_sheet_5_-_engelsk.pdf

[52] "*Facts and Figures: Spain*", information provided by the COE to the International Dental Federation. http://www.fdiworldental.org/resources/assets/facts_and_figures/2004/Spain.pdf

[53] The COEC II Study, *supra 35,* raises the percentage of active dentists in the national health system to 10% (page 46).

[54] COEC II Study, *supra 35*, page 44.

prices; (ii) advertising, (iii) entry to the profession and reserved activities; and (iv) business structure[55].

(93) Law 2/1974, of 13th February, regulating Professional Bodies, included all of these restrictions and practically excluded Professional Bodies from the sphere of application of the Competition Act. Within the framework of its "*Report on the Free Practice of Professions*" ("TDC Report")[56], the TDC complained about the existence of certain restrictions to competition in the practice of professions subject to professional associations and in particular, in the dentistry profession:

> "The greatest problem of restrictions to competition currently imposed by Associations derives precisely from the increase in the restrictive effects that are produced as a result of the simultaneous establishment of diverse restrictions. The case of dentists serves as an example:
> There are a small number of regional Associations; professionals must join the regional Association corresponding to the place where they practise professionally; they may not practise within a 50 kilometre radius of their province, within the limits of the regional boundaries of their Association; they may not open more than one dental clinic; they may not open a clinic in the same building as a competitor, without written authorisation; they may not occupy a flat vacated by another dentist until a year has passed if this dentist continues to practise in the area; they may not advertise; they may not make comparisons with other professionals; they may not contract their services directly with insurance companies; they may not accept clauses in which the insured party is not entitled to choose a dentist from the list; they must apply minimum fees which have been jointly determined for the entire profession and for the entire region based on the fact that the most inefficient dental clinic ensures the dentist "fair" income.
> The sum of all these limitations completely eliminates the possibility of competition between professionals, preventing the provision of dental services at affordable prices for a wider range of the population, preventing cover for dental care in normal medical care policies, restricts innovation and places recently qualified dentists in a situation of sub employment".

(94) The Professional Associations Act has been modified to introduce greater competition between regulated professions. In particular, Law 7/1997, of 14th April, on Liberalizing Measures for Land and Professional Associations, modified Article 2.1 of the Professional Associations Act in such a way that "the practise of registered associations shall be performed in accordance with free competition and shall be subject to the Competition Act and the Unfair Competition Act in terms of the offer of services

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[55] European Commission's "*Report on Competition in Professional Services*", COM (2004) 83 final, 9/2/2004, Section 4.
http://eur-lex.europa.eu/LexUriServ/site/es/com/2004/com2004_0083es01.pdf

[56] TDC, *Report on the Free Practice of Professions: proposal for adapting the regulation on registered professions to the free competition system in Spain*, Madrid (1992). The TDC Report focussed on the most serious restrictions to competition: "In this chapter, only those restrictions that meet two conditions: importance and generality, have been considered. This is coherent with the reform that is proposed, as a radical reform that replaces all of the existing restrictions to competition between professionals is not proposed, but rather a relatively limited reform which will enable the most restrictive practices to be eliminated" (page 14).
http://www.cncompetencia.es/PDFs/OtrosInf/2.pdf

and the establishing their remuneration". However, as a trace of the ability of Professional Associations "to capture the lawmaker", Law 7/1997 allows Professional Associations to establish a scale of fees as guidance (Article 5.ñ) and the Association of Doctors may negotiate voluntary agreements, on behalf of their members, with representatives of healthcare insurance companies, for the determination of fees applicable to the provision of certain services (Article 2.4).

(95) In spite of the modifications to the Professional Association Act, there are still legal/regulatory restrictions and anti-competitive inertias in liberal professions and in particular, in dental services.

(96) First of all, although the number of dentists has increased in recent years to 20,090 registered members, the current figure contrasts, for example, with the number of registered lawyers in Spain (111,313 in 2004)[57].

(97) Secondly, Spanish legislation forbids dental technicians and dental hygienists from directly offering services to patients, without the involvement of a dentist[58]. These restrictions contrast with the more liberal legislation adopted in other countries[59].

(98) Thirdly, guidelines adopted by Dental Professional Associations, continue to be an important restriction to competition which serve to justify to (potential) consumers, the lack of information on the characteristics of the required treatment, the quality of the professional and the prices of competitors, prices which may prove to be excessive in a sufficiently competitive market. These recommended scales of fees are assimilated by the Professional Associations to a "fair price" regardless of the expenses and income structure and the competitive strategy of each professional, considering prices below these scales to be "unfair" or "predatory"[60].

(99) Fourthly, advertising has traditionally been subject to regulations that forbid or restrict advertising in the field of dental services. In particular, the TDC had the opportunity to sanction the COE and the Cordoba Association of Dentists for establishing limitations to dental advertising[61]. It is worth pointing out that in its Ruling, the TDC declared that "such a restriction [of advertising] does not only act in detriment to users, but also represents an obstacle that impedes such an essential question as access of new professionals and promotes the coordination of economic conditions

57 *European judicial systems*, European Commission for the Efficiency of Justice (CEPEJ), 2006: page 129.

58 *Vid.*, *supra 30*.

59 *Vid., supra 49* y *50.*

60 Study COEC I, *supra 33,* p. 22: "At times, competition tends to have been so aggressive that it leads to *depredatory price tactics*: reduction of the price below the cost in order to eliminate a competitor from the market, or at least significantly affect him/her in order to obtain a place in the market. Advertising brochures and information may easily be found on internet offering treatment at prices 50% lower than the COEC recommended fees".

61 Investigation 471/99 Cordoba Dentists, Ruling of 5th October 2000 (partially annulled), analysed by MARCOS, "Dentist Advertising. Comment of the TDC Ruling of 20th October 2000 on advertising of Dentists (Case 471/99)", Mercantile Law Journal 240 (2001), pages 653-671.

between registered members by forbidding the advertising of discounts and modern financing methods" (*F.J. 4, p. 14*).

(100) On 1st January 2003, the new Advertising Act, approved by the COE, came into force[62]. Although the SDC did not raise objections to its contents, it may be considered reprehensible that a Professional Body may determine what "misleading or unfair competition is"[63]. In any case, lawsuits[64] and complaints[65] aimed at restricting the advertising activity of dentists have not disappeared.

(101) In fifth place, consumers are unaware of their rights and a large number of dentists fail to fulfil their obligations in terms of consumer rights. A Study carried out by the Federation of Consumers in Action in 2004 ("FACUA Study") revealed that the lack of information which allows such large price differences is partly generated by the dentists themselves: "These professionals usually make it difficult for users to compare prices between different clinics. In fact, only a third of a total of 502 clinics surveyed by telephone by the FACUA department of Control and Analysis of Products and Services provided their rates and it is not usual practice to have a price list in these establishments" [66].

(102) The TDC Report showed the importance of promoting consumer rights and price transparency in order to ensure increased competition:

> "In the use of professional services, the best defence for the consumer is for professionals to be obliged to give a quote, along with advertising freedom. As far as prices are concerned, "a priori" nothing defends the consumer better than

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62 "Advertising Regulation for Goods and Services related to Oral Health Care", General Council of Spanish Dentists and Stomatologists, available on the web site: http://www.consejodentists.org/Normativa1.pdf

63 Article 1.2. of the Advertising Code: "In particular, all oral-dental advertising is considered to be misleading: …(iv) In relation to fees: - offering free services, which should be considered to be included in complex treatments or for which professionals do not usually receive fees; - or which refer to professional prices or fees without specifying clearly or without omitting the services included or excluded in them".

64 "*The Court of Barcelona does not consider the advertising of free dental clearing to be unfair*", Legal News, 16th November 2004, Lexur Editorial. The article mentions that "the Court of Barcelona does not consider the announcement by a dental clinic in Barcelona offering free dental cleaning to be misleading advertising or unfair competition. The Catalonia Association of Dentists and Stomatologists sued several companies under the trading name of Vital Dent, for the diffusion of an advertising campaign offering up to 24 services completely free of charge".

65 "*Open letter from the President of the COEC professional ethics committee COEC to the registered member [identity omitted by the TVDC] and by extension to other dentists acting in the same way*", COEC Magazine, No. 121 (2005), page 14. The terms of this letter are classified by alone: "In spite of the fact that the majority of health professionals are averse to propaganda, our present legal system allows it. Therefore the COEC does not publicly disapprove of the fact of advertising but it disapproves of the lies. It must be known that it sets a bad example and the adverts scandalize, and for this reason we publicly disapprove of it, regardless of the fact that it may lead to disciplinary proceedings". http://www.coec.cat/revista/121/opinio.pdf

66 *Vid.* Press Release "*FACUA detects differences of up to 433% in the rates of dental clinics in seventeen Spanish cities"*, available on the FACUA web site: http://www.facua.org/facuainforma/2004/28enero2004.htm

knowledge of the cost of the service. The obligation to provide a quote prior to contracting the service is far more favourable to the consumer than the recommended rates, because, with the knowledge of these prices, the consumer may choose a professional bearing in mind the price/reputation relationship that best suits him/her… Consumer organizations will provide users with information on what "is available" in the market. Consumers will choose the professional that best suits them."[67]

(103) In short, although the gradual liberalization of dental services has laid the foundations to introduce more competition in this market, legal/regulatory restrictions and the anti-competitive inertia of dentists continue to give considerable market power to dentists in relation to consumers of dental services, as in the European markets analysed in this Ruling.

3.3.2.2.4 Excessive Prices / Unsatisfied Demand

(104) The limited competitiveness and the lack of transparency in the dental services market is reflected in the way a dentist is selected. According to the COE Study, although "the three most valued characteristics by Spanish people when choosing a dental clinic are, on a scale of 0 to 3, *professionalism* (1.74), *best price* (1.27) and *best quality* (1), [and] other characteristics are far below 1"[68], in practice, the close environment to a person (not necessarily the best informed) is what has most weight (81%) in the choice of a dental clinic: "By a relative, 41%; by a friend, 21%; family dentist, 14%; the friendly society, 5%; the dentist is a friend, 5%; I sae a n advert in the street, 3%; yellow pages, 1%; I received a letter, 1%; magazine/radio advert, 1%; others 8%"[69].

(105) The previous considerations explain the existence of vast price differences between one dental clinic and another for the same treatment, as shown in the FACUA Study [70]. This Study analysed the prices of the four most typical dental treatments at 167 dental clinics in 17 cities and revealed that price differences between dental clinics

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67 *Vid., supra 56*, page 39. A practical reflection of this argument may be found in Investigation C-85/05 *Intur/Euro Stewart,* pages 59-60: "Undoubtedly, the lack of price transparency is one of the most significant problems. In general, the consumer is unaware of the cost of services prior to their use, which are generally used once, or at most, twice in a lifetime, which is why the consumer usually lacks references. This is the case because in the majority of cases, funeral companies fail to provide information related to the price of the various services that a burial may entail, and at times, an estimate of the total cost of services is not even provided until their final provision. It is not strange that companies are averse to communicating their rates by a telephone call. This is all possible because consumers are usually seeking an honourable funeral service without problems, which often implies that their cost is considered to be secondary. The situation of opacity is taken advantage of by funeral companies that lurk around hospitals, origin of most demises, lying in wait for potential clients, in a market in which the rules of competition usually fail to set a guideline. The immediate capture of the client at the opportune moment, does no more but to discourage the search for other alternative companies.[…]. In a market economy, price transparency rules the behaviour of suppliers, competitors and clients". (underlined by the Court)

68 *Vid., supra 34*, p. 38.

69 *Ibid*., p. 37.

70 *Vid., supra 66.*

ranged from 30 to 105 euros for a filling; from 24 to 80 euros for dental cleaning; from 72 to 270 euros for root canal treatment and from 15 to 80 euros for an extraction. Similarly, "comparing prices within the same city may offer savings of up to 289% for extraction, 233% for root canal treatment, 220% for cleaning and 150% for a filling".

