OPHTHALMIC PRACTICE RULES

STATE RESTRICTIONS ON COMMERCIAL PRACTICE

"EYEGLASSES II"

Report of the Staff to the Federal Trade Commission and Recommendation on Proposed Trade Regulation Rule 16 CFR Part 456

Federal Trade Commission
Bureau of Consumer Protection

October 1986

OPHTHALMIC PRACTICE RULES

"Eyeglasses II"

16 CFR Part 456

Final Report by the Staff
to the Federal Trade Commission

BUREAU OF CONSUMER PROTECTION

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This report, required by Section 1.13(f) of the Commission's Rules of Practice, contains the staff's analysis of the rulemaking record and its recommendations as to the form of the final rule. The report has not been reviewed or adopted by the Commission. The Commission's final determination in this matter will be based upon the record taken as a whole, including the staff report and the report of the Presiding Officer under Section 1.13(g) of the Rules of Practice, and upon comments received during the 60-day period after the staff report is placed on the public record.

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CITATIONS and GLOSSARY

Some frequently referred to documents are cited in short form. These are described below. Also included below are descriptions of the major professional organizations that participated in this rulemaking.

Citation form	Record cite	Description
AOA Comment	H-81	Comment of the American Optometric Association (AOA), a trade association representing about 90% of all optometrists in the United States.
NAOO Comment	H-78	Comment of the National Association of Optometrists and Opticians (NAOO), a trade association of 29 optical or optometric chain firms with about 2,500 offices in 49 states.
OAA Comment	H-80	Comment of the Opticians Association of America (OAA), a trade association representing retail optical firms with affiliates in 39 states.
BE Study	B-2-31	The Bureau of Economics Study entitled "Staff Report on Effects on Advertising and Commercial Practice in the Professions: the Case of Optometry," (September, 1980).
Contact Lens Study	B-5-1	The Study by the Bureaus of Economics and Consumer Protection entitled "A Comparative Analysis of Cosmetic Contact Lens Fitting by Ophthalmologists, Optometrists, and Opticians," (December, 1983).
RRNA Study or Nathan Study	J-66(a)	The documents entitled "Ophthalmic Practice Rulemaking Statement and Exhibits — Robert R. Nathan Associates, Inc."
Notice of Proposed Rulemaking or NPR	A-1	The Notice of Proposed Rulemaking found at 50 Fed. Reg. 598 (Jan. 4, 1985).

Explanation of References

Footnotes in this staff report refer to the rulemaking record or to matters subject to official notice. Citations to the record are based upon the system established by the Presiding Officer, which groups record material as follows:

A. Public notices, petitions and motions, etc. not specifically referred to in other categories.

B. Initial Staff Report (1980) and relevant material gathered in staff investigation; staff studies; and memorandum from Director, Bureau of Consumer Protection, to Commission, dated April 13, 1984.

C. Advance Notice of Proposed Rulemaking (ANPR) and comments in response to advance notice.

D. Comments from consumers, consumer organizations and representatives of other non-industry groups.

E. Comments from representatives of federal, state or local governmental entities.

F. Comments from members of the scientific and academic communities not associated with providers or sellers of ophthalmic goods or services.

G. Staff submissions.

H. Comments from providers or sellers of ophthalmic goods or services and from ophthalmic organizations.

J. Transcripts of informal hearings and hearing exhibits.

K. Rebuttal submissions.

Hearing transcripts which appear on the record document J-71, are cited directly to the page number. As an aid to research, statutes, regulations, and case law are cited directly rather than to the record.

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I. INTRODUCTION

A. Summary of Record Evidence and Recommendations

Based on extensive record evidence demonstrating consumer injury, staff recommends that the Commission promulgate a trade regulation rule which would prohibit certain state restrictions on the commercial practice of optometry. The rulemaking record demonstrates that these restrictions raise prices to consumers and, by reducing the frequency with which consumers obtain vision care, decrease the quality of care in the market. Convincing evidence also indicates that these restrictions do not provide any quality-related benefits to consumers. Thus, the record supports a finding that these restrictions are "unfair." Further, states are not acting to remove them.

The recommended rule would bar four types of state restrictions on commercial practice: (1) prohibitions on employer-employee or other affiliations between optometrists and persons who are not optometrists; (2) limitations on the number of branch offices which optometrists may own or operate; (3) prohibitions on the practice of optometry in commercial locations (such as optical or department stores or shopping malls); and (4) prohibitions on the practice of optometry under a nondeceptive trade name. The recommended rule would not interfere with the states' ability to regulate health and safety and prevent consumer abuses.

The recommended rule is based on evidence collected during the course of an eight year investigation begun in 1976 and an extensive rulemaking proceeding initiated in January 1985 when the Commission proposed a trade regulation rule.

The Commission's inquiry into restraints on competition in the ophthalmic industry began when the Commission initiated the "Eyeglasses I" investigation into state and private restraints on advertising of ophthalmic goods and services. During the course of that investigation it became evident that restrictions on advertising were but one part of a larger system of public restraints which appeared to limit competition, increase prices and reduce the frequency with which consumers obtain vision care. Proponents of the restrictions, however, justified them as necessary to protect the public health and safety.

To obtain further evidence on these issues, FTC staff conducted two comprehensive studies. The first, published in 1980 by the FTC's Bureau of Economics, measured the price and quality effects of commercial practice restrictions. The second study, conducted by the Bureaus of Consumer Protection and Economics, provided evidence on the effect of these restrictions by measuring the comparative price and quality of cosmetic contact lenses fitting services of commercial optometrists and other provider groups.

The studies were extensive, including over 400 observations in more than 12 markets in each study. Professional groups such as the American Optometric Association, or recognized optometry

colleges, served as expert consultants in conducting the studies.

Additional evidence on state restrictions on commercial practice was collected. In July of 1980 staff published the results of its investigation in an initial staff report, entitled "State Restrictions on Vision Care Providers: The Effect on Consumers." Based on this report and the evidence discussed, the Commission published an Advance Notice of Proposed Rulemaking (ANPR) in December of 1980, requesting comments on the issues presented by the investigation and on what action, if any, the Commission should take.[1] During the 60-day comment period, 247 comments were received from interested persons.

Based on the survey evidence, the initial staff report and the comments received in response to the ANPR, the Commission, on January 4, 1985, published the Notice of Proposed Rulemaking, initiating this rulemaking proceeding.[2] During the rulemaking proceeding, 243 written comments were received: 12 from consumers and consumer groups; 159 from optometrists, sellers of ophthalmic goods and their professional associations; 69 from federal, state or local government; and 3 from members of the academic communities. Ninety-four persons testified during the three weeks of public hearings.[3] Twenty-four rebuttal comments were filed.

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1 45 Fed. Reg. 79,823 (1980).

2 50 Fed. Reg. 598 (1985).

3 Some organizations sponsored several witnesses; 74 organizations or individuals presented testimony.

At the hearings, the FTC-sponsored studies were subjected to rigorous analysis and the studies' authors were extensively cross-examined. Two additional studies were presented for the record, and other studies were cited or referred to. Other evidence of a less systematic nature was also presented.

The record indicates that the FTC Studies are the most reliable and comprehensive evidence concerning the effects of state restrictions which prevent or limit competition from commercial optometric practices. These studies provide convincing evidence that such restrictions, particularly restrictions on chain firms and other large-volume providers, raise prices to consumers and do not increase the quality of care in the market. Other evidence, including survey evidence, supports these conclusions, and no credible evidence rebuts these conclusions. Further, the record evidence indicates that commercial practice restrictions actually decrease the quality of care in the market by decreasing the frequency with which consumers obtain eye care. Thus, it is clear that state restrictions on commercial practice cause net consumer injury, in the form of higher prices and decreased frequency of eye care, and do not provide any quality-related benefits.

The evidence further indicates that each of the four specific types of restrictions covered by the recommended rule prevents or restricts competition from commercial optometric firms and other providers. Thus, this evidence, along with the study evidence, demonstrates that each of these restrictions

causes net consumer injury.

The magnitude of the consumer injury is great. The number of eye care consumers and the dollars spent on eyewear is substantial. Over half of all Americans use corrective eyewear. Over eight billion dollars was spent on eye exams and eyewear in 1983.[4] Further, the restrictions are prevalent; 44 states have one or more of the restrictions. Eye care consumers in these markets are suffering substantial injury, both financial and health-related. Thus, the aggregate harm from the restrictions is great.

The Commission has enumerated a number of standards that it will consider in deciding whether to issue a trade regulation rule.[5] One, the Commission will require substantial evidence for the factual propositions underlying a determination that an existing practice is legally unfair. Two, the Commission will consider whether the act or practice is prevalent. Three, the Commission will assess whether significant harm exists. Four, the proposed rule must reduce the consumer harm. And five, the Commission will consider whether the benefits of the rule exceed its costs. As discussed in detail in this report, the record establishes that these standards are met here.

In addition, the Commission considers promulgation of a rule

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[4] See, infra, Section II.A., "Description of the Industry".

[5] See, Statement of Basis and Purpose, Trade Regulation Rule on Credit Practices, 16 CFR Part 444, 49 Fed. Reg. 7740, 7742 (1984).

prohibiting state restraints to be a remedy of last resort, appropriate only if consumer injury is clearly shown; the alleged benefits of the state laws are minimal or absent; and the states are not acting on their own to change the laws. This is clearly an appropriate case for promulgation of such a rule. As indicated, the evidence of consumer injury is clear and there is no countervailing consumer benefit. Further, states are not acting to remove the restrictions. Despite survey evidence which has been available since 1980 showing consumer harm and no quality benefits, only a few states have responded by removing these restrictions.[6] It is unrealistic to hope that more than a few states will voluntarily repeal commercial practice restrictions in the foreseeable future.

The recommended rule is drafted as narrowly as possible to avoid any unwarranted intrusion upon the legitimate police powers of the states. The rule would prohibit only four specific types of restrictions found to be unfair acts or practices, and would avoid interfering with the states' legitimate ability to regulate health and safety and prevent consumer abuses.

In addition to prohibiting commercial practice restrictions, the recommended rule would also amend the current "Eyeglasses I" rule, 16 C.F.R. Part 456, which requires that practitioners release eyeglass prescriptions to their patients.[7] The rule

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[6] Only one state, Vermont, has entirely removed its restrictive laws.

[7] The commercial practice provisions were proposed as additions (footnote continued)

currently requires practitioners to release a prescription after every exam regardless of whether the patient requests it. Staff recommends amending the rule to require release only upon request of the patient. The evidence indicates that many consumers are currently knowledgeable enough to request their prescriptions if they want them and that most practitioners are releasing prescriptions when requested to do so.

B. Organization of the Report

The staff report begins, in section II, with a description of the industry, which provides relevant background material. State regulations governing the practice of optometry are then described and detailed charts showing relevant law in all states are presented at the end of this section.

Section III of the report discusses the evidence on commercial practice restrictions. First, in subpart B, we describe each of the specific restrictions and their prevalence and discuss how they restrict or prevent the development of commercial optometric practices, including high-volume practices and other non-traditional providers. We then discuss, in subpart C, the effects of commercial practice restrictions on consumers, especially on price and quality. Much of the evidence in this section deals with restrictions in general which inhibit commercial optometric practice. Some of the evidence focuses on

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to the Eyeglasses I rule.

specific types of restrictions.

Section IV of the report deals with the prescription release questions in this proceeding, including the recommended amendment to the Eyeglasses I rule. Other issues related to release of contact lens prescriptions and rerelease of prescriptions are also discussed.

Next, in section V, we set forth the legal basis for the recommended rule. Subpart A discusses the "unfairness" standard. Subpart B discusses preemption of state law. Issues related to whether the state is a "person", and the impact of Friedman v. Rogers are also discussed.

Staff recommendations and their bases are discussed in section VI. This section includes a discussion of the standards which the Commission considers in deciding whether to promulgate a rule. Also included is a section-by-section analysis of the recommended rule. Complete texts of the proposed rule with recommended changes and of the recommended rule are included at the end of this section.

II. THE VISION CARE INDUSTRY

A. Description of the Industry

1. Overview of Vision Care (Introduction)

The vision care industry affects most Americans, with over half of all consumers and over ninety percent of all elderly consumers using some form of corrective eyewear.[8] In 1983, the market for ophthalmic goods and services amounted to over eight billion dollars in total sales.[9] Of this, approximately one billion was spent on eye examinations, with the rest spent on the purchase of lenses, frames, and other optical goods.[10]

The vision care needs of consumers are met on a retail level by three types of eye care providers: optometrists, ophthalmologists and opticians. The services provided by these different groups overlap to an increasing extent.[11] These retail

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[8] Comment of American Association of Retired Persons, J-2 at p. 6 (Figures from U.S. Department of Health and Human Services, February 1984).

[9] NAOO Comment, at p. 7 (Figure derived from the annual National Consumer Eyewear study conducted by the Optical Manufacturers Association.) The NAOO anticipated that total 1985 sales would exceed nine billion dollars. Id.

[10] Id.

[11] See infra Section II.A.2., "Industry Members." Although the current proceeding is not concerned with the limits on the scope of practice of these provider groups, the proposed rule does impact on the ability of members of these groups to enter into (footnote continued)

eye care providers obtain their optical goods from manufacturers and wholesale optical laboratories. However, there now appears to be some integration of wholesale laboratories with large retailers and direct marketing of optical goods to consumers by wholesale mail order firms.

2. Industry Members

a. Ophthalmologists

Ophthalmologists are medical doctors (M.D.) who specialize in treating diseases of the eye.[12] They are the only eye care practitioners fully qualified to treat all eye and vision system disease, and to diagnose and treat general diseases whose symptoms may appear in the eye. Ophthalmologists may perform surgery, prescribe drugs and corrective eyewear, and use any other treatment available to licensed physicians. In order to receive certification as an ophthalmological specialist, ophthalmologists must complete one year of general internship after medical school and an additional three years of specialized hospital residency training in ophthalmology.[13]

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business relationships with each other.

[12] A small number of ophthalmologists, about two percent, may be doctors of osteopathy (D.O.). U.S. Dept. of Health, Education and Welfare, Ophthalmology Manpower: A General Profile, United States - 1968 (December 1972) (Cited in Federal Trade Commission, Bureau of Consumer Protection, Staff Report on Advertising of Ophthalmic Goods and Services, B-52-1, p. 15).

[13] National Center for Health Statistics, HEW, Health Resources Statistics (1974) (cited in Eyes I Staff Report, B-52-1, p. 16, (footnote continued)

In 1981, there were approximately 11,100 ophthalmologists practicing in the United States.[14] Table I, at the end of this Section, shows relative market shares for sales of examinations, lenses and frames for ophthalmologists, as well as for optometrists and opticians.

b. Optometrists

Optometrists, or doctors of optometry (O.D.), are trained and state-licensed to examine eyes, diagnose refractive problems, prescribe and dispense eyeglasses and contact lenses, and detect eye disease. Unlike ophthalmologists, optometrists are not medical doctors and may not perform surgery or, in most states, prescribe therapeutic drugs.[15] In nearly all states, however, optometrists may obtain board certification to use diagnostic drugs for the purpose of detecting refractive problems or eye disease. When optometrists detect the presence of an eye condition requiring medical treatment, they must refer the patient to an ophthalmologist for further appropriate treatment.[16]

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fn. 33.).

[14] Red Book of Ophthalmology, Professional Press, 1982 p. 4.

[15] G. Easton, President-elect, American Optometric Association, J-4, p. 6. In five states (West Virginia, North Carolina, Florida, Oklahoma and New Mexico) optometrists may now use some therapeutic drugs for the treatment of certain eye diseases.

[16] Optometrists may also detect the presence of other diseases, such as diabetes, which manifest symptoms in the eye. In such cases, optometrists refer these patients to an appropriate specialist. Id. at p. 3.

Candidates for an O.D. must complete four years of training in optometry school. Requirements for admission to optometry school vary, but all schools require at least some undergraduate study. Most optometrists currently hold at a least a bachelor's degree prior to enrolling in optometry school. In addition, the past five years has seen the emergence of post-graduate clinical residencies for optometrists. These residencies prepare optometrists for specialization in such areas as contact lens practice, low vision rehabilitation and binocular vision services.[17] In 1984, there were over 27,000 licensed optometrists in the United States.[18]

Although many industry observers speak of a split between so-called "traditional" and "commercial" optometrists, in reality optometric practices constitute a continuum, from strictly traditional practices at one end, to chain optometric firms at the other. Traditional optometrists engage in solo practice or in some form of partnership or professional corporation, typically practicing under their own names in relatively small office settings, with few, if any, branch offices. These optometrists are not associated with chain firms, optical corporations or other lay persons. In recent years, some traditional optometrists have begun to advertise.

On the other hand, the chain optometric store, where

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17 Id. at pp. 4-5.

18 Blue Book of Optometry, Professional Press, 1985, p. 553.

permitted by law, is often owned and operated by lay corporations. These stores generally offer one-stop shopping to consumers, providing optometric examinations and prescription-filling services in the same location. Various alternative modes of practice have arisen to offer eye examinations to consumers at these locations. Some chain firm locations directly employ optometrists to provide eye examinations. Others utilize the franchise arrangement, in which an optometrist or lay person owns and operates the individual practice location. The practice is conducted under a franchise relationship with the parent company in which the franchisee purchases equipment and supplies from the parent. In exchange, the franchisee derives the benefit of the parent's trade name and advertising.[19] Chain firms also enter into leasing arrangements with optometrists, in which optometrists lease practice space in optical stores. In states that prohibit such leasing arrangements, optometrists often locate adjacent to an optical store in a "side-by-side" or "two-door" arrangement. State restrictions likely influence which mode of optometric practice, if any, a firm chooses to adopt in a given market. According to NAOO, a trade association of large commercial firms,[20] its member firms and affiliates account for approximately 12% of the overall market for vision

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[19] See infra Section III.B.4., "Restrictions on Trade Name Usage," Section III.B.1.c.ii., "Availability of Economies of Scale."

[20] The National Association of Optometrists and Opticians (NAOO) is composed of 29 large commercial optical or optometric firms with around 2500 offices in 49 states.

care goods and services.[21]

In between the traditional optometrist and the chain firm are optometric practices with some attributes of commercial practice. These optometrists may use trade names, open multiple branch offices or locate in mercantile areas such as shopping centers. Optometrists with any of these attributes of commercialism are referred to as "commercial" optometrists in this report. In general, commercial firms are often characterized by their attempt to achieve a high-volume practice, which enables them to take advantage of economies of scale.

c. Opticians

Opticians, also known as dispensing opticians or ophthalmic dispensers, act primarily as retail providers of eyeglasses, contact lenses, and low vision aids. They may fabricate, fit, and adjust such eyewear on the basis of prescriptions issued by optometrists and ophthalmologists.[22] Opticians must therefore

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[21] NAOO Comment at p. 8. The largest of these firms, Pearle Health Services, which operates Pearle Vision Centers and Texas State Optical, has over 1000 affiliated offices and accounts for 4% of market sales. The second largest firm, Cole National Corporation, which operates outlets at Sears and Wards department stores, accounts for just over 1% of the market. Together, the top five firms account for slightly less than 8% of the market. Id.

[22] See OAA Comment at Exhibit A. Some states expressly permit or prohibit the fitting of contact lenses by opticians. However, the ability of an optician to fit contact lenses from a prescription in the absence of written lens specifications has been a matter of dispute in other states. See generally Contact Lens Study. These proceedings do not address the issue of the (footnote continued)

often rely on prescriptions issued by optometrists or ophthalmologists in order to provide their services. Opticians are not authorized to examine eyes, either for the purpose of determining the need for corrective eyewear or for detecting disease, nor may opticians provide treatment for eye disease.

Only 22 states require opticians to obtain licenses. While requirements in these states vary, opticians must generally complete a one or two year associate degree program in a community or technical college, or complete a period of apprenticeship. There are no formal requirements for practice in the remaining states, but most opticians in these states nonetheless complete some form of apprenticeship or training.[23] As many as 17,500 dispensing opticians practiced in the U.S. in 1978.[24] Most of them worked in retail optical outlets, although many were employed by optometrists or ophthalmologists.

Because opticians generally are not subject to the extensive commercial practice restrictions imposed on optometrists, their

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appropriate scope of practice for opticians.

[23] See OAA Comment at p. 5, Appendix A; D. Shaver, "Opticianry, Optometry and Ophthalmology: An Overview,"Medical Care, Vol. XII, No. 9 (September 1974) (cited in FTC, BCP, Staff Report on Advertising of Ophthalmic Goods and Services, B-52-1, p. 24, fn. 74). The American Board of Opticianry has established a standardized, nationwide examination to certify opticians, and the National Contact Lens Examiners has devised a similar examination to provide certification for contact lens fitting. OAA Comment, at pp. 5-6. Moreover, independent non-profit organizations in every state provide certification for opticians. Id at 7.

[24] Id. at Appendix B. Unfortunately, the record fails to disclose more recent figures.

practices may resemble those of commercial firms in their use of trade names, chain practices, and mercantile locations. In fact, a recent development has been the advent of the mail-order dispensing opticianry, in which a consumer may order replacement contact lenses or eyeglasses through the mail by supplying the provider with a copy of the prescription.[25]

d. Manufacturers and Wholesale Laboratories

Manufacturers provide wholesale laboratories and retailers with ophthalmic goods, including eyeglass lenses, eyeglass frames, contact lenses, and accessories. Wholesale laboratories purchase lenses and frames from manufacturers and sell them to retailers. These laboratories generally finish semi-finished lenses and place the lenses into frames in order to provide fully finished eyeglasses.[26]

Whereas most retailers traditionally purchased finished or semi-finished goods from wholesale laboratories, the development of chain optical firms has led to the growth of laboratories owned directly by the commercial firms.[27] As a result,

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[25] One of the interested parties in the proceedings, Dr. Joseph Seriani, conducts a mail order dispensing business, USA LENS, Inc. J. Seriani, President, USA Lens, Tr. 3044. Until recently, the American Association of Retired Persons offered a discount mail-order optical dispensary to its members. Mail-order dispensing is not an issue in the current proceedings, and staff takes no position on its use.

[26] See generally, Federal Trade Commission, Bureau of Consumer Protection, Staff Report on Advertising of Ophthalmic Goods and Services, May 1977, B-52-1, at pp. 11-15.
(footnote continued)

franchisees and other chain outlets may purchase finished goods from laboratories owned by their parent companies.[28] An even more recent development is the growth of the optical "superstore," in which a full service retail outlet has a complete optical laboratory on the premises.[29]

3. Development of the Industry

Optometry did not emerge as a profession until the late 1800's. Prior to that time, physicians provided eye exams and opticians made spectacles, either in spectacle shops or in jewelry stores. By the late 1800's, many of these opticians became "refracting opticians," providing eye refractions for the purpose of fitting spectacles. Physicians opposed the expanded practice of these refractionists, stating that performing eye examinations and issuing prescriptions constituted the practice of medicine. Nonetheless, refracting opticians, now called optometrists, won official recognition through a series of legislative and court battles. By 1924, every state had some form of optometry licensing act.[30]

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[27] See, e.g., "An Interview with Don Phillips," J-30, Exhibit C-1 (attachment to Statement of J. Tierman, California Assn. of Dispensing Opticians).

[28] Id.

[29] See, e.g., Testimony of R. Feldman, President, Spectron, Inc., Tr. 92; Eyeworld advertisements, J-73.

[30] See J. Begun and R. Feldman, A Social and Economic Analysis of Professional Regulation in Optometry, August 31, 1979, B-4-2, pp. 7-8; M. Hirsch & R. Wick, The Optometric Profession, J-41(m) (footnote continued)

With the adoption of state optometry laws and the formation of the American Optometric Association (AOA),[31] members of the optometric community began a strong effort to "professionalize" the industry. Part of this effort was geared towards increasing the educational standards of optometrists. Other aspects of the industry's efforts to "professionalize" optometry involved the elimination of the commercial aspects of optometric practice. States began amending their optometry acts in the 1930's to prohibit such practices as price advertising and corporate employment. Optometric associations also developed codes of ethics prohibiting these practices.[32]

In the 1970's, restrictions on advertising and commercial practice came under increasing scrutiny. Both the United States Supreme Court and the Federal Trade Commission examined restrictions on professional advertising. Beginning in 1976, the Supreme Court issued a series of decisions relating to commercial speech, determining that nondeceptive professional advertising was protected by the First Amendment.[33] In 1978, the Commission determined that optometric advertising bans constituted unfair

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(Attachment to Statement of the Southern California College of Optometry), p. 147.

31 The AOA is a trade association currently representing around 90% of all optometrists in the United States.

32 See J. Begun & R. Feldman, A Social and Economic Analysis of Professional Regulation, B-4-2, p. 9.

33 See, e.g., Virginia State Board of Pharmacy v. Virginia Citizens Consumers Council, Inc., 425 U.S. 748 (1976); Bates v. State Bar of Arizona, 433 U.S. 350 (1977); In re R.M.J., 455 U.S. 191 (1982).

acts or practices.[34]

The current state of the ophthalmic industry reflects competitive and historical tensions between the three primary provider groups. Optometrists and ophthalmologists differ on the extent to which the optometrists, who are not physicians, should be permitted to diagnose and treat eye conditions. Optometrists have slowly gained the right in many states to use diagnostic drugs and are currently seeking the authority to use therapeutic drugs for treating certain eye diseases.[35] They generally are opposed in these efforts by ophthalmologists. Opticians are striving to receive official certification in states currently lacking opticianry laws, and are seeking authorization to fit contact lenses. They are opposed in these efforts primarily by optometrists, who argue that contact lens fitting requires the specialized training and skill of the optometrist.[36]

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[34] 43 Fed. Reg. 23992 (1978) (codified at 16 CFR 456). Advertising provisions of the Eyeglasses I rule were remanded by the D.C. Court of Appeals for reconsideration by the Commission in light of the Supreme Court's decision in Bates. American Optometric Association v. FTC, 626 F.2d 896 (D.C. Cir. 1980).