(106) Audiovisual aids have also analysed the problem of price differences of various multiples, accompanied in many cases by diagnosis differences which are difficult to justify in medical science terms[71].

(107) Therefore, in spite of the fact that the offer of dental services has increased in recent years with the incorporation of new dentists to the employment market, the prices of dental services have continued to rise (although to a lesser degree than in previous periods) in general terms: The COEC I Study admits that "according to data from the National Statistics Institute (INE), the variation of the *Dental services* sub-group in the Consumer Price Index (CPI), has undergone a moderate increase, an average of 3% in the last five years"[72]. An index of dental prices, based on notable market power (higher than competitive prices), continues to grow approximately in line with the CPI in spite of the notable increase in dentists, far from reflecting an excess of aggregate supply and infra-competitive prices, shows that the initial market power, although stabilized, continues to provide supra-competitive prices[73].

(108) In fact, the COEC II Study reveals that expenditure on dental health represents the most important component on family health expenditure: "in Spain the amount spent on dental appointments is higher than payments in chemists or private insurance medical appointments (of every 100 pesetas spent by a family on medical services, 28.4 goes to a dentist and 8.2 on health care insurance in general)"[74].

(109) However, what is most significant is that demand for services is directly related to individual or family income, so there is a segmentation between consumers of dental services (medium-high to high income segment) and infra-consumers (medium-low to low income segment): "in 1995 only 20% of families admitted to oral health expenditure, whereby 67% of this expenditure corresponded to 33% of higher income

[71] "*Reporteros*" Programme of 24th September 2007, Informativos Telecinco, available on the web site http://www.informativos.telecinco.es/reporteros/dentists/dn_54703.htm; and the "*El Ojo Público de los Ciudadanos*" programme of 20th September 2007, TVE, available on the web site: http://www.rtve.es/FRONT_PROGRAMAS?go=111b735a516af85cd9ecfb307b15fdb9fea7138803d67a436edec29452c18b3d66d3f191d5b04301cfde755ba18b6c6e182fef05d02e1714b9f56a8644618f7d

[72] *Vid., supra 33*, p. 22.

[73] This situation is similar to the "Cellophane Falacy" mentioned by the European Commission in Epigraph 19 of its "*Communication on the definition of the relevant market*" and analysed in greater detail in Section 3 of its "*Discussion paper on the application of Article 82 of the Treaty to exclusionary abuses*": To define the relevant market, if the market price is taken as a reference and this is higher than the competitive price due to anti-competitive or abusive practices, there is a risk of extending the relevant market to products that otherwise would not be a substitute for the product analysed. The origin of the "Cellophane Falacy" dates back to the North American Supreme Court Judgement in the case: *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377 (1956).

[74] *Vid., supra 35*, p. 48.

families, or in other words, 'the results obtained considered a visit to the dentist as a luxury for the majority of families'"[75].

(110) In absolute terms, price continues to be an important barrier in the decision to visit a dentist. According to the Consumers and Users Organization (OCU), "2 out of every 3 Spanish people surveyed declared that the high prices of treatment represent a true obstacle to visiting the dentist…which confirms that the socio-economic capacity of an individual directly conditions his/her dental health"[76].

(111) Along the same lines, the COE Study revealed that there was a wide segment of the population, particularly low income, that did not use or hardly used dental services: "By *social class,* it is worth pointing out that the low level is the segment that has not visited the dentist [in the previous 5 years] (22% compared to 12%). 87% of those interviewed in the lower class and more than 70% of those in the medium-low income bracket visit the dentist only if they have a problem, compared with 45% of citizens in the high income bracket and less than 60% of those in the medium-high income bracket (*Figure 7, page 14*). Almost 80% f those interviewed in the low income bracket and more than 50% of those in the medium-low income bracket would prefer to pay less for an adequate quality treatment, rather than paying more for increased quality (*Figure 13, p. 17*)[77].

(112) In relation to the under use of dental services in the Basque Country, the COE Study provided revealing data. On one hand, 76% of those interviewed in the Basque Autonomous Community (compared with 68% of the state average) visited the dentist only if they have a problem or are in pain (*page 13*). "Surprisingly, the Basque Country: is the area in which dentists have been visited less [in the previous 5 years] (36% compared with 12%)" (*page 36*). The Basque Country also "stands out for having performed less fillings (46% compared with 59%), cleaning treatments (44% compared with 53%), check-ups (37% compared with 52%), prevention (3% compared with 8%) and whitening treatments (1% compared with 4%)"(*page 27*).

(113) The direct relationship between income and consumption of private health and dental services is also reflected in the acquisition of insurance. According to the COE Study, "by *social class,* the differences are far more significant. In the case of medical insurance, it ranges from 53% of the higher class to 6% of the low class. In the case of Dental Policy, it ranges from 15% of the higher class to 0% of the low class." (*page 40*). The COEC II Study also emphasized this aspect: "Once access to the dentist in our country is mainly through the private sector with private funding, the externalities created by the fact that there are groups who do not access this type of insurance must be evaluated from the point of view of public policies. In fact, like age and sex, income differences are an important factor in the purchase of a private health insurance: the

[75] *Ibid.,* page 48.

[76] *Vid.,* OCU Press Release, "*The high price of dental treatments is the main obstacle to visiting the dentist*", (August 2005), available on the web site: http://www.ocu.org/map/src/231731.htm

[77] *Vid., supra 34.*

probability is three times higher if an individual has a net family income in excess of 1,500 euros per month".[78]

(114) In short, the existence of a situation of infra-demand for dental services, led the COE to conclude that there was an enormous gap to stimulate demand: "In both cases, [existing and potential consumers of dental services] it is evident that there is still an important potential for demand which for many treatments may be described as exceptional" (*p. 27*).

3.3.2.2.5 Concentration of income in a segment of dentists

(115) As reflected above, the competitive deficiencies of the market do not affect all consumers equally, as low income consumers use few dental services or do not use them at all, giving rise to an exclusion phenomenon.

(116) Insufficient competition also affects dentists unequally as shown in the TDC Report[79]. Those who have been in the professional practice for a long time and have taken advantage of the existing competition restrictions to develop a captive portfolio of clients are the greatest beneficiaries. On the other hand, dentists that are recently incorporated into the profession or are going to do so in the future are relatively affected by the competition restrictions and information asymmetry regarding price and quality. Looking at an analogy with other sectors that were previously protected from competition and which are now liberalized, we may talk about established dentists ("incumbents" or former monopolists) and new dentists ("new entrants").

(117) Along these lines, the COEC I Study revealed that "in accordance with data from the SABI (Annual Iberian Balance Sheet Analysis System) database, it is observed how 68% of net declared income (operating margin) in the dental services market in Catalonia are concentrated in 25% of dental clinics"[80].

3.3.2.2.6 Need to adapt to a free competition market

(118) Although the main objective of the COEC when commissioning two studies into dental services was to initiate a campaign to demand greater regulation of the sector[81].

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78 COEC II Study, *supra 35*, page 65.

79 TDC Report, *supra 56*, p. 49: "there are some sectors of professionals who may be favoured even in the short term, mainly young people and women. By accepting less remuneration, these sub-groups will see an increase in their income and possibility of working with the liberalization of the sector. Extremely competent professionals will not be adversely affected either, as their salaries are already above the rates. Innovative professionals, who try to adapt their services to consumer and user demand will also be favoured. Those who will be most adversely affected will be the numerous men and few women who have been established in the business for some time, whose services are of a similar or lower quality than that of new professionals entering the market".

80 COEC I Study, *supra 33*, pages 29-30.

81 *Ibid.,* p. 11: "It is important to mention that the ultimate objective of this study is to explain the main obstacles faced by the current supply of private dental care services in Catalonia and justify the need to consider regulatory measures, rather than compile and describe market data".

The COEC II Study dedicates a chapter ("*Future Challenges for the Professional", pages 91-97*), to discussing the need for each dentist to adopt a "competitive strategy" in the market, which covers "client loyalty", the "perceived quality of the service and client satisfaction", "human resources", "prices", "the payment system", "advertising", "additional services", "new technologies", the business structure ("alone or associated?"), and the "adaptation of supply to demand".

(119) Like in any other market, the competitive emphasis may focus on service, price or both (*p. 91*). In relation to prices, it is shown that costs leadership is not a monopoly of the large clinics and may even be more easily assumed by professionals (p*age 93*). Similarly, a reduction in fees does not necessarily mean a reduction in income, as it may be offset with greater productivity and improved "economic administration" (*page 93*).

(120) Like in any other market, what is particularly relevant is for dentists to apply price flexibility (some listed and/or ad hoc free services, discounts for certain groups, such as children or senior citizens, discounts to family aggregates, etc.) which allows new clients to be attracted and the loyalty of existing clients to be cultivated (*page 93*). In a progressively competitive market, advertising "marked by passing on an image of trust and credibility" also takes on a great deal of importance (page *94*). In short, each professional must adapt supply to demand: "He/she must be aware of the possibility of changes in the treatment provided in accordance with the type of patient. In terms of the location of the clinic, the Professional must be able to identify the supply and demand of existing services. […]. However, the Professional must not only focus on the existing professional demography in the area, but must also verify existing demand (epidemiological and socio-economic characteristics, membership level of intermediary organizations), prices and services offered by competitors and potential differentiation strategies" (*page 97*).

(121) In conclusion, like any other goods or services market, professional or otherwise, competitive dynamics "forces" the dentist to offer the best service at the lowest price. However, considering a market in which competition still faces diverse legal restrictions and inertias against competition between professionals (for example, in relation to advertising), the competition authorities must pay special attention to avoid conduct in breach of the Competition Act, which endangers the delicate competitive balance of the market:

> "Even following the reform, special vigilance of the sector is required for two reasons. First of all, a sector that has been protected from competition for so long will have inertia to continue operating against free competition. What is called competition in other sectors of the economy is called unfair competition in the professional sector. Secondly, special vigilance is required because as long as radical reform is not proposed, exceptional power, which is not given to other groups of citizens, is left in the hands of professionals and therefore it is necessary to take care so that it is used in the interests of the majority of citizens" (*TDC Study, page 44*).

3.4 JURISPRUDENCE AND ADMINISTRATIVE RULINGS

(122) Prior to commencing the legal evaluation of Section 3.5.b) of the Contract, it is worth studying Spanish and European Community background which may influence or serve as reference in the analysis that this Court must carry out.

(123) Similarly, the two American federal authorities for the protection of competition, the *Federal Trade Commission* ("FTC") and the *Department of Justice* ("DOJ"), have accumulated vast experience in the application of competition regulations in the field of healthcare. Therefore, this Court considers it relevant to study the application of the American competition law's "Most Favoured Customer Clause", as the Contract formally contains an equivalent clause, although its real effects are much more restrictive (minimum price obligation).

3.4.1 EUROPEAN UNION

(124) The European Commission has analysed the effects of a "Most Favoured Nation Clause" on at least two occasions.

(125) In a press release published in 2005, the Commission informed that in the course of an investigation initiated within the framework of Article 81 TCE, the companies E.ON Ruhrgas and Gazprom had agreed to withdraw a Gazprom favourable clause from their gas supply contract, which prevented E.ON from reselling gas purchased outside Germany as well as another E.ON favourable Clause, which prevented Gazprom from offering more favourable conditions to other gas purchasers in Germany[82].

(126) Similarly, the European Commission succeeded in making several Hollywood Studios remove the "Most Favoured Supplier" Clauses from their European Pay Channel contracts. The Commission considered that these Clauses distorted the free setting of prices and produced price standardization similar to a cartel[83].

3.4.2 SPAIN

(127) Competition relations between insurance companies and health professionals have given rise to three types of sanctioning Investigations before the Competition Authorities.