[35] See G. Easton, President-elect, AOA, J-4 at pp. 2-3. Many of these states require that the optometrist obtain Board certification for use of these drugs.

[36] OAA Comment H-80 at p. 4.

Table I - I[37]

Provider Market Share
Eyeglass Lenses

Source	1983 (million-pairs)	1983 %	1981 %	1979 %	1979 - 83 % change
O.D.	20.64	37.1	37.8	39.2	(2.1)
M.D.	5.02	9.0	8.7	14.5	(5.5)
Optician	12.17	21.9	22.2	18.0	3.9
Vision Care Firm	15.53	27.9	25.7	23.8	4.1
Other	2.28	4.1	4.7	4.5	(.4)
Total	55.62	100.0%	100.0%	100.0%	- -

TABLE I - 2

Provider Market Share
Eyeglass Frames

Source	1983 (million units)	1983 %	1981 %	1979 %	1973 - 83 % change
O.D.	18.39	36.4	38.2	39.2	(2.8)
M.D.	4.31	8.5	8.5	13.8	(5.3)
Optician	11.12	22.0	21.7	18.0	4.0
Vision Care Firm	14.56	28.7	26.8	24.8	3.9
Other	2.18	4.3	4.8	4.2	.1
Total	50.56	100.0%	100.0%	100.0%	- -

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37 Tables reprinted from NAOO Comment, pp. 9-10.

TABLE I - 3

Provider Market Share
Contact Lenses

Source	1983 (million pairs)	1983 %	1981 %	1979 %	1973 - 83 % change
O.D.	4.78	41.9	44.8	42.3	(.4)
M.D.	2.26	19.8	18.3	19.6	.2
Optician	1.30	11.4	11.5	11.2	.2
Vision Care Firm	2.75	24.2	22.1	21.0	3.2
Other	.30	2.7	3.3	5.9	(3.2)
Total	11.39	100.0%	100.0%	100.0%	- -

TABLE I - 4

Provider Market Share
Eye Examinations[38]

	For Eyeglasses			For Contact Lenses		
Source	1983 %	1981 %	%Change	1983 %	1981 %	%Change
O.D.	44.2	45.7	(1.5)	45.6	47.4	(1.8)
M.D.	36.1	37.1	(1.0)	31.0	30.9	.1
Optician	2.8	3.0	(.2)	3.3	4.2	(.9)
Vision Care Firm	12.1	9.5	2.6	17.0	15.1	1.9
Other	4.6	4.2	.4	3.1	2.2	.9
Total	100.0%	100.0%	—	100.0%	100.0%	- -

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[38] The data in this table estimate the market share for each provider type for examinations which resulted in the purchase of eyeglasses or contact lenses. It does not show market share for examinations which resulted in no prescription, or where a prescription was written but no purchase made. The percentages do not equal 100% because of rounding.

B. Regulatory Environment

As with many other aspects of health care, the regulation of the practice of optometry has traditionally been a matter of state concern. Federal involvement has been only a minor factor.[39] This section will examine the patterns of regulation in the fifty states and will detail each state's significant regulations in tabular form.

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[39] The Food and Drug Administration and the Federal Trade Commission have minor roles. Contact lenses and spectacles are "devices" within the meaning of the Federal Food, Drug, and Cosmetic Act. 21 U.S.C. § 321(h) (1982); D. Sullins, Tennessee Optometrist, AOA trustee, J-39 at p. 4. As such, this Act prohibits their adulteration or mislabeling. 21 U.S.C. §§ 351-52 (1982). Food and Drug Administration regulations govern their manufacture. 21 C.F.R. Part 820. The FDA also requires that spectacles be impact-resistant, 21 C.F.R. § 410, and prescribes standards of sterility and packaging for contact lens solutions. 21 C.F.R. § 200.50; 21 C.F.R. § 800.10-12.

The Commission's "Eyeglasses I" rule requires optometrists and ophthalmologists to give each patient a copy of his or her spectacle prescription at the conclusion of the examination. 16 C.F.R. § 456.7 (1986). See infra Section IV.A., "Spectacle Prescription Release." The rule does not require the release of contact lens prescriptions, nor does it require prescription release if the patient does not pay for the exam unless the optometrist would normally not demand payment. As promulgated, the Eyeglasses I Rule also preempted certain state bans on optometric advertising. The advertising portions of the rule were remanded to the Commission in American Optometric Ass'n v. FTC, 626 F.2d 896 (D.C. Cir. 1980) because of the intervening U.S. Supreme Court decision in Bates v. State Bar of Arizona, 433 U.S. 350 (1977).

1. Patterns of State Regulation

a. Introduction

Each state[40] has an optometric practice act that typically defines the practice of optometry, provides for the appointment of a state board of optometry, establishes criteria for licensing optometrists, sets procedures for disciplining optometrists, and specifies conduct that warrants professional discipline. Many state acts also provide standards for continuing professional education, minimum eye examinations, and other matters.

State optometric practice acts typically provide for a state board of optometry to govern the practice of optometry. The board generally consists of between three and nine persons appointed by the state's governor.[41] The majority of the members of each state's board must be licensed optometrists, although most states require that at least one lay person be appointed to

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[40] The practice of optometry in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and other insular territories is regulated by locally established authorities and resembles state regulation in all respects. See, e.g., D.C. Code Ann.§ 2-1801 et seq. (1981). P.R. Stat. Tit. 20 § 531 et. seq. The optometry statutes and regulations for these locations are not on the record, B-3-1, and no analysis of them will be made herein.

[41] There are a few exceptions. Central state departments of regulation and licensing govern practice in Illinois, Rhode Island, and Utah. In New York, the board is appointed by the Board of Regents of the state university system. In California, the public members of the board are appointed by the state legislative leaders. L. Thal, President, California Board, Tr. 1853.

the board.

Optometrists play a key role in selecting the optometrist members of the board in many states. In nine states, for example, the governor is required to make appointments to the board from a list of nominees supplied by the state optometric association.[42] In two others, the appointee must be a member of the state optometric association.[43] In one state, the governor must make the appointment from a list of nominees supplied by the board itself.[44] In three states, optometrists practicing in the state elect the nominees sent to the governor.[45]

Every state delegates rulemaking power to the board or other governing body. The scope of delegation varies widely. In many states, the board's rulemaking power is very broad, such as the power to adopt "rules and regulations necessary to govern the practice of optometry,"[46] or the "power to make rules and regulations that it deems necessary or expedient."[47] In other states, the delegation is narrower, and board's rulemaking may be limited to procedural matters.[48]

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42 Arkansas, Delaware, Iowa, Kansas, Kentucky, Maryland, New Mexico, North Carolina and South Dakota. In New York and Virginia, the state associations may nominate board members, but the Governor is not compelled to appoint its nominees.

43 North Dakota, Texas.

44 Alabama.

45 Louisiana, South Carolina, Idaho.

46 Alaska.

47 Delaware.
(footnote continued)

The following subsections survey the types of regulations prevalent in the 50 states. For the purpose of this report, state regulation of the practice of optometry will be divided into three categories: regulation of scope of practice; regulation of business practices, and regulation apparently intended to assure quality of care.[49] While these classifications necessarily overlap to an extent,[50] they facilitate an organized review of the patterns of state regulation.

b. Regulation of Business Practice

Restrictions on business practices, with which this rulemaking is concerned, arise from many sources. In many cases, the restrictions are found in statute. In others, they arise from regulations promulgated by the state board of optometry. In some cases, attorney general opinions, judicial interpretation, and board interpretation may reveal restrictions not apparent from the face of the statute or regulation. For the purpose of this report, no distinction will be made between bans arising

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[48] Vermont.

[49] Classification of a statute or regulation into one of these three groups does not imply any judgment as to the actual intent or effect of a particular statute. The classification is intended only as an organizational aid.

[50] It is argued by some that scope of practice regulations and commercial practice restrictions are intended to protect quality of care. For example, regulation of the use of therapeutic drugs is a scope of practice regulation, and is doubtless intended to protect quality of care.

from statute, regulation, attorney general opinion, court decision, or board interpretation.

Commercial practice restrictions include restrictions on entering into employment or other business relationships with lay-controlled corporations and lay persons, on trade names, on branch offices, and on mercantile locations. These restrictions are discussed in detail elsewhere in this report.[51]

In addition to commercial practice restrictions, states regulate business practices in other ways. Restrictions on advertising and soliciting of patients are found in almost all states, although fewer advertising restrictions exist than was the case before 1978, when Bates v. State Bar of Arizona[52] was decided. All states prohibit false and deceptive advertising. Many states retain restrictions on advertising that specify the types of advertisements, and the size and number of office signs that may be used. The advertisement of free examinations and eyeglasses is forbidden in several states. The extent to which these restrictions are enforced after Bates is unclear from the record.

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51 See infra Section III., "Commercial Practice Restrictions."

52 433 U.S. 350 (1977). The Bates decision applied First Amendment protection to non-deceptive professional advertising. Subsequent decisions expressly applied this protection to optometric advertising. E.g., Rogers v. Friedman, 438 F. Supp. 428, 429 (E.D. Tex. 1977), rev'd in part on other grounds sub nom. Friedman v. Rogers, 440 U.S. 1 (1979).

c. Regulation of Quality of Care

Bona fide regulation of quality of care is beyond the scope of this rulemaking.[53] Since the effect of commercial practice restrictions on quality of optometric care is relevant to the rulemaking, however, some discussion of state quality regulation is appropriate.

i. Qualifications to Practice

Every state requires that optometrists be licensed in order to practice. All states require that each person applying for an license to practice optometry be a graduate of an approved optometry school.

Most states also require that the optometrist's license be displayed in the office. States that permit an optometrist to practice outside of the office frequently require the optometrist to give each patient a copy of his or her name and registration number.

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[53] To the extent that restrictions may be alleged to be related to quality of care, but bear no bona fide relation to it and have the effect of restricting commercial practice they remain within its scope. For example, a "quality of care" regulation that requires an optometrist to be physically present at each branch office for at least fifty percent of the time it is open is in effect a commercial practice restriction, since it restricts branch offices and has no relationship to quality. See infra Section III.B.2., "Branch Office Restrictions.

Continuing professional education is a requirement for license renewal in virtually every state. Optometrists are required to complete a specified number of hours of courses or seminars approved by the board, usually taught by the state optometric association, the AOA, or an optometry school.

ii. Standards of Practice

Regulations exist in virtually all states that are apparently designed to ensure that standards of optometric practice do not fall below minimal levels.

Twenty-five states specify a minimum examination that an optometrist must perform on each patient.[54] States typically include requirements that certain tests be run, that particular equipment be used, that records of minimum examinations and prescriptions be kept, or simply that a "proper" examination be conducted.

Nineteen states specify the minimum equipment that must be present in an optometrist's office.[55] While most of these states specify the equipment needed, several simply require equipment adequate for a thorough eye examination. Some states also

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[54] See chart at infra pp. 33-46. Three states require specific procedures to be employed only if the optometrist advertises eye examinations.

[55] Id. At least one state imposes a minimum equipment requirement for branch offices, but has no such requirement for principal offices.

prescribe sanitation requirements. Twenty-eight states require optometrists to keep patient records. Nineteen states specifically require optometrists to refer patients with signs of pathology to ophthalmologists or other competent health care providers.[56]

Seven states require the optometrist to verify that lenses prepared pursuant to his or her prescription have been properly manufactured. Several states apparently make the optometrist responsible for verifying prescriptions filled by others; others simply require the optometrist to direct the patient to return with the filled prescription for verification.

Finally, almost every state explicitly requires optometrists to practice "competently." The formulation used for this requirement varies from state to state. Incompetence, gross malpractice, gross incompetence, gross ignorance or inefficiency, negligence, gross negligence, and failure to comply with usual and customary standards are all used as standards. In many states, the applicable standard is defined in some detail.

iii. Professional Conduct

All states prohibit fraud and misrepresentation in the

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[56] Id. Some states also require the optometrist to advise the patient of the pathology and to assist the patient in obtaining further care. The requirement that an optometrist practice competently may well impose this requirement in other states as well.

practice of optometry. As noted above, many states separately prohibit false and deceptive advertising.

Virtually all states also regulate the personal conduct of optometrists that reflects on fitness to practice. In most states, discipline may be imposed for drug or alcohol abuse, for sexual misconduct with patients, or for conviction of a crime. In most states an optometrist's license may be suspended due to physical or mental disability affecting his or her ability to practice.

d. Regulation of Scope of Practice

Every state optometric practice act contains a definition of the practice of optometry. The definition and related provisions describe the acts for which a license to practice optometry is required, and may specifically describe certain acts that are beyond the scope of optometric practice.

Scope of practice restrictions serve two purposes. First, they define the limits of an optometrist's authority to practice. For example, most states now include the use of diagnostic drugs within the scope of optometric practice. A few permit the use of therapeutic drugs.[57] Second, they define the areas from which persons not licensed to practice optometry are excluded. For example, in many states, only optometrists and

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57 See, e.g., J. Robinson, Secretary, North Carolina Board, Tr. 2973.

ophthalmologists may fit contact lenses, whereas in others, opticians may also do so.

Regulation of the scope of optometric practice is not part of this rulemaking[58] and will not be discussed in detail. While the Initial Staff Report examined two scope of practice restrictions -- restrictions on the fitting of contact lenses and on the duplication of lenses by opticians[59] -- the Commission did not propose rulemaking in these areas.[60]

2. State Regulation in Detail

The charts on the following pages detail the regulation of the practice of optometry in the fifty states. The information is based upon the most recent information available to staff, including statutes, regulations, and, in some cases, judicial decisions and testimony by state officials. Because statutes and regulations change from time to time, because some states declined to supply a recent copy, and because some regulations may be based on judicial, attorney general, or board interpretation not on the rulemaking record, this chart may not

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58 To the extent that these types of restrictions have the effect of restricting commercial practice, however, they are within its scope. For example, some states define the practice of optometry as including the employment of an optometrist to practice optometry. While ostensibly a scope of practice regulation, this is in effect a commercial business practice restriction since it would ban lay employment.

59 Initial Staff Report at viii-ix, 93-138, 148-193.

60 Notice of Proposed Rulemaking at p.600.

be completely accurate in each state. Any resulting inaccuracies are believed to be minor and would not materially change the overall profile.

The charts include regulation of commercial practice, other business practices, and quality of care. The charts do not include scope of practice regulations. Inclusion or classification of a particular regulation in the charts does not imply that the provision would be affected by the proposed rule.[61]

The word "Yes" in a column indicates that the practice in questions appears to be affirmatively prohibited in that state. "No" means that the practice is explicitly permitted. A practice that, to the best of staff's knowledge, is not subject to regulation is denoted by a dash (--). The numbers in parentheses refer to notes describing or qualifying the regulation appearing on the page facing the chart.

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61 See infra Section VI., "Recommendations," for a discussion of what types of regulations and statutes would be affected.

Restrictions on Lay Association

	Lay Employment	Partnership	Franchising	Fee Splitting	Leasing (17)
Alabama	Yes (1) (2)	Yes	—	(9)	—
Alaska	Yes (1)	—	—	—	Yes (18)
Arizona	Yes (1)	Yes	—	Yes (9) (10) (11) (16)	No
Arkansas	Yes (1) (3) (4)	—	—	—	—
California	Yes (1)	Yes	Yes	(12) (16)	Yes (19) (21)
Colorado	Yes (1) (3)	Yes	—	(12) (13)	Yes
Connecticut	Yes (1)	Yes	—	—	No
Delaware	Yes (1) (3) (4) (5)	—	—	—	Yes (18)
Florida	Yes (1) (4)	Yes	—	—	(19) (20)
Georgia	(6)		—	—	(13) —
Hawaii	Yes (1)	—	—	—	(20)
Idaho	Yes (1) (5)	Yes	—	(13)	(21)
Illinois	No		—	—	—
Indiana	Yes (1)	—	—	—	—
Iowa	—		—	(13)	—
Kansas	Yes (1) (4) (6)	—	—	Yes (10) (12)	(19) (20)
Kentucky	Yes (1)	—	—	(11) (13)	—
Louisiana	Yes (1) (6)	—	—	—	—
Maine	Yes (1) (2) (4)	Yes	—	Yes (11) (14)	Yes (18)
Maryland	(2)		—	(13)	—
Massachusetts	Yes (1)	—	—	Yes (9) (14)	(20) (21)
Michigan	—	—	—	(13)	—
Minnesota	(6)	—	—	Yes (14)	—
Mississippi	(1)	—	—	Yes (9) (11) (13)	—
Missouri	No	No (7)	—	—	(22)
Montana	Yes (1) (6)	—	—	—	(23)
Nebraska	—	—	—	(13)	—
Nevada	Yes (1)	—	—	Yes (10) (14)	(20)
New Hampshire	(4)	Yes (8)	—	Yes (14)	(20)
New Jersey	Yes (1) (4)	Yes	—	Yes (14)	—
New Mexico	Yes (1) (2) (6)	—	—	Yes (14)	—
New York	No	—	—	No	No
North Carolina	Yes (1) (3) (4) (6)	—	—	—	—
North Dakota	Yes (1) (3) (4)	—	—	Yes (9) (13)	(20) (24)
Ohio	Yes (1)	—	—	Yes (14)	—
Oklahoma	Yes (1)	Yes	—	—	—
Oregon	(4)	Yes	—	Yes (14)	—
Pennsylvania	Yes (1) (2) (3) (4)	—	—	Yes (10) (14)	Yes
Rhode Island	(2)	—	—	Yes (9) (14)	(20)
South Carolina	(6)	—	—	—	Yes (18)
South Dakota	Yes (1)	Yes	—	Yes (14)	—
Tennessee	Yes (1)	—	—	(13)	—
Texas	Yes (3)	—	—	Yes (10) (14) (15)	No (19)
Utah	—	—	—	Yes (15)	—
Vermont	No	No	—	—	—
Virginia	Yes (1) (6)	—	—	Yes (14)	Yes (18)
Washington	Yes (1)	—	—	—	(19) (22)
West Virginia	Yes (1) (4)	Yes	—	—	Yes (18)
Wisconsin	No	—	—	Yes (14)	—
Wyoming	Yes (3)	—	—	Yes (14)	—

1 Prohibits practicing as employee on the basis of fee splitting, or as employee of non-licensed person, firm or corporation.

2 Aiding or abetting an unlicensed person in the practice of optometry is prohibited.

3 Prohibits any non-licensed person, firm or corporation from employing an optometrist.

4 Corporation prohibited from practicing optometry. Corporation cannot hire optometrist to assist it in practicing optometry.

5 Optometrist may not permit use of name by non-licensed person.

6 Optometrist may not place his/her license at the disposal of one not licensed.

7 Permitted provided that nature of relationship and name of firm are clearly disclosed to patients before contracting for services.

8 Grandfather clause permits some partnerships; others prohibited by implication.

9 Prohibits business associations including employment, profit sharing, leasing on basis of fee splitting or on a percentage basis.

10 Prohibits fee splitting with any professional except in proportion to service or responsibility.

11 Prohibits receipt or payment of rebates.

12 Prohibits fee splitting with dispensing optician or manufacturer or distributor of eyewear.

13 Prohibits splitting fees for referrals, solicitation.

14 Prohibits fee-splitting arrangements with any unlicensed person.

15 Fee-splitting prohibitions inapplicable to partnerships, professional corporations, employee-employer relationships or percentage leases.

16 Prohibits profit-sharing plans.

17 See also Restrictions on Mercantile Locations.

18 Unlawful to practice as lessee of commercial or mercantile establishment.

19 Lease agreements are unlawful if terms of lease require optometrist to agree to conditions concerning practice of optometry. Unlawful to remove any phase of practice from exclusive control of optometrist.

20 Prohibits leasing arrangements on basis of percentage of fees, income, receipts, or payments.

21 Prohibits optometrist from entering into prefential lease arrangement with an optical company or optician.

22 Leasing permitted provided O.D. discloses nature of relationship before contracting with any patient.

23 Leasing permitted provided optometrist advertises independently of lessor.

24 Optician who pays rent for optometrist is a capper or steerer in violation of the law.

Yes Practice is prohibited
No Practice is expressly permitted
— No regulation

	Restrictions on other Business Relations			Restrictions on Trade Names	
	Capping and Steering	Free Products and Exams	Interference w/prof. judg.	Direct Restrictions	Disclosure Requirements
Alabama	Yes (30)	—	—	Yes (39)	—
Alaska	(30)	—	—	(40) (41)	—
Arizona	(25)	—	—	Yes (42) (43)	—
Arkansas	Yes	(31)	—	(39)	—
California	Yes (26)	(32)	—	Yes (42) (44)	—
Colorado	Yes	—	—	—	—
Connecticut	(30)	—	—	—	—
Delaware	Yes	—	—	(39)	—
Florida	—	—	—	Yes (39)	—
Georgia	—	(31)	Yes	No (47)	(52)
Hawaii	(26) (30)	(31) (33)	—	(39) (47)	—
Idaho	(25) (27)	—	—	(39) (42) (45)	—
Illinois	—	—	—	(39)	—
Indiana	—	—	—	Yes (47)	—
Iowa	—	—	—	(42)	—
Kansas	Yes (25)	(31) (34)	(36)	(39) (42) (45)	—
Kentucky	Yes	—	—	(39)	(53)
Louisiana	Yes	—	—	(47)	—
Maine	(25) (28)	—	—	(39) (43) (49)	—
Maryland	Yes	—	—	—	—
Massachusetts	—	(32)	—	(39) (50)	—
Michigan	(26)	—	—	—	(54)
Minnesota	Yes	(32)	—	(45) (48)	(53)
Mississippi	(25) (26)	—	—	Yes	(52)
Missouri	—	(32) (34)	—	(47)	(55)
Montana	Yes (30)	(32)	—	(42)	(52)
Nebraska	—	—	—	—	—
Nevada	(30)	(32)		(42) (50)	—
New Hampshire	—	—	—	—	—
New Jersey	Yes	(31) (32) (35)	—	(39) (42)	(53)
New Mexico	—	—	—	(39)	—
New York	(26)	—	—	—	—
North Carolina	(26)	—	—	(39) (43) (45)	(52)
North Dakota	(30)	—	—	(41)	—
Ohio	Yes (30)	—	—	(39)	—
Oklahoma	(25) (29) (30)	—	—	(39)	—
Oregon	(25) (30)	—	—	(42) (47)	—
Pennsylvania	—	—	—	Yes (51)	—
Rhode Island	(30)	—	—	—	(53)
South Carolina	Yes	(31) (33)	—	—	—
South Dakota	Yes	(32)	—	(39) (43)	—
Tennessee	(30)	—	—	(39) (42)	—
Texas	(30)	—	Yes (37)	No	(53) (51)
Utah	—	—	—	(39)	—
Vermont	—	—	—	—	—
Virginia	Yes (30)	(32)	—	Yes (39) (43)	—
Washington	(26) (30)	(31) (32)	(38)	Yes (42) (43)	—
West Virginia	—	(32)	—	(39)	—
Wisconsin	—	—	—	(39)	—
Wyoming	Yes (30)	—	—	(45)	—

25 Prohibits mutual referral arrangements between optometrists and opticians as payment for securing patients.

26 Prohibits receipt/payment of discount rebate, commission or kickback for referring patients.

27 Prohibits regular referrals from opticians to optometrists who are located in proximity to each other.

28 Referrals by optical firm owned by optometrist must be made to other optometrists.

29 Optometrist prohibited from allowing optician to solicit for him.

30 Prohibits door-to-door canvassing or soliciting.

31 Prohibits firm, person from offering free eyeglasses as inducement for purchase.

32 Unlawful to advertise free exams, treatment or optometric services.

33 Prohibits advertising discount for services or goods.

34 Where free exams are advertised, optometrist must disclose that patient will receive prescription upon completion of exam, or must make full disclosures of all conditions.

35 Optometrist who provides goods and services to a group at less than usual fee is considered to be soliciting.

36 Every phase of an optometrist's practice on leased premises or when using leased equipment must be under optometrist's exclusive control.