(128) First of all, on various occasions, the TDC has sanctioned insurance companies with a dominant position in regional healthcare insurance markets for imposing exclusivity agreements on professionals forming part of their medical lists, aimed at

[82] European Commission Press Release: "*Competition: Commission secures changes to gas supply contracts between E.ON Ruhrgas and Gazprom*", IP/05/710, 10/07/2005

[83] European Commission Press Release: "*Commission closes investigation into contracts of six Hollywood studios with European pay-TVs*", IP/04/1314, 26/10/2004: "The European Commission decided to close its investigation into the so-called Most Favoured Nation (MFN) clauses found in the contracts of the Hollywood film studios with a number of pay television companies in the European Union after the studios decided to withdraw the clauses. […]The Commission's competition services believe that these clauses have the effect of aligning the prices of the broadcasting rights bought by the television companies…".

preventing or limiting competition with other insurance companies. The Rulings of 27th September 2000[84] ("Igualatorio Médico Quirúrgico Cantabria"); 6th July 2000[85] ("Aseguradoras Médicos Vizcaya") and 1st April 1992[86] ("IMECOSA") are included in this group.

(129) Secondly, the TDC and the Competition Court of Catalonia ("TCDC") have sanctioned agreements and price recommendations, as well as boycotting professional health associations in their relations with insurance companies. TDC Rulings of 11th January 1999[87] ("Asisa I") and 28th June 1995[88] ("Spanish Gynaecologist Association"); as well as the TCDC Ruling of 31st October 2006[89] (Gynaecologist Association of Catalonia) fall into this group.

(130) In the "Asisa I" Ruling, the TDC sanctioned the Seville Medical Association for preventing or hindering its registered members from forming part of the medical list of ASISA, following the break down of negotiations between the Association and the insurance company to sign a Joint Agreement.

(131) In the "Spanish Gynaecologist Association" Ruling, the TDC sanctioned an Association that represented 200 of the 4,850 gynaecologists practising in Spain for establishing a scale of fees for the integration of their members in the medical lists of insurance companies and for having jointly negotiated with insurance companies. In its Ruling, the TDC rejected that this joint negotiation was necessary to counter-attack the dominant position of insurance companies, a circumstance that was not proven.

(132) In the "Gynaecologist Association of Catalonia" Ruling, the TCDC sanctioned the Gynaecologist Association of Catalonia for adopting a joint scale of fees in relation to contracts with insurance companies and boycotting ADESLAS in order to ensure the acceptance of this scale.

(133) Finally, the TDC has rejected various claims against SDC files regarding complaints against supposedly abusive and anti-competitive fees imposed by insurance companies on the professionals that form part of their medical lists.

(134) In its Ruling of 3rd June 2003[90] ("Asisa II"), the TDC rejected the complaint of the Balearic Islands Medical Association ("COMIB") regarding the filing of a report against the ASISA insurance company for the abuse of a dominant position and economic dependence consisting of imposing lower fees than in other regions and a failure to update them.

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[84] Investigation 473/99, Igualatorio Médico Quirúrgico Cantabria.
[85] *Vid. supra 16.*
[86] Investigation 305/91, IMECOSA.
[87] Investigation 423/98, Asisa.
[88] Investigation 351/94, Spanish Gynaecologist Association.
[89] Investigation 12/06, Gynaecologist Association of Catalonia.
[90] Investigation R 549/02 Asisa

(135) In its Ruling of 10th May 2002[91] ("Mutualidades/Asisa"), the TDC rejected the COMIB the filing of a claim against ASISA civil service friendly societies for anti-competitive agreements and abuse of a dominant position. The complaint filed arose from the decision by the friendly societies to include part of dental healthcare for children under the age of 14 in their health services, requiring cover by the registered insurance companies. To fulfil this request, ASISA had extended dental services to be performed by dentists on its medical list with discounts for treatments which ranged "between 60% and 90%" of the market prices. The TDC considered that the conduct of the Mutualidades (Friendly Societies) and ASISA was neither anti-competitive nor abusive, highlighting the freedom of dentists to establish their commercial prices (private):

> "whereby it must also be highlighted that this situation does not prevent the rates charged by dentists to private clients from being absolutely free, in such a way that it may be verified, as the Service pointed out, that these agreements may prove to be beneficial for the market, by representing a considerable reduction in the prices of at least some of the services offered by dentists, increasing their quality by promoting competition… whereby the conduct of ASISA regarding the provision of these services through the professionals that are voluntarily included on their medical list, establishing the rates for these services, does not represent any abuse as this conduct does not limit, control or set the commercial prices nor are they intended to divide the market or for any other anti-competitive purpose."[92] (underlined by the Court)

In its Ruling of 14th December 2000[93] ("Imeco/Caja Salud"), the TDC filed a complaint from the Association of Dentists and Stomatologists of the Balearic Islands (COEOB) against the insurance company IMECO for "the practice of conduct contrary to free competition in the implementation and marketing of a "Dental Supplement" in its healthcare insurance". The TDC considered the fact "that the rates dentists may charge private patients are totally free"[94] as one of the elements that excludes the unlawfulness of the condemned conduct.

(136) In short, the administrative practice of the TDC can be summarised as follows:

1. Having verified the dominant position of an insurance company in the regional health care insurance market, the TDC has considered their agreements with health professionals which prevent or hinder the competition of other insurance companies to be abusive. In particular, exclusivity agreements that linked 72% ("Aseguradoras Médicos Vizcaya")[95] and 18% ("Igualatorio Médico Cantabria")[96] of the doctors practising private medicine in a region have been sanctioned.

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[91] Investigation R 501/01 Mutualidades/Asisa.
[92] *Ibid.*, F.J. 2.
[93] Investigation r 419/00, Imeco-Caja Salud
[94] *Ibid.*, F.J. 3.
[95] Investigation 464/99, Aseguradoras Médicos Vizcaya, F. J. 3.
[96] Investigation 473/99, Igualatorio Médico Quirúrgico Cantabria, F.J. 7. The TVDC has calculated the % of doctors involved (360) compared to the registered doctors practising private medicine (2,400 registered members – 500 active in the National Health Service).

2. The horizontal price agreements or recommendations of health care professionals, whether accompanied by pressure measures or not, in their relations with insurance companies have been sanctioned by the TDC and the TCDC regardless of the number of professionals involved (4.12% in the case of the "Spanish Gynaecologist Association"[97] and unknown in the case of the "Gynaecologist Association of Catalonia").

3. The TDC has not considered that agreements of a dominant[98] or non-dominant[99] insurance company, with health professionals may represent abuse of a dominant position or economic dependence (excessively low prices) or the setting of anti-competitive prices in relation to the services provided by the dentists to patients of the insurance company. However, the TDC unequivocally confirmed in the "Imeco/Caja Salud" and "Mutualidades/Asisa" Rulings that one of the elements that validated the negotiating conduct of the insurance companies with health professionals was that no restrictions or limitations were imposed on their freedom to set their private rates. In this Ruling, however, it has been proven that IMQ imposes minimum private rates on dentists included in its Dental Policy.

3.4.3 THE UNITED STATES

(137) In The United States, both the "FTC" and the "DOJ" have carried out extensive activity in the field of health[100]. In particular, the application of the "Most Favoured Customer Clause" by insurance companies has been investigated and forbidden on diverse occasions.

(138) It is also worth pointing out that this Clause was the object of particular analysis within the framework of the Public Hearings on healthcare and the right to competition, held jointly by the FTC and the DOJ from February to October 2003. These Hearings

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97 Investigation 351/94 Spanish Gynaecologist Association, Background to Fact 4: "The Spanish Gynaecologist Association had around 200 members in 1990 out of 4,850 registered members in this speciality for the same date." The % calculated by this Court does not rule out registered professionals who do not practice privately, which was taken into account by the TDC in the legal basis of the Ruling. In any case, even applying a conservative estimate (50% of registered members in private health care), the sanctioned Association would only have represented 8.24% of active professionals in the national market.

98 In Investigation R 501/01, Mutualidades/Asisa, the claim alleged that Asisa had a 71% market share in the health insurance market of the Balearic Islands (Background to Fact 1).

99 In the Investigation R 419/00, Imeco/Caja Salud, IMEC's market share in healthcare insurance in the Balearic Islands was 26.34%

100 Both the FTC and the DOJ have a section dedicated to health on their web sites and in their staff: http://www.ftc.gov/bc/healthindex.shtm (FTC); http://www.usdoj.gov/atr/public/health_care/health_care.htm (DOJ).

led to the joint Report "Improving Healthcare: A Dose of Competition" published in February 2004[101].

(139) Analysis of decisions by Competition Defence authorities and jurisprudence allows the following principles to be deduced:

1. These Clauses may be pro- or anticompetitive according to the circumstances of each case, which excludes their classification "*per se*" as legal or illegal.
2. In the health care insurance market, the Clause may produce two types of anti-competitive effects:
   a. "Oligopostic Effect": Favours collusion between insurance companies in the health care insurance market.
   b. "Abusive or Exclusive Effect": Allows the insurance company with market power to eliminate or restrict the competition of other insurance companies.
3. In the healthcare market, the Clause may produce effects equivalent to price agreements between professionals ("cartel effect").

(140) In any case, in order for any of the identified anti-competitive effects to occur, it is necessary for market power to exist, although this market power may be shown in different forms or intensities.

1. Looking at the "oligopolistic effect", it must be proven that the insurance company market has an oligopolist structure and the Clause, applied by one or several insurance companies, contributes to establishing a reference price (in fees or excess) for all insurance companies on the market. In this case, market power is jointly exercised.
2. Looking at the "abusive effect", the analysis must determine whether there is an insurance company with significant market power, so that the Clause discourages professionals from offering discounts to other insurance companies or private patients (as it would imply an obligation of extending these discounts to the dominant insurance company and its insured parties).
3. Looking at the "cartel effect", the analysis must determine whether the imposition of a Most Favoured Customer Clause facilitates or leads to price agreements for professional services with effects on the market.

(141) By virtue of these principles, the FTC and the DOJ have pursued the Most Favoured Customer Clauses and have reached "*Consent Settlements*" on diverse occasions. The first consent settlement in this field took place in 1994 with *Delta Dental Plan of Arizona, Inc.*, an insurance company from Arizona controlled by dentists who imposed a Most Favoured Customer Clause on its members (85% of dentists in the State)[102]. Soon afterwards, the national application of a "Most Favoured Customer

[101] All of the documentation related to these Public Audiences and the "Improving Health Care: A Dose of Competition" Report is available on the DOJ web site http://www.usdoj.gov/atr/hchearing.htm. The MFC Clause is analysed in Chapter VI (Competition Law: Insurers), Section IV (Current controversies), Paragraph A (Most Favoured Nation Clauses).

[102] DOJ Press Release: "*Department of Justice and Arizona State Attorney General break up of dental group's conspiracy to eliminate discounting*".

Clause" by the leading insurance company in opthamologic insurance, *Vision Service Plan*, was condemned for the first time. The DOJ made it clear that this type of Clauses may produce anti-competitive effects, reducing the incentives of professionals to offer discounts and impeding the competition of other insurance companies[103].

3.5 THE ECONOMIC THEORY

(142) Although Section 3.5.b) of the Contract formally represents a "Most Favoured Customer Clause", in practice it imposes a minimum price on registered dentists, which must be applied to private patients (uninsured parties)[104]. Therefore, it is necessary to study the evaluations of the Economic Theory in relation to price discrimination and the ban on discriminatory prices (different).

(143) The Economic Theory understands that the objective of price discrimination is to attract maximum income from the consumer and requires three conditions: (a) certain market power; (b) segmentation of demand; and (c) impossibility of arbitration/re-sale between the different segments of demand[105].

(144) Although having certain market power is essential in order to apply discriminatory prices, in markets with imperfect competition (differentiated services; information asymmetry, etc.) price discrimination may coexist with intense competition.