37 Prohibition excepts optometrists who control three or fewer locations.

38 Optometrist shall resign if right of independent professional services is abridged by party engaging O.D.'s services.

39 Prohibits practicing under name(s) other than one's own.

40 Trade name prohibited for branch office.

41 Prohibits display of sign with other than name and other specified data.

42 Prohibits practicing under false, assumed name.

43 Exempts partnerships and optometrists employed by other optometrists.

44 Permit for trade name required.

45 Specified words (e.g., "optometric") must appear in name.

46 Exempts professional corporations.

47 Professional corporation name must consist of one or more doctors' names.

48 Prohibits names connecting optometry with non-vision related business.

49 All optometrists' names must appear in any associated name.

50 Name may not include names of doctors not actually conducting practice.

51 Trade names banned in advertising.

52 Signs, cards, advertising must identify optometrist.

53 Names of optometrists practicing in office must be posted.

54 Name of optometrist in charge must be posted.

55 Advertisements must identify at least one optometrist.

Yes Practice is prohibited
No Practice is expressly permitted
— No regulation

Restrictions on Mercantile Locations

	Retail Establishments	Shopping Centers	Two-Door	Exclusive Control	Signs, Advertising
Alabama	—	—	—	Yes	—
Alaska	Yes	Yes	—	—	—
Arizona	No	No	No	—	—
Arkansas	(56)	—	—	Yes	—
California	(57) (58) (59)	—	—	Yes	(71) (72) (73)
Colorado	(57) (60)	—	—	Yes	(72) (74) (75)
Connecticut	No	No	—	—	—
Delaware	Yes (58) (61) (62)	—	—	—	—
Florida	No	No (66)	—	—	—
Georgia	No	No	—	—	—
Hawaii	Yes (57)	(66)	(68)	Yes	—
Idaho	—	—	—	—	—
Illinois	—	—	—	—	—
Indiana	(63)	—	—	—	—
Iowa	—	—	—	—	—
Kansas	Yes (60) (63)	(66)	—	Yes	(72) (73)
Kentucky	—	—	(68)	—	—
Louisiana	—	—	—	—	—
Maine	(57) (58) (61) (63)	—	(70)	—	(76)
Maryland	—	—	—	—	—
Massachusetts	Yes (58) (61)	(66)	(68)	—	—
Michigan	(58)	—	—	—	—
Minnesota	—	—	—	—	—
Mississippi	Yes	—	(68)	—	—
Missouri	—	—	—	—	(77)
Montana	Yes (57) (60)	—	—	Yes	(74) (78) (79)
Nebraska	—	—	—	—	—
Nevada	Yes (61)	(66)	—	—	—
New Hampshire	—	(66)	—	—	—
New Jersey	Yes (64)	—	—	—	—
New Mexico	Yes (61)	—	—	—	—
New York	—	—	—	—	—
North Carolina	(61) (62)	—	(68)	—	—
North Dakota	(58)	(66)	(68)	—	—
Ohio	—	—	—	—	—
Oklahoma	Yes (58) (59) (63)	—	(68)	—	(73)
Oregon	(57)	—	—	Yes	(71) (77)
Pennsylvania	—	—	(68)	—	—
Rhode Island	(58) (65)	(66) (67)	(68)	—	—
South Carolina	Yes (62)	—	(68)	—	—
South Dakota	(58)	—	(68) (69)	—	—
Tennessee	Yes	—	(68)	—	—
Texas	Yes (60)	—	(68) (69)	—	(72)
Utah	—	—	—	—	—
Vermont	—	—	—	—	—
Virginia	Yes	—	(68)	—	—
Washington	(57)	—	—	Yes	(71) (72) (74) (77)
West Virginia	Yes	—	—	—	—
Wisconsin	No	—	—	—	—
Wyoming	—	—	—	—	—

56 Optometrist must have 24-hour access to premises.

57 Optometrist's premises must be separate and distinct from mercantile establishment.

58 Optometrist may not lease space from optician.

59 Optometrist may not practice in proximity to optician.

60 Optometrist may not practice as branch or concession of store.

61 Optometrist may not practice where material not needed in practice is displayed or sold.

62 Optometrist may not hold self out as optician.

63 Impression may not be conveyed that optometrist is connected with commercial establishment.

64 Lease from optician is permitted; practice in other mercantile locations prohibited.

65 Optometrist may not locate where over 50% of remaining space is used by occupants who sell merchandise to general public.

66 Percentage leases prohibited.

67 Optometrist may not practice where over 50% of remaining space rented under percentage leases.

68 Separate entrance for optometrist's office required.

69 Floor-to-ceiling partition between optometrist's premises and commercial location required.

70 Optical shop owned by optometrist must be clearly separated.

71 Signs must be separate and distinct.

72 Prohibits signs which read "optical department," "optometric dept."

73 Prohibits linking of name with commercial concern.

74 Optometrist's name may not be used in mercantile establishment advertisements. Optometrist's ads must be kept separate.

75 Telephone number must be listed in name of optometrist, not mercantile establishment's.

76 No connection between optometrist's practice and optometrist's optical shop permitted in ads or listings.

77 Optometrist who leases space on premises for business which deals in optometric goods and is not associated with that business shall disclose that fact to his patients before rendering services.

78 Advertisements must indicate that the practice is conducted by optometrist and not any company.

79 Advertisements must state that optometrist is located at practice site, but must not indicate that an optometric department is located there.

Yes Practice is prohibited
No Practice is expressly permitted
— No regulation

	Restrictions on Branch Offices			Advertising Restrictions
	Limitations	Permit or Registration	Disclosure Requirement	General(120)
Alabama	(80)	—	—	Yes (101)
Alaska	(81)	Permit (87) (88)	(95) (96) (99)	Yes (102-105)
Arizona	(82)	—	—	(102) (106)
Arkansas	—	(87) (88)	(96) (97)	Yes (102) (106-108) (112)
California	1 branch (82)	Permit (88)	(96)	(102) (106) (109) (113)
Colorado	None	None (88)	—	(102) (110)
Connecticut	—	—	—	—
Delaware	1 branch	(89)	(95)	Yes (103) (106) (110) (111)
Florida	—	Permit (88)	—	(102)
Georgia	—	(87)	—	(102) (105)
Hawaii	—	—	—	(102) (106) (112)
Idaho	1 branch	(90)	—	(101)
Illinois	—	(88)	—	(102) (111) (113)
Indiana	—	(87)	—	(102) (114)
Iowa	—	(87)	(95)	(102) (115)
Kansas	1 branch	(87)	—	(102) (112)
Kentucky	1 branch (80)	(87)	—	(102) (112)
Louisiana	—	—	—	(102) (107) (112)
Maine	1 branch	Permit (91)	—	(102)
Maryland	—	(87)	—	(102)
Massachusetts	(83)	Permit (87) (92)	—	(102) (106) (112) (116) (119)
Michigan	—	—	—	(102)
Minnesota	—	—	(95) (96)	No (102)
Mississippi	1 branch (82)	(87) (93)	—	(102) (106) (108) (119)
Missouri	—	(88)	(98)	(102) (106) (112)
Montana	—	—	—	(102) (115) (119)
Nebraska	—	—	—	(102) (106)
Nevada	1 branch (82)	Permit (87) (88)	—	(101) (102) (107) (112)
New Hampshire	—	—	—	—
New Jersey	—	Permit (94)	(96)	(102) (111) (117)
New Mexico	1 branch	—	—	(102) (106) (118)
New York	—	—	—	(102) (106) (108)
North Carolina	—	Permit (88)	—	(102) (119)
North Dakota	—	—	—	(102) (118)
Ohio	—	—	(96)	(112)
Oklahoma	Prohibited	N/A	N/A	(102)
Oregon	(85)	(88)	(95) (96)	(102) (106) (112) (119)
Pennsylvania	(82) (86)	Permit (88) (93) (94)	(95)	(102) (117) (118) (119)
Rhode Island	—	—	—	(102)
South Carolina	None	None (88)	(100)	(102) (112)
South Dakota	—	—	(96)	(102) (106-108) (112) (116)
Tennessee	(86)	Permit (88) (92)	(95) (96)	(102) (106)
Texas	—	—	—	(102) (112)
Utah	—	—	(96)	(102) (106) (112)
Vermont	None	None	—	—
Virginia	—	—	—	(102) (106) (119)
Washington	—	—	(98) (99)	(102) (105) (106) (112)
West Virginia	—	(88)	(96)	(102) (106) (107)
Wisconsin	—	—	(99)	(102) (106)
Wyoming	—	(87)	(96)	(102)

80 Optometrist must "be in charge of" branch office.

81 No commercial name permitted in connection with branch in nature of "chain exploitation."

82 Optometrist must be physically present during hours open to public, i.e., at least half of the time the office is open.

83 Optometrist must maintain ownership or lease arrangement of branch office.

84 Branch office must be attended during business hours.

85 To advertise branch, optometrist must be physically present at least one day per week.

86 Branch office must be located within certain distance of principal office.

87 Must register with state or local governing board or county clerk.

88 Duplicate license required for each branch office.

89 Board must certify that no previous branch office certificate was issued.

90 Optometrist may obtain waiver of branch office limitation if he can show that community will otherwise be deprived of services.

91 Permit required to exceed number of offices shown in "limitations" column.

92 Board certification contingent on optometrist's ability to provide adequate care.

93 Optometrist must provide floor plans of branch office to the board.

94 Board will issue license if the branch office deemed to serve public interest.

95 Optometrist must display certificate of licensure at branch office.

96 When practicing at location other than main office, optometrist must deliver to patient receipt which states name, principal address, hours, phone number, prescription, certificate number, fee charged or a specified combination of the above information.

97 At each office, optometrist must disclose where reachable during regular business hours.

98 Display of certificate by optometrist will serve in lieu of obligation to deliver receipt containing certificate number address, etc.

99 Optometrist's name must be posted.

100 Office hours must be posted.

101 May only advertise openings, relocations, etc.

102 Bans false, misleading ads.

103 Signs resembling eyes or eyeglasses banned.

104 Spectacles may not be displayed so as to be visible outside office.

105 Bait and switch advertising banned.

106 Bans claims of superiority.

107 Bans price advertising.

108 Bans unsubstantiated claims.

109 Optician cannot advertise optometrist's services.

110 Mercantile location may not advertise optometrist's name.

111 Restrictions on use of boldface type or other formats.

112 Specified disclosures required with certain types of ads.

113 Only optometrists, ophthalmologists may advertise eye exams.

114 Bans trade name advertising.

115 Prohibits advertising false or assumed name or in a manner allowing public to believe optometrist is practicing for unlicensed person.

116 Bans advertisements that intimidate, appeal to fears, ignorance, or anxiety, uses testimonials, guarantees, satisfaction, or cures.

117 Limits size of outdoor sign.

118 Only specified types of ads may be used. Board may approve others in some states.

119 Advertising must include optometrist's name.

120 This tabulation makes no determination as to whether the regulation is constitutional.

	Regulatory Structure		Regulation of Practice		
	Board Appointed by	Public Members	Licensing Required	Educational Requirements	Continuing Education
Alabama	Gov. (121)	No	Yes	Yes	Yes
Alaska	Gov.	Yes	Yes	Yes	Yes
Arizona	Gov.	Yes (130)	Yes	Yes	Yes
Arkansas	Gov. (122)	No	Yes	Yes	Yes
California	(123)	Yes	Yes	Yes	Yes
Colorado	Gov.	Yes	Yes	Yes	Yes
Connecticut	Gov.	Yes	Yes	Yes	Yes
Delaware	Gov. (122)	No	Yes	Yes	Yes
Florida	Gov.	Yes	Yes	Yes	Yes
Georgia	Gov.	Yes	Yes	Yes	Yes
Hawaii	Gov.	Yes	Yes	Yes	Yes
Idaho	Gov. (121)	No	Yes	Yes	Yes
Illinois	Dept. Head	(131)	Yes	Yes	Yes
Indiana	Gov.	Yes	Yes	Yes	Yes
Iowa	Gov. (124)	Yes	Yes	Yes	Yes
Kansas	Gov. (122)	Yes	Yes	Yes	Yes
Kentucky	Gov. (122)	Yes	Yes	Yes	Yes
Louisiana	Gov. (121)	No	Yes	Yes	Yes
Maine	Gov.	Yes	Yes	Yes	Yes
Maryland	Gov. (122)	Yes	Yes	Yes	Yes
Massachusetts	Gov.	Yes	Yes	Yes	Yes
Michigan	Gov.	Yes	Yes	Yes	Yes
Minnesota	Gov.	Yes	Yes	Yes	Yes
Mississippi	Gov.	No	Yes	Yes	Yes
Missouri	Gov. (125)	Yes	Yes	Yes	Yes
Montana	Gov.	Yes	Yes	Yes	Yes
Nebraska	Dept. Head	Yes	Yes	Yes	Yes
Nevada	Gov.	Yes	Yes	Yes	Yes
New Hampshire	Gov.	Yes	Yes	Yes	Yes
New Jersey	Gov.	No	Yes	Yes	Yes
New Mexico	Gov. (122)	Yes	Yes	Yes	Yes
New York	Bd. of Regents (124)	Yes	Yes	Yes	No
North Carolina	Gov. (122)	Yes	Yes	Yes	Yes
North Dakota	Gov. (126)	Yes	Yes	Yes	Yes
Ohio	Gov.	No	Yes	Yes	Yes
Oklahoma	Gov.	No	Yes	Yes	Yes
Oregon	Gov.	Yes	Yes	Yes	Yes
Pennsylvania	Gov.	Yes (132)	Yes	Yes	Yes
Rhode Island	Dept Head (127)	Yes	Yes	Yes	Yes
South Carolina	Gov. (121)	Yes	Yes	Yes	Yes
South Dakota	Gov. (122)	Yes	Yes	Yes	Yes
Tennessee	Gov.	No	Yes	Yes	Yes
Texas	Gov. (128)	Yes	Yes	Yes	Yes
Utah	None (129)	N/A	Yes	Yes	Yes
Vermont	Gov.	Yes	Yes	Yes	Yes
Virginia	Gov. (124)	No	Yes	Yes	Yes
Washington	Gov.	Yes	Yes	Yes	Yes
West Virginia	Gov.	Yes	Yes	Yes	Yes
Wisonsin	Gov.	Yes	Yes	Yes	No
Wyoming	Gov.	No	Yes	Yes	Yes

121 Governor appoints optometrist members from list elected by state's optometrists.

122 Governor appoints optometrist members from list supplied by state optometric association.

123 Governor appoints optometrist members and one lay member; legislative leaders appoint two lay members.

124 Members may be nominated by state board, but appointing authority not required to appoint them.

125 Governor appoints from list supplied by state department head.

126 Optometrist members must be members of state optometric association.

127 optometrist members must be approved by Governor; public member appointed by Governor.

128 Three optometrists must be members of state optometric association; three must be members of state association representing commercial optometrists.

129 Profession directly regulated by state department of professional regulation.

130 Also one medical doctor.

131 Unspecified.

132 Also state department head.

Yes Practice is prohibited

No Practice is expressly permitted

— No regulation

Regulation of Quality of Care

	Minimum Examination	Minimum Equipment	Record-Keeping	Referral of patients	Verification of Eyewear
Alabama	—	Yes (138)	—	—	—
Alaska	Yes (133)	—	Yes	Yes	—
Arizona	Yes	—	Yes	Yes	Yes
Arkansas	—	—	—	—	—
California	(134)	—	Yes	Yes	—
Colorado	—	—	—	Yes	—
Connecticut	Yes	—	Yes	—	—
Delaware	—	—	—	—	—
Florida	Yes	Yes	Yes	Yes	—
Georgia	—	—	—	—	—
Hawaii	—	—	—	—	—
Idaho	—	—	Yes	Yes	Yes
Illinois	Yes	—	Yes	Yes	—
Indiana	Yes (135)	—	Yes	—	Yes
Iowa	—	—	—	—	—
Kansas	Yes	Yes (137)	Yes	Yes	—
Kentucky	Yes	Yes	Yes	—	Yes
Louisiana	Yes	Yes	—	—	—
Maine	Yes	—	Yes	—	—
Maryland	Yes	Yes	Yes	Yes	—
Massachusetts	Yes (136)	Yes	Yes	—	Yes
Michigan	Yes	—	Yes	Yes	Yes
Minnesota	Yes	—	Yes	Yes	—
Mississippi	Yes (135)	Yes	Yes	Yes	—
Missouri	—	—	—	Yes	—
Montana	(134)	—	Yes	—	—
Nebraska	—	—	—	—	—
Nevada	—	—	—	—	—
New Hampshire	—	—	—	—	—
New Jersey	Yes	Yes	Yes	—	—
New Mexico	Yes (133)	—	—	—	—
New York	—	—	Yes	—	—
North Carolina	—	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	—	—
Ohio	—	—	Yes	—	—
Oklahoma	—	Yes	—	—	—
Oregon	Yes (133)	—	Yes	—	—
Pennsylvania	—	Yes	Yes	Yes	—
Rhode Island	Yes	Yes	—	—	—
South Carolina	—	—	—	Yes	—
South Dakota	Yes	Yes	—	Yes	—
Tennessee	—	Yes (137)	—	—	—
Texas	Yes	—	Yes	—	Yes
Utah	Yes	Yes	Yes	—	—
Vermont	—	—	—	—	—
Virginia	—	—	Yes	—	—
Washington	—	Yes	Yes	—	—
West Virginia	—	—	—	—	—
Wisconsin	Yes	Yes (137)	Yes	Yes	Yes
Wyoming	—	—	—	Yes	—

133 Applies only when examinations are advertised.

134 Requires use of certain equipment.

135 General requirement of thorough examination.

136 Applies to contact lenses only.

137 General requirement of adequate equipment.

138 Applies to branch office only.

Yes Practice if prohibited

No Practice is expressly permitted

— No regulation

	Regulation of Quality of Care			Other
	Fraud	Personal Misconduct	Incompetence/ Malpractice	Prescription Release
Alabama	Yes	Yes	Yes	—
Alaska	Yes	Yes	Yes	—
Arizona	Yes	Yes	Yes	Yes (139) (140)
Arkansas	Yes	Yes	Yes	Yes (139) (140)
California	Yes	Yes	Yes	—
Colorado	Yes	Yes	Yes	—
Connecticut	Yes	Yes	Yes	—
Delaware	Yes	Yes	Yes	Yes (139) (141)
Florida	Yes	Yes	Yes	Yes (139)
Georgia	Yes	Yes	—	—
Hawaii	Yes	Yes	—	—
Idaho	Yes	Yes	Yes	—
Illinois	Yes	Yes	Yes	—
Indiana	Yes	Yes	Yes	—
Iowa	Yes	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	—
Kentucky	Yes	Yes	Yes	Yes (140)
Louisiana	Yes	Yes	—	—
Maine	Yes	Yes	Yes	—
Maryland	Yes	Yes	Yes	—
Massachusetts	Yes	Yes	Yes	—
Michigan	Yes	Yes	Yes	—
Minnesota	Yes	Yes	Yes	—
Mississippi	Yes	Yes	—	—
Missouri	Yes	Yes	Yes	—
Montana	Yes	Yes	Yes	—
Nebraska	Yes	Yes	Yes	—
Nevada	Yes	Yes	Yes	—
New Hampshire	Yes	Yes	Yes	Yes (142)
New Jersey	Yes	Yes	Yes	Yes (140) (143)
New Mexico	Yes	Yes	Yes	Yes (139) (140)
New York	Yes	Yes	Yes	Yes (139)
North Carolina	Yes	Yes	Yes	Yes (139) (140) (144)
North Dakota	Yes	Yes	Yes	Yes (139)
Ohio	Yes	Yes	—	Yes (141)
Oklahoma	Yes	Yes	Yes	Yes (139) (140)
Oregon	Yes	Yes	Yes	—
Pennsylvania	Yes	Yes	Yes	—
Rhode Island	Yes	Yes	Yes	—
South Carolina	Yes	Yes	Yes	—
South Dakota	Yes	Yes	Yes	Yes (139) (140)
Tennessee	Yes	Yes	Yes	Yes (139) (140)
Texas	Yes	Yes	Yes	Yes (141)
Utah	Yes	Yes	—	—
Vermont	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	Yes	Yes (139) (141)
Washington	Yes	Yes	Yes	—
West Virginia	Yes	Yes	Yes	—
Wisconsin	Yes	Yes	Yes	—
Wyoming	Yes	Yes	Yes	—

139 Upon patient's request.

140 Applies to spectacles only.

141 Applies to spectacles and contact lenses.

142 Applies only when optometrist practices away from office and dispenses lenses.

143 Contact lens prescription released only to optometrist or ophthalmologist.

144 Expiration date may be no less than 365 days.

Yes Practice is prohibited

No Practice is expressly permitted

— No regulation

III. COMMERCIAL PRACTICE RESTRICTIONS

A. Introduction

In Section B below we discuss four specific types of state restrictions on competition from commercial optometrists and other providers: (1) restrictions on employer-employee relationships and other affiliations between optometrists and persons who are not optometrists; (2) restrictions on mercantile locations; (3) restrictions on branch offices; and (4) restrictions on trade name use. We describe each restriction in detail and discuss the prevalence of each. We also discuss the manner in which each of the restrictions prevents or restricts the development of commercial optometric firms, particularly chain optometric firms and other high-volume providers.

At least 44 states have at least one of the four types of restrictions. First, 39 states prohibit employer-employee or other business affiliations between optometrists and persons who are not optometrists, including partnerships, joint ownership or equity-participation agreements, franchise agreements, landlord-tenant agreements and other similar affiliations. Second, at least 19 states limit the number of branch offices which may be owned or operated by optometrists, often limiting optometrists to one or two branch offices. Third, 30 states restrict optometrists from practicing in mercantile locations such as

department stores, shopping malls, and other retail establishments. Fourth, at least 32 states impose prohibitions on the use of nondeceptive trade names by optometrists.

In Section C we discuss evidence demonstrating the price and quality effects on consumers of restrictions which limit the development of commercial optometric practice. We discuss systematic survey evidence which demonstrates that consumers in markets without commercial providers are faced with higher prices yet obtain no quality-related benefits. The two FTC studies, a third study, as well as other evidence, support this conclusion and no credible survey or other evidence supports a contrary conclusion. The record also indicates that the quality of care in such markets is lower since consumers obtain vision care less frequently as a result of the higher prices. Record evidence dealing with the effects on consumers of specific restrictions is also discussed in Section C.

Section B discusses in detail the evidence demonstrating that each of the specific restrictions at issue here prevents or restricts the development of commercial optometric firms. Thus, in total, the evidence establishes that, as a result of the restrictions at issue here, consumers throughout the country are suffering higher prices and decreased availability of vision care, with no countervailing benefit.

B. Nature of Specific Restrictions and Their Effect on the Formation of Commercial and Volume Practices

1. Restrictions on Lay Associations and Other Business Relationships

a. Introduction

This section will examine the various restrictions that 39 states impose on the ability of optometrists to enter into business associations or affiliations with lay individuals or corporations.[62] These restrictions include bans on corporate employment of optometrists, the forming of partnerships between optometrists and lay persons, the splitting of optometrists' professional fees, leasing arrangements, and other business agreements between optometrists and lay persons. Restrictions on lay association frequently prohibit optometrists from practicing as employees, franchisees, or partners of lay persons or corporations.

This section will first survey the various restrictions, and then examine the effects of the restrictions on the formation of commercial and volume practices. The record demonstrates that

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[62] For the purpose of this discussion, lay individuals, including optical dispensers, and corporations will be referred to as "lay persons," and the associations between laypersons and optometrists, whether employment, franchising, leasing, or other business relationships, will be referred to as "lay association."

restrictions on lay association hinder the development of volume practices such as chain firms.

b. Nature of Restrictions

i. Corporate Employment

Thirty-seven states have one or more statutes or regulations that expressly prohibit optometrists from practicing as employees of lay individuals and lay-controlled corporations. In some states, several types of restrictions apparently achieve the same effect. Thirty-two states expressly prohibit optometrists from accepting employment from persons or firms not licensed to practice optometry.[63] Nine states achieve the same effect by forbidding lay persons from employing optometrists.[64] Twelve states prohibit corporations from practicing optometry and define

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[63] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii Idaho, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, Montana, Nevada, New Jersey, (by Attorney General Opinion, See B. Eglow, President, New Jersey Optom. Ass'n., H-158), New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Virginia (with an exception for those covered by a grandfather clause), Washington and West Virginia. In Washington, the record is unclear. The State Board reports that lay employment is prohibited. S. Beckett, Executive Secretary, Washington State Board of Optometry, E-26. Counsel for the state optometric association, however, testified that an optician could hire an optometrist. W. Erxleben, Counsel, Washington Optometric Ass'n., Tr. 1425.

[64] Arkansas, Delaware, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Texas, and Wyoming. Two of these, Texas and Wyoming, apparently do not impose the corresponding ban on optometrists accepting employment from laypersons.

the practice of optometry as including the employment of an optometrist.[65]

In addition to these thirty-seven states, two other states apparently prohibit optometrists from accepting lay employment.[66] An examination of these states' statutes and regulations, however, does not reveal an employment ban other than a prohibition against an optometrist's license being loaned to, or placed at the disposal of, another person.[67] Although this prohibition apparently operates as an employment ban in those states, similar prohibitions in two other states do not have that effect.[68]

Eleven states, on the other hand, permit lay persons and corporations to employ optometrists. In five of those states,

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[65] Arkansas, Delaware, Florida, Kansas, New Hampshire (with a grandfather clause for those existing before 1951), North Carolina, North Dakota, Oregon (by Attorney General Opinion. See, W. Wheeler, Member, Oregon Board, Tr. 2214), Pennsylvania, Rhode Island, Washington (see D. Hanford, Washington Optometrist, H-146) and West Virginia.

[66] Georgia, South Carolina. See NAOO Rebuttal, K-1 at p. 10.

[67] Ga. Code §§84-1101 et. seq., Ga. Admin. Comp. ch. 430-1-01 et. seq.; S.C. Code Ann. §§40-37-10 et. seq.; Rules of S.C. Board of Examiners in Optometry and Opticianry, reprinted at S.C. Code Ann. §95-1 et. seq.

[68] Minnesota, Utah. It is possible that in these states this provision is interpreted to simply prohibit an optometrist from aiding another to assume a false identity. Similar provisions appear in six states that have explicit lay employment bans. Kansas, Louisiana, New Mexico, Ohio, Virginia, and Wyoming. Whether these states interpret this provision as a corporate practice ban, in that a corporation or lay individual could be "practicing optometry" by virtue of the optometrist's licensed status, is unknown.

lay employment is permitted by explicit statutory language.[69] The other five do not address the issue by statute or regulation. The record indicates that employment is permitted in these states.[70]

ii. Fee-splitting and Leasing

Fee-splitting refers to the division of a professional fee by an optometrist with another person. Restrictions on fee-splitting have existed for many years under the rationale that they are necessary to prevent professionals from hiring non-professionals to solicit patients and refer them to the doctor for reasons other than quality of care.[71] Many states also ban

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[69] Illinois, Missouri, New York, Vermont, and Wisconsin. In addition, four other states permit corporate employment only where the corporation or individual are protected under grandfather clauses. Connecticut (applies to optometrists employed before 1963), Rhode Island (protects firms employing optometrists before 1936), Utah and Virginia (applies to locations where optometrists were employed before 1938).