(145) There are three types of price discrimination:

1. First Level: the company is aware of each consumer's evaluation of the good and may charge each consumer the maximum that he/she is willing to pay (theoretical supposition that seldom occurs in economic reality);
2. Second Level: the company applies a different unit price according to the units sold (for example, bulk discounts); and
3. Third Level: the company applies different prices to consumer segments according to their demand elasticity.

(146) The Economic Theory understands that in a sufficiently competitive supply and demand market, second or third level price discrimination increases the economic efficiency and well-being of consumers[106]. On one hand, the possibility of applying a different price according to each consumer's evaluation of the good, enables the

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http://www.usdoj.gov/atr/public/press_releases/1994/211902.htm

103 DOJ Press Release: "*Justice Department stops agreements that inhibited vision care discounting nationwide*". *http://www.usdoj.gov/opa/pr/Pre_96/December94/702a.txt.html*

104 *Vid., supra Section 2.2* and *infra* Section 3.6.1 of this Ruling.

105 *Vid.*, among others, Dennis W. Carlton and Jeffrey M. Perloff, *Modern Industrial Organization*, Third Edition, Addison-Wesley, 1999, pages 277-280.

106 This Section of the Ruling is mainly inspired on the book "The Pros and Cons of Price Discrimination", (2005), published by the Swedish Competition Authority (Konkurrensverket), which includes articles by experts in Competition Law and Economy on a worldwide scale. http://www.kkv.se/upload/Filer/Trycksaker/Rapporter/Pros&Cons/rap_pros_and_cons_pricediscrimination.pdf

company to efficiently maximise its production (for example, varying the price of air tickets as the date of the flight approaches). On the other hand, if each consumer pays for a good in accordance with his/her evaluation of the good, no group is favoured (the group that is willing to pay more) nor is anybody excluded (the group that is willing to pay less) through uniform prices, hence increasing the total demand for the good. Therefore, PERROT confirms that the ban on discriminatory prices may adversely affect the aggregate well-being of consumers by reducing or excluding the demand of an important segment of consumers[107].

(147) Even in supply and / or demand markets where there is insufficient competition, a ban on price discrimination may in certain cases generate anti-competitive effects. For example, SPECTOR[108] confirms that the ban on applying different prices imposed on the seller by purchasers with market power may strengthen the seller's market power, because the purchasers will have no incentive to negotiate more advantageous prices, hence reducing competition in both markets. Similarly, the ban on prices facilitates collusion in both markets. PERROT also analyses the ban on discriminatory prices as a strategic mechanism to maintain higher prices[109], whilst GERARDIN and PETIT reach the same conclusion in relation to oligopolist markets: in a market with a downward ogilopolist demand, the ban on different prices imposed on the supplier standardizes the costs of the oligopoly and favours collusion in retail prices. Likewise, in ologopolist supply markets, the ban on different prices favours price collusion against purchasers[110].

3.6 COMPATIBILITY OF CONDUCT WITH THE COMPETITION ACT

[107] "*Towards an effects-based approach of price discrimination*", ANNE PERROT, "The Pros and Cons of Price Discrimination", (2005), pages 161 and following: "The second lesson is that if discrimination banning leads the firm to leave the segment of consumers with low valuation in order to serve only high value consumers at a higher price, then discrimination banning is a bad thing: it leads in this case to a reduction in total quantity which is certainly disadvantageous for consumers" (p. 171).

[108] "*The strategic uses of price discrimination*", DAVID SPECTOR, "The Pros and Cons of Price Discrimination" (2005), pages 187 and following: "Any discussion of price discrimination should balance the possible drawbacks of discrimination against those of non-discrimination. It turns out that in many settings, a ban on discrimination would facilitate the exercise of monopoly power, or facilitate collusion" (pages 199-200).

[109] PERROT, *supra* 107, page 170, note 7: "It may be the case, however, that bans on price discrimination play the role of a commitment device not to lower some prices available to some consumers. The impossibility to price discriminate may then allow the firm to reach more profitable outcomes. Situations where these commitment problems arise are very close to those where a monopolist sells a durable good: it would benefit from a commitment not to lower its price after high valuation consumers have bought the good. Discrimination banning has the same effect as a "most favoured customer clause" through which a firm aims at committing itself to maintain high prices".

[110] *Vid.,* also "*Price Discrimination under EC Competition Law: The Need for a case-by-case Approach*", DAMIEN GERARDIN and NICOLAS PETIT, "The Global Competition Law Centre Working Papers Series", Working Paper 07/05*:* "Third, the decisional practice of the Commission and the Community courts' case-law tend to ignore the fact that a ban on price discrimination may facilitate tacit collusion at both retail and supply levels, in a similar way as 'Most Favoured Nation Clauses' notoriously do" (p. 23).
http://www.coleurop.be/content/gclc/documents/GCLC%20WP%2007-05.pdf

(148) Article 1.1 of the Competition Act "forbids all joint agreements, decisions or recommendations or organised or conscientiously parallel practice, that aims to produce or may produce the effect of preventing, restricting or distorting competition in the entire or part of the national market and, in particular, those that consist of: a) direct or indirect fixing of prices or other commercial or service conditions".

(149) This Section of the Ruling clarifies the practical scope of the Clause, regardless of its formal consideration (*Section 3.6.1*); It confirms the existence of an agreement between IMQ and each of the dentists in relation to this Clause (*Section 3.6.2*) and a IMQ's situation of market power compared to them (*Section 3.6.3*); and concludes that the Clause objectively restricts competition (*Section 3.6.4*). Having concluded that the Clause is contrary to the Competition Act, the Court considers it pertinent and necessary to impose a sanction on IMQ (*Section 3.6.5*).

3.6.1 SCOPE OF THE CLAUSE

(150) The SVDC and IMQ disagree on the scope of the Clause on two basic aspects.

(151) IMQ states that the Clause only guarantees its insured parties the lowest prices that each dentist on its medical list offers to private patients. The SVDC considers, however, that the Clause bans dentists from offering lower prices than those fixed in the excesses in the IMQ Dental Policy to private patients or patients from other insurance companies.

(152) First of all, this Court must evaluate whether the Contract imposes a "Most Favoured Customer Clause" or another more restrictive obligation, such as a ban on discounts, or even, a minimum price obligation.

(153) Formally, the Clause only obliges dentists on the IMQ dental list to offer its insured parties the lowest prices that are offered to other patients and therefore respond to the mechanics of a Most Favoured Customer Clause. However, in the proven Facts, it has been shown that the IMQ Contract is a contract of adhesion in which the prices of the three excess levels are unilaterally set by IMQ and are the same for all dentists. Similarly, the Contract does not foresee the updating of the prices set for each level, although Section 4.3 establishes that IMQ may not lower the amounts of the excesses without the consent of the Professional[111]. IMQ admitted that the price variation takes place unilaterally and applies to all dentists in its response dated 23rd May 2006.

(154) Therefore, the Most Favoured Customer Clause in a Contract of Adhesion that does not include any mechanism that enables this Clause to be put into practice, forces all dentists to respect the excesses of the Contract in their relations with private patients, denying them the possibility of offering lower prices or discounts (the dentist "expressly renounces lowering his/her private prices if this is in breach of the aforementioned obligation"). As the excesses of prices are set unilaterally by IMQ for all dentists, this

[111] Section 4.3 of the Contract (*Sheet 37*).

ban on discounts establishes a uniform minimum price for all IMQ dentists for all private patients (present or future).

(155) In short, the Clause, in the context of the Contract, fixes minimum prices regarding the dentist's private patients. The existence of three price levels in the contract and the possibility of dentists to opt for any of them each year reduces the standardization of prices imposed by IMQ but does not alter the setting of minimum prices for the private patients of each dentist.

(156) As for clients affected by the Clause, the Proposal-Report concludes that the Most Favoured Customer Clause covers the prices charged to insured and uninsured patients. On the other hand, IMQ has alleged that the term "private patient" is used in medical terminology to refer exclusively to an uninsured patient.

(157) In spite of the fact that the IMQ has not provided any evidence to support its declaration, this Court is willing to accept that "private patient" is used in medical terms to refer to an uninsured patient.

(158) However, legal hermeneutics require the Clause to be analysed in its entirety to define its scope. Therefore, this Court considers that even accepting that the term "patients requesting their services privately" used in the Clause, is equivalent to "uninsured patient", it is difficult to reconcile with the end of the same phrase "without referring to their condition as IMQ insured party and / or beneficiary". Effectively, this expression is either entirely redundant (something strange in a legal contract) or it aims to limit the scope of the term "uninsured patient" to patient not insured by IMQ and, therefore, extend the scope of the Most Favoured Customer Clause to prices charged to all patients who have not cited "their condition of IMQ insured party and/or beneficiary".

(159) In any case, having resolved that the Clause is contrary to Article 1.1a) of the Competition Act, even if the scope is limited to uninsured patients, it is not necessary to make a pronouncement on this question.

3.6.2 TERMS AGREEMENT BETWEEN IMQ AND DENTISTS

(160) The Contract in which the Clause object of this disciplinary Investigation is inserted is a Terms Agreement between IMQ and each of the dentists ratifying the Contract to form part of the dental health list of the Dental Policy that IMQ offers its insured parties.

3.6.3 MARKET POWER OF IMQ COMPARED TO DENTISTS

(161) The Proposal-Report states that: (1) IMQ enjoys a high market share in dental insurance in Vizcaya; (2) there is a close relationship between dental insurance and health insurance, in which IMQ occupies a dominant position; and (3) IMQ offers an important discount when the Dental Policy is taken out as a supplement to a Health Policy.

(162) The competitive analysis of the relevant markets confirms the existence of IMQ's market power in dental insurance in Vizcaya.

(163) Effectively, there is a close relationship between health insurance and dental insurance, which determines that the competitive position of a company in the former market determines its competitive position in the latter[112]. This close relationship is based on various factors:

(164) First, healthcare insurance has limited dental coverage. Therefore dental insurance complements the health care insurance cover of each insurance company.

(165) Second, in economic terms, it is far more efficient for insurance companies offering a Dental Policy to sell it to their insured parties than to third parties. The insured party is familiar with the insurance company in terms of the brand and service, is located and more easily accessible to the insurance company's commercial agents and the administration costs of its Dental Policy are considerably lower. Therefore, insurance companies target clients of their general health care insurance, optimizing marketing, sales and administration costs and exploiting the synergies of both markets.

(166) In the specific case of IMQ, "although the IMQ Dental policy has no formal limits in terms of potential clients, IMQ commercial action basically targets those who are already IMQ clients by virtue of general healthcare policies, as a supplementary product due to the fact that these policies have extremely limited dental cover"[113].

(167) IMQ encourages insured parties of its General Policy to take out its Dental Policy by offering an annual price of 54 Euros if it is taken out as a supplement, compared with a cost of 114 Euros if taken out separately. Therefore, it is not surprising that forecasts for individually contracted dental policies are equal to 2.18% in 2007; 1.95% in 2008; 1.88% in 2009 and 1.93% in 2010[114].

(168) Likewise, other insurance companies also prioritize the marketing of their dental insurance as a supplement to their health care insurance. MAPFRE, the second insurance company dental insurance market share in Vizcaya, appears to sell its dental insurance exclusively as a supplement to its health insurance or reimbursement of costs[115]. SANITAS, the third insurance company in the ranking, offers dental insurance as a supplement to its general policy at a cost of 7.21 Euros whereas it costs 10.81 Euros

[112] *Vid.,* as an approximation to this question, Section 3.3.1 of this Ruling.

[113] Termination Proceeding of the SDC, Investigation 2586/05 (*page 62*).

[114] *Vid.,* Table annexed to Section 2.d of the IMQ document dated 19th November 2007.