[70] Iowa, NAOO Rebuttal, K-1 at p. 10; Maryland, H. Glazier, President, Maryland Board of Examiners in Optometry, E-29; Michigan, NAOO Rebuttal, K-1 at p. 10; Minnesota, Sister M. Ashton, Minnesota Commissioner of Health, E-2; Nebraska, NAOO Rebuttal, K-1 at p. 10; and Utah, J. Ingalls, President, Western States Optical, Tr. 2181-82. NAOO lists a twelfth state, Alabama, as permitting lay employment. NAOO Rebuttal, K-1 at p. 10. Alabama has a statute prohibiting lay association, however. Ala. Code §34-22-22(16).

[71] P. Zeidman, Counsel, Int'l Franchise Ass'n., Tr. 612-13. See, W. VanPatten, Secretary, Nevada Board, Tr. 2258-59. This is known as "capping and steering." F. Honaker, President, Kentucky Board, Tr. 716-17. Capping and steering is directly prohibited by sixteen states. Alabama, Arizona, California, Idaho, Iowa, Louisiana, Michigan, Minnesota, Nebraska, North Dakota, Oklahoma, Oregon, South Dakota, Tennessee, Washington, and Wyoming.

fee-splitting out of a concern that the person with whom the fee is split will interfere in the optometrist's professional judgment.[72] Thirty-six states restrict fee splitting in one form or another.[73] The most common restriction is an explicit ban, found in twenty-one states.[74]

Fee-splitting restrictions are also used to ban percentage leases. In several states, an optometrist is prohibited from entering into a lease under which a percentage of revenue is paid as rent. At least eight states prohibit optometrists from entering into percentage leases with any lay person.[75] Another state bans them when the lessor is an optician.[76] Three of the states that ban fee-splitting, however, expressly permit percentage leases.[77]

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[72] A. Gorz, President, Wisconsin Optometric Ass'n., J-25 at p. 4; C. Beier, President, Kansas Board, Tr. 2137-39; W. VanPatten, Secretary, Nevada Board, Tr. 2251-53.

[73] Alabama, Arizona, California, Colorado, Georgia, Idaho, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennesee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

[74] Arizona, Kansas, Maine, Massachusetts, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Utah, Virginia, Wisconsin, and Wyoming. Two states expressly ban profit-sharing plans. Arizona and California.

[75] Florida (Board opinion, NAOO Comment, App. B. at p. 27), Hawaii, Kansas, Massachusetts (F. Rozak, Vice-President, Cole National Corp., Tr. 356), Nevada (W. VanPatten, Secretary, Nevada Board, Tr. 2251), New Hampshire, North Dakota, and Rhode Island.

[76] California.

(footnote continued)

Several states prohibit optometrists from entering into leasing arrangements with opticians or other lay persons. These restrictions are discussed in the section on mercantile locations.[78]

iii. Partnerships

Many states prohibit optometrists from practicing in partnership with non-optometrists. Fourteen states ban this explicitly.[79] Other states may achieve the same result by prohibiting the splitting of fees with anyone not licensed to practice optometry,[80] which would effectively frustrate the purpose of most partnerships. Other states require that the practice of optometry be under the exclusive control of licensed optometrists.[81] This could prohibit lay partners from entering into a partnership with an optometrist if they exercised direct or constructive control over the optometrist's practice. Only one state explicitly permits lay partnerships.[82]

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77 Arizona, New York, and Texas. See also infra Section III.B.3., "Restrictions on Mercantile Locations."

78 See id.

79 Alabama, Arizona, California, Colorado, Connecticut, Florida, Idaho, Maine, New Hampshire (by implication of grandfather clause permitting some to exist) New Jersey, Oklahoma, Oregon, South Dakota, and West Virginia.

80 See supra Section III.B.1.b.ii., "Fee-splitting and Leasing."

81 Colorado, Hawaii, Kansas, Oregon, Texas, and Washington. This could also be interpreted to ban other forms of lay association as well.

82 Vermont.

iv. Franchising

Franchising is becoming increasingly common in the marketing of ophthalmic goods and services.[83] Franchising has been defined by the Commission as a relationship characterized by the franchisee selling trademarked goods or services that meet the franchisor's quality standards, the franchisor exercising control over or significantly assisting the franchisee's business operation, and the franchisee paying the franchisor a fee.[84] Under an optometric franchising arrangement, the optometrist pays the franchisor for a specified set of goods or services, which might include the use of the franchisor's trade name and trademarks, the benefits of its goodwill, proven method of doing business, volume discounts on equipment and inventory, financing available through franchisor, and participation in the franchisor's advertising program. The franchisor controls many aspects of the franchisee's business organization, such as office design, items stocked, and minimum quality standards.[85]

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[83] E.g. "An Interview with Don Phillips," J-30, Ex. C-4 (attachment to Testimony of California Association of Dispensing Opticians).

[84] 16 C.F.R. § 436.2(a) (1985). See also P. Zeidman, Counsel, Int'l Franchise Ass'n, Tr. 591-92.

[85] J. Solish, Attorney, R.H. Teagle Corp., Tr. 1368-72; Cf. P. Zeidman, Attorney, National Franchise Association, Tr. 591 (describing attributes of franchising agreements generally). Typical optometric franchise agreements are found at NAOO Comment, Apps. J & K.

Only one state, California, expressly prohibits franchising. In California, franchising is prohibited on the grounds that the practice of optometry includes engaging in the business management of the practice. Therefore, a franchisor would be engaged in the unlicensed practice of optometry.[86]

At least two states also prohibit franchising as a form of fee-splitting,[87] and a third prohibits franchising for reasons that are not clear from the record.[88] The extent to which other states prohibit franchising as a form of fee splitting, a prohibited trade name use, or under some other rationale is not clear from the record.[89]

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86 California Ass'n of Dispensing Opticians v. Pearle, 143 Cal. App.3d 419 (1983), applying Calif. Op. Att'y Gen. 82-307 (June 10, 1982), which in turn applies Painless Parker v. Board of Dental Examiners, 216 Cal. 285 (1932). But see, Messner v. Board of Dental Examiners, 87 Cal. App. 199 (1927). A bill pending before the California legislature would remove these restrictions. H. Snyder, West Coast Director, Consumers Union of the U.S., Tr. 1067-69.

87 Kentucky, J. Honaker, President, Kentucky Board, Tr. 713-14; Nevada, W. Van Patten, Secretary, Nevada Board, Tr. 2251. Two other states that ban fee-splitting, however, may not view this as outlawing optometric franchising. Texas, E. Friedman, Texas Optometrist, Tr. 2397; Wisconsin, A. Gorz, President, Wisconsin Optometric Ass'n, Tr. 1102.

88 Kansas, C. Beier, President, Kansas Board, Tr. 2138; H. White, President, Kansas Optometric Ass'n, H-84.

89 Franchising can potentially be prohibited under other provisions as well. For example, a regulation requiring that optometric practices be under the exclusive control of a licensed optometrist could have this effect.

c. Effects of Restrictions on Commercial and Volume Practices

Restrictions on lay association impede the formation of optometric chain firms and other volume operations. In some cases, the restrictions prohibit them directly, while in others they deter market entry by raising the costs of forming such practices. This section will examine the effect of restrictions on forming lay associations and volume practices.

i. Impact on Capital Formation

The establishment or expansion of an optometric practice requires capital. Traditionally, an optometrist could raise capital in two ways. He or she may borrow money, or he or she may go into partnership with an established optometrist or hire other optometrists. A third alternative, which is prohibited by lay association restrictions, is for the optometrist to expand through the use of equity capital. This would include practicing in a corporate structure, purchasing a franchise, or going into partnership with a well-financed lay person.

Significant expansion through debt capital may not always be feasible. It may be difficult for an optometrist to obtain a loan large enough to expand significantly.[90] Moreover, the

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[90] A loan of about $60,000 is needed to establish a single (footnote continued)

benefits of expansion may not appear for some time after the loan is made, and it may be difficult to service the debt in the interim.[91] A new or expanded business may require more capital to survive this start-up period than it can borrow.

Moreover, expansion through association with other optometrists may be possible only up to a point. As long as an expanding practice is limited to the states in which the optometrist is licensed, a practice may be able to grow large enough to produce cost savings.[92] However, should the optometrist/entrepreneur find it desirable to expand his or her practice into other states, restrictions on lay association may prevent expansion. In states in which the optometrist/entrepreneur is not licensed, he or she is a layperson in the eyes of those states, and is subject to any lay association restrictions that may exist there.[93]

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office. California Department of Consumer Affairs, Commercial Practice Restrictions in Optometry, J-24(b) at p. 9.

91 Cf, id. at pp. 5-6.

92 This assumes an absence of branch-office restrictions. This expansion has occured primarily in the commercial context. E.g., J. Solish, Attcrney, R.H. Teagle Corp., Tr. 1367; J. Ellis, President, Eyexam 2000, J-48(c) at p. 5. However it has also occurred to a limited extent in the non-commercial context. E.g., D. Staten, Nevada Optometrist, Tr. 1189-90; E. O'Connor, Indiana Optometrist, H-108.

93 An example of such a case is an optometric firm controlled by an optometrist licensed in several states. This firm, which prefers to employ optometrists, has been able to expand to states in which that optometrist happens to be licensed and in which employment is otherwise permitted. It has found it impossible to expand into other states because of state restrictions against employment. J. Ellis, President, Eyexam 2000, J-48(c) at p. 5.

The remaining option available to an optometrist is the use of equity capital. With equity capital, an existing or new corporation may use retained earnings or the proceeds of a stock offering to employ optometrists, opticians, and other personnel. Corporations may also sell franchises to optometrists,[94] or form partnerships with them.

Restrictions on lay associations, by inhibiting the formation of equity capital, prevent or deter corporations and other large-scale providers from entering restrictive markets.[95]

ii. Availability of Economies of scale

Restrictions on lay association inhibit the formation of volume practices and thus make it difficult for optometrists to achieve optimum economies of scale. Significant economies of scale accrue to large-scale providers of ophthalmic goods and services. These economies can be achieved in the areas of labor, equipment, rent, utilities, and overhead expenses. There are several ways that this volume may be efficiently achieved, including the employment of optometrists by a chain, the sale of

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[94] P. Zeidman, Attorney, Int'l Franchise Ass'n, Tr. 610. One large commercial firm, Pearle Vision Services, concentrates on this approach. "An Interview with Dan Phillips," J-30, Ex. C-4 (attachment to testimony of California Ass'n of Dispensing Opticians).

[95] J. Ellis, President, Eyexam 2000, J-48(c) at p. 5; F. Rozak, Vice-President, Cole National Corp., Tr. 369-70; E.D. Butler, President, Precision Lens Crafters, Tr. 380; J. Ingalls, President, Western States Optical, Tr. 2184-86.

franchises, and the lease of equipped offices by chain firms to optometrists. Optical dispensers are often particularly interested in entering into the latter type of arrangement with optometrists.[96]

The economies of scale that may be achieved in a volume practice are discussed in the following subsections.

(a) Office operation and equipment

The use of volume discounts for equipment, material, and supplies reduces costs significantly. The National Association of Optometrists and Opticians (NAOO), whose members are volume operators, states that the cost of equipping a single optometrist's office without volume discounts is $29,548.50. With volume discounts, the same office can be equipped for $19,856.18, or about two-thirds of the retail price.[97] Savings

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[96] E.g., R. Feldman, President, Spectron, Inc., Tr. 80.

[97] NAOO Comment at pp. 26-28, and Apps. F and G. The NAOO equipment list includes the following: AO chair/stand; B&L Accu-chart Projector; B&L Keratometer; AO Lens-ometer; AO Phoropter; AO Slit Lamp; AO Non-Contact Tonometer; AO Retinoscope; B&L Ophthalmoscope Binocular indirect; AO Counter-balanced Table; Color Blind Test; and Stereopsis Test. Volume-based savings, according to price lists on the record, begin when as few as three of an item are purchased, and savings continue to increase until as many as ten or more are purchased. Id. at Apps. F and G. NAOO's calculations does not include office furnishings or business equipment such as calculators and typewriters. Presumably similar discounts would be available for this type of equipment as well. See also, M. Newman, Virginia Optometrist, H-90.

The California Optometric Association points out that private optometrists rarely pay list price and that office (footnote continued)

can also be achieved in equipping an optical dispensary. An optical dispensary that can be equipped at retail for $8,970 can be equipped for $7,164.75 with volume discounts.[98] Moreover, materials such as frames and lenses can be purchased at discounts of up to 25% when purchased in volume.[99]

(b) Management and Payroll

The percentage of revenue spent on personnel and management costs is generally lower in high volume and multi-site operation than traditional solo practices. Much of the savings result from specialized use of employees' skills.[100] In a volume operation,

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equipment prices are negotiable. Response by Calif. Optom. Ass'n to Dept. of Consumer Affairs Report, K-12 at p. 6 (attachment to Rebuttal of California Optometric Ass'n). It does not dispute that volume discounts exist. Even if office equipment prices are negotiable, it follows that a large volume practice such as a chain firm would be able to negotiate a better deal than an individual purchasing a single item.