[115] Mapfre, *Oral dental Guarantee Contract: Odontology Supplement*: "Purpose and Duration of the Cover: This guarantee aims to extend dental and stomatological services of the healthcare policy or reimbursement of expenses to those incorporated. It will come into effect as of its inclusion in the Specific Terms and shall have no validity on its own", available on the company web site: http://www.mapfre.com/ccm/content/documents/salud/fichero/Garantia-Buco-Dental.pdf

independently (2 euros is also charged for non excess service)[116]. ARESA, the fourth insurance company in the ranking, presents dental insurance as “Ideal to complete the guarantees of its Aresa Health Plan”[117].

(169) Third, it is easier for consumers to take out dental insurance with their healthcare insurance company as they are already familiar with its services (web page, offices, phone lines, invoicing, medical centres, etc.), in addition to being more economical.

(170) Fourth, bearing in mind that (i) income level is an important factor when taking out health insurance (general or dental); and (ii) unlike general healthcare, dental care is not considered to be vital (only in the case of oral cancer) and in many cases is perceived as aesthetic treatment, the consumer’s priority is to take out health insurance and, only when this need is covered, is a supplementary dental insurance considered.

(171) Therefore, the competitive position of IMQ in the dental insurance market must be analysed in accordance with its leading position in the health insurance market.

(172) In the disciplinary Investigation *Seguros Médicos Vizcaya* against IMQ, the company agreed with the TDC in its definition of market (private healthcare insurance in Vizcaya) and in the existence of IMQ’s dominant position in the market (with a market share of between 80% and 87%), limiting its disagreement to the abusive nature of its conduct[118]. In the ADESLAS/IGUALMEQUISA Report, the TDC declared that IMQ continued to be the dominant healthcare insurance operator in Vizcaya in 2004. The company enjoyed a market share of 87.9% whilst SANITAS and AEGON hardly reached 5.2% and 4.5% respectively; and other insurance companies in the market failed to reach 1%[119]. Finally, in the SDC Investigation 2586/05, which gave rise to this Investigation, IMQ also admitted that it held a dominant position “as a healthcare insurance company”[120]. IMQ’s privileged position, far from being weakened due to the effect of competition, appears to be solidly stable and even strengthened if we consider the evolution of its market share for the period 2004-2005, which rose from 87.9% to 91%[121]. In contrast to the significant advance of IMQ (a company with an extremely

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116 “Sanitas Dental”, information available on the company web site: http://www.sanitas.es/jsp2/web/web09/tipos_planes_detalle.jsp?v_codigo=1&v_id_idioma=3&v_idtipo=5&v_tipo_seguro=salud

117 “Dental Plan”, information available on the company web site: http://www.aresa.es/cas/plan_salu_dental.asp

118 *Vid., supra 16.* IMQ’s appeal against the TDC Ruling was rejected by the High Court (Sentence of 11th September 2003).

119 ADESLAS/IGUALMEQUISA Report, *supra 6,* page 56, page 58 (Table No. 9 – Healthcare Premiums in Vizcaya, 2004) and page 88 (Conclusion 4ª). Page 56 mentions a market share of 84.16%, which comes from Table No. 8 of the Report (page 57). This Table presents a time series (2002-2004) using Total Health data in order to preserve time homogeneity, having detected problems in the data for 2003. According to this time sequence, IMQ would have decreased its market share from 87.86 % in 2002 to 84.16% in 2004. In any case, the TDC makes it clear that the Healthcare data used in Table No. 9 best reflects IMQ’s market share in 2004.

120 SDC Termination Proceeding, Investigation 2586/05 (*page 61*).

121 The SVDC Proposal-Report, pages 10 and 12, referring to ICEA data (*pages 840 and 842*).

high market share), the market share of SANITAS experienced a slight increase (from 5.2% to 6%) and AEGON's market share fell significantly (from 4.5% to 2%)[122].

(173) The aforementioned considerations are a true reflection of the competitive dynamics of the dental insurance market in Vizcaya and IMQ's leadership position in this market:

(174) IMQ launched its Dental Policy in 2005. Its most direct competitors had begun to operate many years earlier (MAPFRE in 2002[123], SANITAS in 1997[124] and ARESA in 1997[125]); and therefore initially had a competitive advantage for having positioned themselves in the market. However, in spite of being last to enter the market (1/1/2005), IMQ has experienced meteoric growth, reaching 48.94% of the individual dental insurance market share in 2006. Its two closest competitors, MAPFRE and SANITAS must make do with market shares of 28.25% and 14.03% respectively. Only three other companies compete in this market and their market shares are irrelevant in competitive terms. IMQ's market share IMQ in Vizcaya (almost 50%), acquired in the space of 2 years, compared with the leadership of MAPFRE in Gipuzkoa (53.38%) and SANITAS in Araba (51.14%).

INDIVIDUAL DENTAL INSURANCE MARKET IN VIZCAYA (POLICIES)

2006	IMQ	ALLIANZ	ARESA	AEGON	SANITAS	MAPFRE	TOTAL
ARABA	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
VIZCAYA	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
GIPUZKOA	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
TOTALS	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Source: Data provided by the insurance companies to the SVDC (Appendix 1 of the Proposal-Report)

INDIVIDUAL DENTAL INSURANCE MARKET IN VIZCAYA (MARKET SHARE)

2006	IMQ	ALLIANZ	ARESA	AEGON	SANITAS	MAPFRE	TOTAL
ARABA	3.04%	5.97%	0.00%	0.98%	51.14%	38.87%	100.00%
VIZCAYA	48.94%	1.09%	5.91%	1.78%	14.03%	28.25%	100.00%
GIPUZKOA	0.54%	2.56%	4.68%	8.96%	29.88%	53.38%	100.00%
TOTALS	29.00%	2.05%	4.91%	3.95%	22.86%	37.23%	100.00%

[122] *Ibid*. The TVDC has compared ICEA 2005 data with Table No. 9 of the ADESLAS/IGUALMEQUISA Report, which also cites ICEA as a source.
[123] Appendix No. 3 of the MAPFRE document, *pages 588 a 590*. The date refers to the first contracts signed by MAPFRE with dentists in Vizcaya (1st January 2002).
[124] SANITAS Document, *pages 697-698*.
[125] ARESA Document, *page 350*.

Source: Data provided by the insurance companies to the SVDC (Appendix 1 of the Proposal-Report)

(175) IMQ's dominant position in health care insurance and therefore its leadership position in dental insurance, brings with it market power compared to dentists.

(176) In general, insurance company-dentist relations appear to include a variant of the "prisoner dilemma", a conflict model studied at great length by the Theory of Games[126]. In principle, each dentist would obtain greater benefits if all dentists refused to offer more advantageous conditions to insurance companies (the organized practice of professional associations and bodies illegally pursue this result). However, a dentist is particularly affected if he/she refuses to offer his/her services to an insurance company and another dentist agrees to do so (the latter will absorb the insurance company's clients). Therefore, all dentists have an incentive to work with insurance companies and the final result is a transfer of income from dentists to insurance companies and their clients.

(177) The prisoner's dilemma is particularly evident around IMQ, due to its dominant position in health care insurance and consequent leadership in dental insurance. Dentists in Vizcaya identify the competitive position of IMQ in the private dental insurance market (and therefore its negotiating power compared to their own) with its dominant position in the private healthcare market in Vizcaya[127]. This explains that although "there are no relevant conflicts in the values of the excesses, although the respective *nomenclatures vary*"[128], the COEV and ADEBI only condemn the IMQ Services Provision Contract.

(178) IMQ, like the rest of the insurance companies, unilaterally establishes the contents of its Dental Services Contract and the professionals are only able to accept or reject them. In spite of the fact that both COEV and ADEBI considered that the prices of the excesses established by IMQ were lower than the cost of providing the service; COEV filed a complaint against IMQ on two occasions to open its dental health list to all dentists interested in forming part of it in view of the strong presence of IMQ in private health insurance in Vizcaya.

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126 Theory expressed by the mathematician Von Neuman in his *Theory of games and economic behaviour,* (1944). Further information: http://es.wikipedia.org/wiki/Dilema_del_prisionero

127 In relation to COEV: "The Body notified IMQ on 21/01/2004 that it was aware of the Plan and…given IMQ's strong presence, its ideas should be opened to all interested registered members in Vizcaya …Subsequently, on 25/02/2004, Body notified IMQ of the posture adopted at the Extraordinary General Meeting of "frontal rejection of the Dental Plan". Similarly, "on the basis of the strong presence of the Igualatorio in Vizcaya, we request that all registered members who wish to be included on the medical list should be allowed to do so" (SDC Termination Proceeding, pages 62-63). In relation to ADEBI: "ADEBI…declared that…"the facts object of the complaint… were the dentistry professional services availability contracts which are the basis of the "IMQ Dental Policy …Given that, as declared and recognised, the IMQ holds 85% of the policies underwritten in the private insurance market in Vizcaya, so the imposition of prices in the Contracts represents a reduction in rates that are not subject to these Contracts" (SDC Termination Proceeding, *page 64*).

128 IMQ Response to the Statement of Facts, *page 810*.

(179) In spite of the supposedly "abusive" conditions of its Contract, IMQ has a dental health list comprising of a high number of dentists (123 according to IMQ; 132 according to COEV; 147 according to SDC; 149 according to SVDC), compared with the considerably more limited lists of its competitors.

(180) Confirming that IMQ has market power does not imply that all dentists are legally obliged to work with the company (this would be equivalent to a monopoly)[129]. In this case, IMQ has refused to open the lists of its Dental Policy to all dentists, in spite of COEV's express request to do so, and IMQ has limited the possibility of entering its dental lists practically to the dentists on its General Policy, refusing practically all applications from dentists that are not included on its Health Policy medical list, to form part of its Dental Policy list[130]. IMQ's market power implies that the company may impose its conditions on dentists without the counterweight of competitive pressure from other insurance companies and dentists themselves.

3.6.4 RESTRICTION ON COMPETITION

(181) The Clause aims to set minimum prices for dental services to private patients and represents a restriction on competition contrary to Article 1.1.a) of the Competition Act.

3.6.4.1 Setting Minimum Prices for Private Patients

(182) The "Most Favoured Customer Clause" guarantees a company the most advantageous price offered by its supplier at all times. The academic doctrine and the Competition Defence authorities coincide on the fact that this Clause may have pro or anti-competitive effects depending on the market power of the beneficiary[131]. In this case, IMQ has enormous market power in private dental insurance in Vizcaya, under its dominant position in private healthcare insurance. It must be taken into account that the dental services market is characterised by the existence of regulatory restrictions (for example, recommended price scales). These circumstances suggest that IMQ's imposition on dentists of a "Most Favoured Customer Clause" in relation to the prices offered to private patients may produce anti-competitive effects.

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[129] In the same way that IMQ's dominant position in health care insurance does not imply that all doctors are obliged to form part of its medical lists, and in fact, in the "Aseguradoras Médicos Vizcaya" Ruling, it was proven that IMQ's exclusivity requirement only affected 72% of doctors practising in Vizcaya.

[130] In Section 1.d of IMQ's Reply to the Best Supplier Procedure ordered by the TVDC, IMQ has clarified that within the framework of its "commercial policy" it determines the number of dentists that form part of its medical list for its General Policy and Dental Policy. In fact, IMQ considers that the need for dentists for its General Policy (and its Dental Policy by extension) is covered with the dentists that currently form part of its medical list (229 professionals). In spite of the fact that 106 of them declined to extend their services to the Dental Policy, IMQ has rejected 38 of the 42 applications from professionals interested in simultaneously accessing both the General Policy and the Dental Policy

[131] *Vid., supra* Section 3.4 of this Ruling.

(183) However, the Clause is not limited to guaranteeing IMQ the status of most favoured customer and imposes a minimum price on dentists for dental services to their private patients.

(184) IMQ's imposition on dentists included in its dental list of minimum prices for private services aims to restrict competition in the dental services market and indirectly in the private dental insurance market.

(185) The above Conclusion breaks up all IMQ allegations.

(186) First of all, the Clause does not exclusively regulate "a supply price between supplier and client", but it also restricts the freedom of prices of dentists on IMQ's dental health list in relation to third parties, uninsured patients.

(187) Secondly, the Clause represents "a fixed or minimum price agreement" in relation to third parties to the agreement, uninsured patients and therefore is beyond the vertical services provision relationship to IMQ insured parties. In reality, both IMQ and dentists compete to offer their services (insurance or dental service) to uninsured patients and in this case it is possible to talk about a horizontal or competition relationship between both parties. In any case, the minimum price agreement represents a particularly serious restriction on competition and therefore would not be covered by Regulation 2790/1999.

(188) Thirdly, there is no legal obstacle to sanction a Most Favoured Customer Clause in accordance with Article 1 of the Competition Act, as the Commission makes in relation to Article 81 of the EC Treaty. However, in this case, the restriction on competition is far more serious: the Contract transforms the Most Favoured Customer Clause into a minimum price obligation.

3.6.4.2 Objective Restriction of Competition

(189) The Clause aims to reduce competition between the parties, between IMQ and other insurance companies and between dentists on the dental health list.

3.6.4.2.1 IMQ-Dentists

(190) As previously mentioned, the relationship between IMQ and dentists has a horizontal or competition component. The patient may select a dentist and contract his/her dental services privately or take out a dental insurance which enables the patient to use the dental services of any dentist that forms part of the insurance company's dental health list, in accordance with the conditions agreed between the insurance company and the dentists. By unilaterally establishing the minimum price that dentists included on its dental health list may offer their dental services to third parties, IMQ

prevents private prices from being more competitive than the prices of the excesses on its Dental Policy[132].

3.6.4.2.2 IMQ – Insurance Companies

(191) Still assuming, to the benefit of IMQ, that the Clause only forbids discounts to patients requesting dental services without providing proof of insurance cover, its application may restrict competition of other insurance companies in the private dental insurance market for diverse reasons.

(192) First, who have taken out a dental insurance in which costs are reimbursed and make use of the option of visiting a dentist on the IMQ dental list, will see that the possibility of obtaining lower prices than those established by IMQ for its insured parties is diminished. This ban on discounts penalizes the emergence or growth of dental insurance in which costs are reimbursed.

(193) Second, the ban on lower prices than those set by IMQ for its excess prices may persuade holders of health insurance to take out a dental supplement. As far as health insurance holders are concerned, IMQ enjoys a dominant position in the private healthcare insurance market in Vizcaya and its market share is 91%[133]. Therefore, if there is an increase in the contracting of dental insurance as a supplement to health insurance, there is a high probability that it will be monopolized by IMQ.

(194) Third, patients without health insurance may be influenced to take out individual dental insurance or combined health and dental insurance in the event or likelihood of important dental expenditure[134]. Yet again in this case, IMQ's dominant position in health insurance and its leadership position in dental insurance is likely to attract demand for dental insurance or for a package that includes health insurance and a dental supplement.

3.6.4.2.3 Dentists

(195) Contrary to IMQ defence, the Clause imposes minimum prices on dentists included in its dental list, for application on private patients. This ban restricts competition between dentists on IMQ's dental health list in relation to private patients and has the effect of a price cartel. It also restricts competition between dentists on the IMQ dental list and other dentists, who are not subject to any minimum price obligation.

3.6.4.3 Anti-competitive effects

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[132] The price of the premium has marginal importance in relation to most of the excesses, as price comparisons are practically limited to excess treatments.

[133] *Vid.,* Epigraph (172) of this Ruling.

[134] For example, a person aged 16-25 years old would pay 45 Euros a month for an IMQ General Policy and 49.5 Euros if he/she took out the supplementary Dental Policy. On the other hand, taking out a Dental Policy alone would cost him/her 9.5 Euros a month.

(196) Although the Clause is objectively anti-competitive for imposing minimum prices on all dentists on the Dental Policy list for private services, its potentially restrictive effects on competition are significant.

(197) In the Investigation, there is contradictory data on the number of registered members that form part of the IMQ dental policy list. In the reply to the request for information from SDC dated 12th January 2005, COEV stated that the number of registered members assigned to the dental insurance was 132 (*page 63*), whilst IMQ accepted the figure of 127 in response to the Statement of Facts (*page 809*); reducing it to 125 in the reply dated 17th May 2005 (*page 61*), and reducing it even further (123 registered members) in its reply dated 19th November 2007, to the request for information from the TVDC.

(198) On the other hand, the number of registered members in the COEV on 1st January 2005 was 743 (*page 63*); a number which increased to 836 registered members in the IMQ document dated 19th November 2007. IMQ has also stated that the Stomatologists registered in the Vizcaya Medical Association should be added to this number, but in 1999, the High Court clarified that Stomatologists are obliged to register in the Association of Dentists and Stomatologists, without affecting their medical registration[135].

(199) Initially, IMQ offered all of the dentists on its medical list (225) the possibility of forming part of its Dental Policy list, which would have represented approximately 30% of dentists registered with COEV (225 out of 743). However, it must be taken into account that not all of the registered members are active (practising as dentists) and a certain number of active dentists work exclusively in the National Health Service. If the COE estimates for the whole of Spain are extrapolated to Vizcaya[136], the effective number of active members in Vizcaya on 1st January 2005 (date on which the contract came into force) would be 558 (75% of 743), of which 536 (96% of 558) would be practising privately. Therefore, IMQ offered 41% of active members practising privately in Vizcaya (225 of 536) to sign the Contract. In spite of the recommendation against COEV and the ADEBI complaint against IMQ, 22.2% of the theoretically active registered members in the private sector (119 of 536) agreed to sign the Contract. The list of dentists in the IMQ Dental Policy is not closed and is open to new incorporations of dentists from its Health Policy medical list and from other dentists in extraordinary cases[137].

(200) On the other hand, the number of dentists linked by the Contract is only an approximation of the effects of the Contract in the dental services market. The most relevant criteria would be the economic weight (invoicing) of the private dental services offered by these dentists. In this respect, IMQ has practically limited the possibility of forming part of its dental list to dentists from its medical list. IMQ has admitted that the "IMQ medical list has always included a large group of dentists"[138], so it must be

[135] Vid. Sentence 1112/1998 of the High Court, 31st January 1999.
[136] *Vid., supra 52*.
[137] IMQ Response dated 19th November 2007, page 2.
[138] IMQ response to the SVDC request for information, *page 186*.

concluded that the economic weight of these dentists is significantly greater in relation to other younger dentists, excluded from the IMQ dental list.

(201) Regardless of the percentage of dentists linked by the Contract and their importance in terms of private patient portfolio, the competition restrictive effects are important because price competition is seriously affected by legal restrictions and the lack of information on prices and services, so that competition between dentists (whether they belong to the IMQ dental list or not) in relation to private patients is extremely limited.

(202) The negative effect on consumers is also notable and particularly affects lower income consumers. Approximately 80% of residents in Vizcaya do not have health insurance[139]. In turn, extrapolating data from the COE Study to Vizcaya, it can be confirmed that practically 100% of residents without health insurance do not have dental insurance[140]. This segment is mostly represented by medium-low and low income citizens who are unable to access private health insurance or dental insurance[141]. By forbidding dentists on the dental list from charging patients without insurance lower prices than the cost of excess, IMQ is restricting price competition in detriment to a sensitive segment of the population, reducing their demand for dental services and therefore, their well-being.

(203) IMQ has repeated that the Clause was not aimed at relations between medical professionals and other medical insurance policies. The TVDC questions why the IMQ implicitly accepts that the Clause is only in breach of the Competition Act if it is applied to insured patients and not to uninsured patients. If the Clause is applied to relations between professionals patients insured with other companies, only a minority of patients insured with other companies are adversely affected, mostly those with medium-high income. If the Clause is applied to private patients, a large proportion of uninsured patients are adversely affected, particularly those with low incomes. Furthermore, private patients incur the cost of searching, comparing and selection unaware of the fact that they are unable to negotiate lower prices than those specified by IMQ.

(204) The Proposal-Report has shown that the IMQ price excesses accepted by some dentists are higher than the price excesses imposed by other insurance companies and accepted by these dentists (Proposal-Report, p. 13, *page 839*). In other words, IMQ accepts that in this case, the success of its Dental Policy is not threatened but the contrary applies when preventing the same dentists from offering lower prices to private patients, even if they are limited to equalling the lowest prices of the excesses imposed by other insurance companies.

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139 The ADESLAS/IGUALMEQUISA Report, *supra* 6, citing data from the Basque Government, estimates that 19.6% of the population of Vizcaya is insured (page 57), a figure that IMQ and ADESLAS increased to 23.84%.

140 *Vid., supra* Epigraph (68) of this Ruling.

141 *Vid., supra* Section 3.3.2.2.4 of this Ruling.

(205) Finally, IMQ has confirmed in its reply to the Statement of Facts that on one hand, "there are no relevant conflicts in the values of the excesses, although the respective *nomenclatures vary*" (*page 810*) of the different dental insurance; and, on the other hand, that "it would be unthinkable not to include an agreement on these contents which otherwise is generalized and is implicit in service provision relations between doctors and dentists and healthcare companies" (*page 807*). In this respect, it must be stated that this Investigation is limited to compatibility with the Competition Act of the Clause imposed by IMQ on dentists of its Dental Policy and the possible existence of similar infractions may not exonerate blame from IMQ. In any case, the existence of minimum price obligations, or in its mildest form, similar Most Favoured Customer Clauses would only highlight the anti-competitive effects of the Clause. Effectively, a network of similar agreements would contribute to extending a system of minimum prices (similar) even further in private dental services creating a true competitive paralysis in relation to the majority of consumers, and particularly affecting medium-low and low income consumers[142].

3.6.4.4 Lack of Applicability of the "*de minimis*" Rule

(206) In relation to the supposed "*de minimis*" effect of the Clause, this Court must reject such a consideration for two reasons.

(207) Epigraph 7 of the "*de minimis* Communication"[143] excludes from its sphere of application agreements between competitors "when the joint market share of the parties in the agreement does not exceed 10 % in any of the reference markets affected by the agreement" (section (a)) and agreements between non-competitors "when the market share of each of the parties to the agreement does not exceed 15 %" (section (b)). IMQ has a private dental insurance market share in Vizcaya of around 50%. It is more than likely that the dentists on the Dental Policy list represent more than 15% of invoicing for private dental services in Vizcaya.

(208) Regardless of the market shares of the parties, epigraph 11 of the "*de minimis* Communication" excludes from its sphere of action all agreements that contain serious restrictions on competition, such as the fixing of the sales price of products to third parties by competitors (section 1(a)). As already mentioned, both IMQ and the dentists on its Dental Policy list compete to offer their services to uninsured consumers and even to insured consumers, who may choose to go privately or even renounce their insurance if they consider that private prices and quality are better than those covered by dental insurance. The IMQ has ensured that the purpose of the Clause is to make its dental insurance attractive in relation to private dental services.

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[142] The European Commission reached a similar conclusion in relation to the "Most Favoured Nation Clauses" imposed by diverse Hollywood studios, *supra 83.*

[143] *Commission Communication on agreements of lesser importance that do not significantly restrict competition with respect to Section 1 of Article 81 of the European Union Treaty* (de minimis), Official Journal C 368/13, 22nd December 2001.

3.6.4.5 Conclusion

(209) In view of the aforementioned, this Court must conclude that the 3rd paragraph of Section 5.3.b) of the Contract (the Clause), although formally drawn up as a "Most Favoured Customer Clause", is in reality an obligation imposed by IMQ on dentists included in its dental list, to apply minimum prices to their private patients, with the purpose and effect of restricting competition in the services and dental insurance market in Vizcaya. This minimum price obligation is contrary to Article 1.1.a of the Competition Act.

(210) This Conclusion is totally coherent with the practice of the TDC in terms of the freedom of commercial prices for professionals working with insurance companies and with the administrative practice of the European Commission and the American competition authorities in relation to the "Most Favoured Customer Clause", bearing in mind that this Clause is less restrictive than the minimum price obligation, which is the object of this Ruling.

(211) Similarly, this Resolution is supported by the Economic Theory, which has demonstrated the anti-competitive effects of non price discrimination in situations of market power or oligopolist.

(212) Within the framework of dental services, each dentist should be free to adapt his/her prices and quality to the needs of each consumer in such a way that their production is optimised, increasing the well-being of their patients. This freedom is particularly necessary in a market in which diverse legal and regulatory restrictions subsist, as well as anti-competitive inertia among professionals.

(213) On the other hand, if a third party imposes a minimum price on a dentist for private services, he/she is prevented from offering sufficiently attractive prices to consumers who would be willing to hire their services at a lower price. This minimum price obligation is considerably more harmful than a fixed or uniform price obligation, because the dentist maintains the freedom to discriminate prices "upwards", or in other words, to obtain more income from consumers who are willing to pay more than the minimum price. Therefore, the minimum price obligation does not benefit any private consumer and seriously affects low income consumers and any other consumer who may be attracted by a special price (first treatment free of charge, family discounts, etc.).

(214) The strategic use of the ban on discounts or imposition of minimum prices, described in the Economic Theory, demonstrates its entire potential in the services and dental insurance markets. Through the imposition on dentists of the minimum price to be charged to private patients, IMQ produces a "cartel effect" in the dental services market, further restricting competition that is already deteriorated due to legal restrictions and information asymmetry. At the same time, this minimum price for private services is likely to increase the market power of IMQ in dental insurance and healthcare insurance through the transfer of private patients to insurance ("abusive or exclusive effect"). Similarly, bearing in mind that the dental insurance market is highly

concentrated, the imposition of minimum prices may relax the competitive tension between IMQ and other insurance companies, generating or strengthening an "oligopolist effect".

(215) In short, the justification and the final purpose of competition regulations in the European Union, the United States, Spain and all countries with advanced Competition Defence systems is the protection and well-being of the consumer ("*consumer welfare*"). IMQ, like any other company, may use all of its competitive energy in the market, but business success cannot be achieved at the expense of the well-being of the majority of consumers.

(216) In any case, the withdrawal of the Clause, far from restricting the competitive capacity of IMQ, would contribute to strengthening its zeal compared to dentists and other insurance companies, and this would all lead to a greater efficiency of IMQ and improved well-being of all insured or uninsured consumers.

3.6.5 SANCTION

(217) The Competition Act sets out in Article 10. 1 that the TVDC "may impose fines of up to 150,000,000 pesetas (901,518.16 euros) on economic agents, companies, associations, unions or groups that violate, either deliberately or through negligence, the stipulations in Articles 1, 6 and 7, whereby this amount may be increased by up to 10 percent of the sales volume corresponding to the economic period immediately prior to the Ruling".

(218) IMQ has deliberately or negligently acted against the Competition Act, which deserves an economic sanction.

(219) Article 10.2 of the Competition Act states that "The amount of the sanctions will be set in accordance with the severity of the infraction, bearing in mind: a) the mode and scope of the restriction on competition; b) the size of the affected market; c) the market share of the corresponding company; d) the effect of the restriction on competition on effective and potential competitors, on other parties in the economic process and on consumers and users; e) the duration of the restriction on competition; and f) the repetition of the forbidden conduct.

(220) This Court considers that, in accordance with the principles of disciplinary law, the fine may be divided into three levels. To establish the level of the corresponding sanction, this Court must take the following parameters into account:

(221) IMQ and the dentists in its Dental Policy have no intention of creating a price cartel (although the Clause may produce similar effects), nor is IMQ guilty of abusing its dominant position. Therefore, it appears reasonable to exclude the application of the maximum level of the sanction.

(222) On the other hand, in this case, a series of elements are combined justifying the application of the middle level of the sanction (300,507-601,012 euros):

1. IMQ is a dominant company in the private healthcare insurance market in Vizcaya and has considerable market power in the related private dental insurance market in Vizcaya.
2. The IMQ Contract prevents dentists on its dental health list from applying lower rates that those set by IMQ in the Contract to their private patients, hence producing cartel effects in the dental services market rand excluding and /or oligopolist effects in the healthcare/dental insurance markets.
3. This ban is objectively restrictive and as a result of its effects, the competition between (a) IMQ and dentists on its dental health lists; (b) IMQ and other insurance companies, particularly those that opt or may opt for the reimbursement model; and (c) dentists on its dental health lists, and between these and other dentists. This restriction on competition acquires special importance when dealing with a market in which competition between dental professionals has been non-existent and in which legal restrictions and significant information asymmetries persist.
4. The restriction on competition has the potential effect of reducing the well-being of uninsured consumers in Vizcaya, who represent approximately 80% of citizens. This restriction on well-being particularly affects medium-low income consumers who cannot afford health insurance with a dental supplement or a dental insurance. Similarly, the restriction on competition in dental insurance (without ruling out an indirect effect on health insurance), may reduce the well-being of consumers insured in Vizcaya by IMQ and with other insurance companies.

(223) In order to set the exact amount of the sanction within the middle level, this Court considers it to be relevant that (a) the dental insurance market lacks significant economic weight and only represents a small part of insurance companies' business; (b) insurance companies are developing competitive strength in the healthcare and dental insurance market compared to the rejection of the professional Bodies and Associations; and (c) the Contract allows certain competition between the three price levels set out in the Contract. Therefore, this Court considers setting the sanction at the lowest amount of the middle level (300.507 Euros), without taking into consideration in this specific case, the possible concurrence on the IMQ of the repetition factor.

(224) This sanction represents approximately 0.24% of the value of IMQ insurance premiums in 2005[144]. Although no information on IMQ invoicing in the last economic period prior to this Ruling is available, there have been no significant changes in IMQ business since 2005, so it appears reasonable to conclude that the sanction imposed does not exceed the maximum limit set out in the Competition Act (10% of IMQ's total invoicing).

(225) For future reference, this Court wishes to indicate its willingness to take into account the graduation of the fine, the initiatives of companies to offset the damage

[144] The Proposal-Report estimates that the value of IMQ insurance premiums totalled 123,868,235 Euros in 2005 (*page 842*).

caused, either to companies and consumers directly affected by their conduct, or to consumer associations, when it is impossible to identify the individually affected consumers[145].

4 SECONDARY QUESTIONS

(226) In the Investigation and, particularly in this Ruling, other conduct has been identified which raises doubts in terms of its compatibility with the Competition Act. A lack of transparency in the cost of dental services has been detected, which may require the active intervention of the Administration to counteract it.

4.1 JOINT RECOMMENDATIONS AND AGREEMENTS BETWEEN PROFESSIONALS

(227) The campaign developed by the COEC against insurance companies and dental franchises, as well as in favour of more restrictive regulation of the profession is a paradigmatic example of an initiative by an economic group to increase its "capture" of the legislator in order to increase its privileges (recognised in the Professional Associations Act) in detriment to consumers of dental services and recently qualified dentists.

(228) The unoriginal COEC arguments in an attempt to isolate an economic sector from free competition, were forcefully refuted by the TDC Report: price freedom generates unfair competition (COEC I Study p. 22; TDC Report, p. 55); joint business [franchises and insurance] promotes the lack of responsibility of professionals (COEC I Study, pages 30-31; TDC Report, page 55); freedom of prices will lead to "bad practice" and, in general, a reduction in quality (COEC Study, pages 30-31; TDC Report, pages 55-56); freedom of prices has a limit: the dignity of the profession (COEC I Study, p. 73; TDC Report, p.57).

(229) Although attempts to "attract the legislator" are legitimate in a democracy and cannot be legally reproached, business conduct that restricts competition and is not exempt by law, may violate the Competition Act. In particular, joint negotiation with insurance companies without the protection of Article 2.5 of the Professional Associations Act or the application of different pressure measures and boycotts against them or other economic operators, may fall into the sphere of the Competition Act and

[145] *Vid.,* Commission Decision, of 21st October 1998, regarding a procedure in accordance with Article 85 of the EC Treaty (IV/35.691/E-4: Cartel in the pre-insulated tube market, *DO L 24, of 30/01/1999*, Epigraph 172 (reduction in the basic amount of the fine of 30 million Ecus), http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31999D0060:ES:HTML;
and Commission Decision, of 30th October 2002, regarding a procedure in accordance with Article 81 of the EC Treaty and Article 53 of the EEE Agreement (COMP/35.587 PO Video Games, COMP/35.706 PO Nintendo Distribution and COMP/36.321 Omega — Nintendo, *DO L 255 de 8/10/2003,* Epigraphs 440-441 (reduction of the fine by 300,000 Euros), http://eur-lex.europa.eu/LexUriServ/site/es/oj/2003/l_255/l_25520031008es00330100.pdf.

Law 3/1991, of 10th January, on Unfair Competition, if their application requirements are fulfilled[146].

(230) On the other hand, competition regulation does not prevent companies from reaching different cooperation and integration agreements to obtain increased efficiency and offer a better service to consumers. Dentists and other health professionals who seek increased integration of their activities may be guided by the "Commission Communication on horizontal cooperation agreements"[147]. Similarly, the DOJ Communication on cooperation agreements between health professionals[148], added to the extensive administrative practise of the FTC and the DOJ in this field, may offer interpretive criteria, superseded in all cases by the administrative and case law practice of the authorities and the European and Spanish courts.

4.1.1.1 DOJ COMMUNICATION: COOPERATION AGREEMENTS BETWEEN HEALTH PROFESSIONALS

(231) In the United States, the DOJ formulated some "Statements" (similar to the European Commission Guidelines or Communications) in 1996, clarifying the application of the American competition regulations in the field of health services. In particular, "Statements 4 to 9" regulate business cooperation agreements between health professionals and third parties, like insurance companies[149].

(232) "Statement 4" analyses the joint communication of information not related to prices (for example, medical questions) to purchasers of services to influence their purchasing decision. "Statement 5" analyses the joint communication of information on prices, which must follow the general principles that govern the exchange of information between competitors (for example, information must be compiled by a third party). This "Statement" excludes any type of joint negotiation of prices by "non-

146 Introduction by the President to the COEC I Report, *supra 33*, is particularly hostile towards legitimate business models such as insurance companies and franchises: "…a series of intermediaries have been placed between us and the patients–dental insurance and franchises-that have not contributed to the protection of dental health. The main objective of this study is to condemn before society and through the media…. that these types of companies trivialize the profession, as they seek business profit above professionalism and consideration for the patient's health as the sole objective. […]. This Study wishes to clarify that this is all a lie. Dentistry, like the rest of medicine, is not subject only to the law of supply and demand. It is not true that intermediaries offer the best prices or the best quality. We may even say that it is exactly the opposite.. compared to these business practices that weaken professional ethics and dare I also say business ethics" (pages 5-6).

147 "Commission Communication – Guidelines on the applicability of Article 81 of the EC Treaty to horizontal cooperation agreements", Official Journal C 003 de 06/01/2001 http://eur-lex.europa.eu/LexUriServ/site/es/oj/2001/c_003/c_00320010106es00020030.pdf

148 This Section provides a brief analysis of the DOJ Communication for informative purposes.

149 Statements of Antitrust Enforcement Policy in Health Care, DOJ, 1996, available on the web site: http://www.usdoj.gov/atr/public/guidelines/1791.htm#CONTNUM_40.

integrated" professionals against third parties and any pressure method (boycott, negative supply, etc.) from its sphere of protection. "Statement 6" discusses the question of the exchange of information on prices and costs. "Statement 7" deals with common purchases by professionals, which lack problems unless purchasers have market power or the cost of the product or service purchased represents an important percentage of the product or service sold. "Statement 8", related to networks of doctors or specialists who market their services jointly, is particularly relevant. In principle, "Statement 8" offers legal cover to networks formed exclusively by less than 20% (30% if they are non-exclusive) of members of the relevant health services market, who share a considerable financial risk (indication of sufficient integration like generating notable efficiency). Finally, "Statement 9" looks at the professional networks. "Statement 9" also analyses, the "Messenger"" in which a third party acts as a messenger between professionals and the insurance companies to save transaction costs but may not provide any type of joint negotiation of prices.

4.1.1.2 CONDUCT OF THE COEV AND ADEBI

(233) Although both the COEV and ADEBI may legitimately defend the rights of their members, they cannot act as an instrument to unify the business conduct of their members in relation to third parties such as insurance companies, for example through pressure and boycotts.

(234) In relation to the COEV, the Termination Proceeding mentions that the "Association informed ADEBI that on 25-02-2004 it had notified IMQ of its opposition to the insurance company's Dental Plan– decision which had been adopted at an Extraordinary Meeting held on 18-02-2004- although the letter that was sent to the insurance company was only signed by 154 members, scarcely 20% of its membership" (*page 65*). Effectively, in its document dated 25th February 2004, the COEV notified IMQ of its "frontal rejection of the Dental Plan" (*page 62*). Similarly, a communication from the COEV to IMQ is mentioned, in which three guidelines are indicated, including "that the recommended prices approved by the Executive Board are respected" (*page 63*).

(235) In relation to ADEBI, the Termination Proceeding mentions a "*Written Claim to Association of Dentists and Stomatologists of Vizcaya*", issued to COEV by ADEBI, requesting the former's intervention before the IMQ insurance company in relation to the Dental Policy that this company was considering launching on the market" (*page 65*). Similarly, in the reply from COEV to ADEBI, mentioned in the Termination Proceeding, it is pointed out that the ADEBI document "was signed by 43 members (we are unaware of what percentage this figure represents within the association) of which, 24 had signed to continue in the IMQ under the same conditions and what was more surprising was that of these signatories, four (4) had signed the IMQ Plan Dental" (*page 65*).

(236) On 1st December 2004, ADEBI held a General Meeting and, "among the aspects that were analysed, the agreement adopted to defend the business group from the dentistry sector in Vizcaya, in light of the emergence of the IMQ Dental Policy and

the serious economic repercussions that its launch will generate on the market stood out"[150].

4.1.1.3 RECOMMENDED SCALES AND JOINT NEGOTIATION IN LIGHT OF THE "COAPI" DECISION

(237) In this Investigation, it has been proven that the recommended price scales are in line with market prices for Professional Associations and insurance companies. Therefore, COEC appears to consider the excesses which are (considerably) lower than the recommended levels established by the COEC to be unfair or predatory[151]. Likewise, the complaint by ASEBI and COEV seem to consider the IMQ excesses far lower than the recommended scales adopted by COEV. In particular, the COEV asked the IMQ to respect the recommended scales adopted by the Association[152].

(238) The Professional Association Act and the Basque Law 18/1997, of 21st November, on the practice of qualified professionals and Professional Associations and Councils, establishes the adoption of recommended price scales as one of the functions of the Professional Associations.

(239) From reading the Explanatory Preamble of Law 7/1997, modifying the Professional Association Act, it may be concluded that the establishment of recommended fees Professional Associations is not imposed: "First of all, in general, the subjection of the practice of the registered professions to the free competition system is recognised. […]. Finally, the legal authority of the Professional Associations to establish minimum fees is eliminated, although they may establish recommended scales of fees" (underlined by the Court)

(240) On the other hand, Article 2 of the Professional Associations Act appears to subject the recommended scales to the Competition Act. Article 2.1 of the Professional Associations Act establishes that "the practice of registered professions will be performed within the system of free competition and will be subject to the Competition Act and the Unfair Competition Act in terms of the range of services and establishing remuneration". Along the same lines, Article 2.4 states that "agreements, decisions and recommendations of the Associations with economic transcendence will observe the limits of Article 1 of Law 16/1989, of 17th July, on Competition Defence, with out detriment to the fact that the Associations may request the singular authorisation, set out in Article 3 of this Law".

[150] "*ADEBI held its General Meeting*", Journal of the Business Association of Vizcaya (CEBEK), No. 19, January 2005, page 20. http://www.cebek.es/ie/revistas/pdfs/CEBEK_19.pdf
[151] *Vid., supra* Epigraphs (75) y (76).
[152] *Vid., supra* Section 4.1.1.2 of this Ruling.

(241) The Decision of the European Commission in the COAPI matter[153] established that the imposition of minimum price scales by the Association of Industrial Property Agents on its members, still covered by the then valid wording of the Professional Associations Act, constituted an infringement of Article 85 (now, 81) of the EC Treaty, as far as it was not imposed by the Professional Associations Act:

> "Section ñ) of Article 5 of the Law 2/1974, by specifying that the "regulation of minimum fees for professions" corresponds to the Professional Associations, does not establish an obligation to do so. This Law does not establish the rates, or the criteria for their establishment, and leaves the responsibility of doing so with the associations. Price competition is not restricted by the Law in itself, but by the acts, permitted by this Law, of private operators brought together in their professional organization, acts which are not in line with the exercise of public power." (Epigraphs 44-45)

(242) This Court considers that there are signs that the recommended scales of fees of the Professional Associations, particularly those that are not considered as maximum price scales, represent an infraction of Article 81 of the EC Treaty, when they affect intra-community trade.

(243) The recommended price scales adopted by Professional Associations may infringe Article 1 of the Competition Act and are not exempt by Article 4 (exempt *conduct by law*). The general principle of the subjection of Professional Associations to the Competition Act may lead to a restrictive interpretation of Article 4 of the Competition Act in this field, because the Professional Associations Act establishes the subjection of Professional Association agreements to the Competition Act, <u>does not force</u> them to adopt the recommended scales of fees and, if the Professional Associations decide to adopt them, they may do so in such a way that they comply with the Competition Act, limiting them to maximum recommended prices. This interpretation compiles with the jurisprudence of the European Courts, which restrict the application of community Competition Law to legally <u>imposed conduct</u>, not merely facilitated by public bodies[154].

(244) Finally, from a constitutional point of view, the legal authorisation granted to the Professional Associations to establish average or minimum recommended scales of fees does not appear to respect the principle of equal rights[155].

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[153] IV/33.686 – COAPI, Commission Decision, of 30th January 1995, regarding an application procedure of Article 85 of the EC Treaty, Official Journal No. L 122 de 02/06/1995 p. 0037 – 0050.
http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31995D0188:ES:HTML

[154] "*Report on Competition in Professional Services*", *supra 55,* Epigraph 77: "This obligation exception imposed by the State is only applied when the State imposes a certain conduct [C-359/95 P y C-379/95 P, *Ladbroke*, Rec. [1997] I-6265, Sections 33 and 34]. Therefore, if national law simply allows, promotes or facilitates companies to incur autonomous anti-competition conduct, the obligation exception imposed by the state cannot be applied [Accumulated Issues T-191/98 T-212/98 a T-214/98, *Atlantic Container Line/Commission* Rec. [2003]]."

[155] In the Investigation 1/2007 *ASETRAVI*, the TVDC imposed a sanction of 250,000 Euros on a road haulier company in Bizkaia (ASETRAVI) for two joint price recommendations.

4.2 INSURANCE EXCESSES AS A HORIZONTAL PRICE AGREEMENT

(245) In this investigation, it has been proved that both IMQ and other insurance companies operating in Vizcaya fox excesses or prices to be paid by the insured party to the dental professional for most of the medical treatments covered by the insurance policies.

(246) These prices are unilaterally set by the insurance company in its standard services provision contract and are the same for all professionals subscribed to it, without detriment to the establishment of different price levels. In principle, the efforts of an insurance company to negotiate the most advantageous services to the benefit of their insured parties contribute to promoting increased competition in the dental services market.

(247) However, the excesses of the professional services provision contract may produce the same effect as a horizontal fixed price agreement between the professionals on each medical list. These professionals have undertaken to establish a certain price for all clients of an insurance company and therefore, they can only compete in terms of the quality of their service to capture some of these clients. Similarly, the insured parties cannot negotiate with the professionals on the dental health list even having verified, as this information is public, that some of these professionals have offered their services to other insurance companies at a lower cost.

(248) In turn, the use of a fixed price system by insurance companies in a considerably concentrated (IMQ, MAPFRE and SANITAS will take more than 90% of dental insurance in Vizcaya) and transparent (the excesses of each insurance company are public) market may facilitate oligopolist behaviour resulting in higher than competitive excess prices. In fact, the IMQ has admitted that the excess prices are similar and only the nomenclature of the medical treatments varies.

(249) For all these reasons, this Court considers that there are indications that fixed excess prices restrict competition significantly more than the establishment of a maximum price, without any apparent economic justification for this.

(250) For example, IMQ offers dentists on its medical lists the possibility of subscribing to one of three different existing rates for each medical act subject to excess. In this way, certain competition between groups of rates is allowed. There does not appear to be any justification for not establishing a maximum price mechanism (or even individual fixed prices updated by the professional, which must be below the maximum prices established by the insurance company), which establishes a competitive market within each medical list and between the different medical lists.

4.3 LACK OF CONSUMER INFORMATION

(251) This Investigation has proven that regardless of the country of residence[156], consumers of dental services face a lack of transparency that restricts the search and selection of professionals to quality and the cost of their services.

(252) In other countries active strategies have been adopted to encourage price transparency in dental services recurring to electronic means. In Spain, a similar system has been used to introduce increased transparency in the petrol station prices: all wholesale operators and all those who effectively manage fuel points of sale to supply vehicles are obliged by Order ITC/2308/2007 to issue the prices applied at this point of sale every Monday and whenever these prices change. This information is available to the public on the web page of the Ministry for Industry[157].

(253) Public or private action in this respect would contribute to introducing increased price transparency in dental services to reduce information asymmetry which Basque consumers face. Advertising maximum prices could be accompanied by other data which is considered to be relevant in the selection of a professional (for example, year of registration, academic record, post-graduate studies, professional recognition, publications, etc.).

(254) Consumer associations may play an important role in protecting consumers of dental services, promoting a greater awareness of them, efficient search and selection methods for the ideal professional and greater transparency in the market.

5 RULING

The Basque Competition Court has ruled:

FIRST. – Declare that IGUALATORIO MEDICO, S.A. DE SEGUROS Y REASEGUROS has infringed Article 1.1 a) of the Competition Act 16/89, by imposing minimum prices to be charged to private patients (uninsured parties) on dentists forming part of their Dental Policy lists.

SECOND. – Order IMQ **to notify each dentist on its** Dental Policy list in writing that they have absolute freedom to establish prices for their private patients (uninsured parties).

THIRD. - Impose a fine of three hundred thousand, five hundred and seven (300.507) Euros on IGUALATORIO MEDICO, S.A. DE SEGUROS Y REASEGUROS.

FOURTH. - Order IGUALATORIO MEDICO, S.A. DE SEGUROS Y REASEGUROS to publish, at its own cost and within a period of two months from notification of this Ruling, its verdict in the two general information newspapers in Spanish and Basque with the largest circulation in Vizcaya. In the event of failure to

[156] *Vid., supra* Section 3.3.2 of this Ruling.
[157] http://193.146.123.247/aplicaciones/carburantes/index.aspx

comply with the aforementioned, a fine of six hundred (600) Euros will be imposed for each day's delay.

FIFTH. – IGUALATORIO MEDICO, S.A. DE SEGUROS Y REASEGUROS will justify before the Basque Competition Defence Service its full compliance with all of the obligations imposed in the previous paragraphs.

SIXTH. – Urge the Basque Competition Defence Service to watch and pay attention to the fulfilment of this Ruling.

Communicate this Ruling to the Competition Defence Service and notify the interested parties, informing them that this ends the administrative channel and any appeals may be filed in the High Court of Justice in the Basque Country, within a period of two months to be counted from the time of notification.