98 NAOO Comment at pp. 27-29 and Apps. F and H.

99 NAOO Comment at pp. 24-25 and Apps. C, D and E. These cost savings, while of primary importance to large-scale firms, may also be utilized to some extent by individual optometrists who join buying cooperatives. Such co-operatives exists in several states. Comment of H. Smiley, President, Rhode Island Optom. Ass'n, E-47; Response by Calif. Optometric Ass'n to Dept. of Consumer Affairs Report, K-12 at p. 6 (attachment to Rebuttal of Calif. Optometric Ass'n). COA maintains that volume discounts of ten percent are available to individual optometrists with a laboratory volume of $2,600 a month, the industry average. Id. at pp. 6-7. However, the same price list used by COA indicates that a 15% discount would be available to a provider with a lab volume of $4,000 and over. Even if a small discounts are available to small-scale purchasers, this does not contradict the finding that larger discounts are available to large scale purchasers.

100 NAOO Comment at p. 19. See Initial Staff Report at p. 37 (Citing NAOO Eyeglasses I Rulemaking Comment, B-2-52-35; Letter (footnote continued)

optometrists usually concentrate on eye examinations, while optometric assistants perform tests and other tasks under their supervision, opticians dispense eyewear, and managers attend to the business end of the practice.[101] By contrast, in a typical small office, the optometrist may examine patients, dispense eyewear, keep the books, order supplies, supervise employees, and handle other administrative chores.[102] All of the non-professional tasks can be handled by non-professionals at lower cost.[103] Savings may also result from the consolidation of tasks that would otherwise have to be separately performed for both optometrist and optician, such as receptionist and janitorial service. Multi-office firms may consolidate jobs, such as accounting and purchasing, that would otherwise have to be separately performed in each office. Finally, corporations may shift employees from one store to another as workloads require in order to make more efficient use of personnel.

Evidence on the record suggests that many traditional optometrists practice in a less efficient manner. Data from a

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from F. Rozak, Vice-President, Cole National Corp., to FTC (Nov. 26, 1975), B-2-52-36).

101 NAOO Comment at p. 19; D. Staten, Nevada Optometrist, Tr. 1189; R. Moroff, N.J. Optometrist, J-51(d); M. Albanese, Illinois Optometrist, J-48(d) at p. 2; J. Kwoka, Professor, George Washington Univ., J-12 at pp. 2-3.

102 California Department of Consumer Affairs, Commercial Practice Restrictions in Optometry, J-24(b) at pp. 4-6 (attachment to Statement of H. Snyder, West Coast Director, Consumers Union of the U.S.).

103 E.g., NAOO Comment at p. 19; D. Staten, Nevada Optometrist, Tr. 1189.

1979 Study in the State of California shows that 64% of optometrists worked less than 40 hours per week; 31% worked less than 35 hours per week. Since 73% of the optometrists in the Study were in solo practice, this suggests that equipment and office space may not be used as efficiently in traditional practices as in commercial firms, which are often open for longer hours.[104] Further, according to this California data, the vast majority of optometrists did not employ any help (other than a receptionist), such as frame stylists, technicians or opticians, on even a part-time basis.[105] Optometrists in private practice often perform aspects of the dispensing function. Further, the vast majority of traditional practitioners are in solo practice, rather than group practice, making it virtually impossible to share the cost of personnel or achieve other economies of scale.[106]

Management may become more efficient as firms become larger. Professional managers, on the whole, are more skilled in

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104 See e.g., NAOO Comment at p. 3; J. Ingalls, President, Western States Optical, Tr. 2175.

105 Commercial Practices Restrictions in Optometry, State of California, Dept. of Consumer Affairs, 1982, J-24(b) at pp. 3-6, citing Optometric Management, Jan. 1981. Only 1% of the optometrists in the Study were employed by optical chains. COA, in discussing this 1979 data, pointed out that factors other than inefficiency may explain the shorter workweek, including a preference for less work-time, and time spent in training. COA does not dispute the figures on personnel employment. See, Rebuttal Statement of COA, K-12 at p. 4.

106 Commercial Practices Restrictions in Optometry, State of California, Dept. of Consumer Affairs, 1982, J-24(b) at pp. 3-6, citing Optometric Management, Jan. 1981.

business operation than are optometrists.[107] With sufficient volume, it may be cost-effective for corporate employers to hire professional managers, whereas a solo practitioner could not justify this expense.[108] Franchisors can supply business expertise and a proven means of doing business.[109]

Overhead management costs, such as computerized bookkeeping and word processing, also become increasingly cost-effective as volume increases.[110]

In a survey of several large-volume practices, according to NAOO figures, personnel costs as a percent of revenue decline from nineteen percent of total revenue in offices with a total volume of between $100,000 and $200,000 to fourteen percent of total revenue in offices with an annual volume of over $500,000.[111] Restriction on lay association inhibit the formation of volume practices that could achieve these savings in payroll costs.[112]

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107 This generalization is obviously subject to many exceptions. Some optometrists are highly capable business managers, just as some "professional" business operators are poor managers. NAOO Rebuttal, K-1 at p. 12. While optometric education does include required courses in management, RRNA Rebuttal, K-4 at p. 8, it is not clear how effective those courses are. The focus of optometric education, and the motivation of most optometry students, is the practice of optometry, not the operation of a business.

108 J. Kwoka, Professor, George Washington, J-12(a) at p. 3.

109 J. Solish, Attorney, R. H. Teagle Corp., Tr. 1368-72.

110 M. Newman, Virginia Optometrist, H-90.

111 NAOO Comment at pp. 21-22, 33.

(footnote continued)

(c) Rent

Large volume operators may achieve substantial economies of scale in rent. First, the fixed costs of overhead are spread across a large number of patients, resulting in a reduced share of overhead per patient.[113] Second, firms that operate in department store chains often negotiate favorable master leases with the chain covering all of its locations.[114] Third, large firms are often able to obtain favorable leases if their financial conditions are sound enough that their leases are assets against which a shopping center developer can borrow. Such firms are known as "financable" tenants.[115] Individual optometrists and smaller firms, however, do not generally qualify

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[112] Cost savings through more efficient use of personnel are not limited to large chain firms. Small firms have reported cost savings of some degree because they have employed similar techniques. E.g., D. Staten, Nevada Optometrist, Tr. 1189-90. In this case, an ophthalmologist employed two optometrists as well as various ancillary personnel. Employment of an optometrist by an ophthalmologist is apparently prohibited under Nevada law. Id. at p. 1177.

[113] The average total fixed cost of a volume operation is higher at a commercial establishment than at an individual traditional optometrist's office. Critics have argued, without support, that the higher cost leads to pressure to overprescribe or reduce examination thoroughness, L. Strulowitz, member, New Jersey Board, J-1 at p. 3, and that they eliminate the savings that are passed on to consumers, COA Rebuttal, K-12 at p. 6. The former allegation is responded to at infra Section III.C.3.c.iii.(a)(1)(b)., "Effect on Adequacy of Exam." With regard to the latter, it is unlikely that firms would seek to practice in mercantile locations if revenue from increased volume did not offset the increased rent.

[114] E.g., J. Solish, Attorney, R.H. Teagle Corp., Tr. 1367.

[115] NAOO Comment at p. 24.

as financable tenants.[116] Holders of multi-location master leases and financable tenants are often able to negotiate more favorable leases than an individual optometrist could because of the volume of rent involved and the asset value of the lease.[117]

Rent as a percentage of gross revenue, according to NAOO's survey of its members, drops from 20 percent for firms with annual receipts of $150,000 to a mere 5.5% for firms with revenues over $500,000.[118] It is reasonable to assume that an even greater difference would result in a comparison between a large firm and a solo practitioner. Restrictions on lay association inhibit the entry and growth of firms that can achieve these large savings.

(d) Advertising

Economies of scale reduce advertising costs.[119] A chain can advertise several of its outlets in a single advertisement for less than the same number of optometrists can advertising separately.[120] A volume operator with a large number of patients can spread its advertising costs over many patients, resulting in a smaller proportion of the advertising bill being passed on to

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116 Id.

117 Id.

118 Id. at pp. 22-24.

119 See infra Section III.B.4.c.ii., "Effect on Firms' Costs."

120 Id.

any individual patient. An individual optometrist who chooses to advertise, on the other hand, must spread the cost among fewer patients, resulting in higher costs per patient.

Restrictions on lay association have, in some instances, made it impossible for firms to engage in price advertising.[121] In markets where restrictions prevent the lay volume operator from controlling the price of optometric examinations at its locations,[122] it cannot establish a nationwide or regionwide price for eye exams. If it cannot do this, it cannot engage in price advertising for examinations and examination/eyewear packages. Large firms must forego price advertising of these services in those markets.[123]

iii. Other Effects

Several opponents of the proposed rule have expressed the fear that the elimination of restrictions on lay association will compromise the ability of the independent practitioner to compete and survive.[124] A related concern is that should state bans on

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[121] A. Goodman, Vice-President, Sterling Optical, Tr. 363.

[122] In many states, an optometric practice must be under the exclusive control of a licensed optometrist. See infra Section III.B.1.b.iii., "Partnerships." At least two states specifically forbid lay persons from influencing or attempting to influence an optometrist's fees. Georgia, Texas.

[123] A. Goodman, Vice-President, Sterling Optical, Tr. 363. D. Loomis, Vice-President, Pearle Vision Centers, Inc., Tr. 360.

[124] G. Mitchell, United States Senator from Maine, E-44; E. Herb, Colorado Optometrist, H-87 at p. 6. Other independent (footnote continued)

corporate employment of optometrists be removed, optical companies that currently lease space to optometrists would cancel their leases and either hire the optometrists as employees or replace then with other optometrists who are willing to work as employees.[125]

The record does not demonstrate that removal of commercial practice restrictions leads to the demise of independent optometry. Independent optometrists have continued to exist alongside commercial firms.[126] Independent optometrists from several states that permit lay employment testified at the hearings. While generally opposed to the proposed rule, they did not make the case that they or their collegues were being forced out of business.[127]

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optometrists, however, stated that the elimination of restrictions on lay association would not affect their practice. G. Schwab, California Optometrist, J-64 at p. 4.

One witness stated that large firms would drive out small solo practitioners in his state, and in difficult economic times they would close, leaving residents of those communities with no vision care services. B. Corwin, President, South Dakota Board, J-44 at p. 5. During periods of economic hardship, however, it is likely that a large chain firm would have more financial resiliance than a solo optometrist, and would hence be more likely to survive.

125 E. Herb, Colorado Optometrist, H-87 at p. 6; C. LoParo, Pennsylvania Optometrist, H-106; W. Kimball, Connecticut Optometrist, H-155.

126 See, infra Section III.C.1.a, "BE Study." See also, S. Vinson, Assistant Minority Leader, Illinois House of Representatives, Tr. 2161.

127 H. Glazier, Maryland Optometrist, J-21; E. McCrary, Vice-President, Maryland Optometric Ass'n, J-5; J. Kennedy, Minnesota Optometrist, J-26; A. Gorz, President, Wisconsin Optometric Ass'n, J-25(a). It may well be that there are two sub-markets for optometric goods and services: a price-sensitive market that (footnote continued)

Further, that some traditional providers might find themselves at a competitive disadvantage does not address the issue of consumer injury. As discussed herein, restrictions on lay association cause consumer injury in the form of higher prices without affecting quality. The removal of those restrictions may encourage large firms to enter the market and compete with traditional providers. To the extent that traditional providers respond to consumer demand, they are not likely to find themselves at a competitive disadvantage.[128]

2. Branch Office Restrictions

a. Introduction

This section analyzes state-imposed restrictions on the number of offices in which an optometrist may practice. At least 19 states limit the number of branch offices which may be owned or operated by optometrists, often limiting optometrists to one or two branch offices.[129] The record indicates that these

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is served by commercial optometrists, and a non-price sensitive market in which independent optometrists compete successfully. See, California Department of Consumer Affairs, Commercial Practice Restrictions in Optometry, J-24(b) at p. 15 (attachment to Statement of H. Snyder, West Coast Director, Consumers Union of the U.S.). Cf. BE Study at p. 25; J. Kwoka, Professor, George Washington Univ., J-12(a) at pp. 6-7.

[128] For example, traditional optometrists may meet consumer demand for more personalized or more specialized services.

[129] See chart supra at pp. 33-46. For the purpose of this discussion, no distinction is made between the terms "branch offices" and "multiple offices."

restrictions limit the development of volume practices and create barriers to the development of chain firms.

Multiple office optometric practice exists in a variety of forms. In its simplest form, a solo practitioner may open a single branch office on a part-time basis, offering only the most basic services,[130] with more complex cases referred to the practitioner's main office. At the other extreme, an optometrist may own a chain of full service offices, each fully equipped and with its own full-time professional and support staff. The multiple office setting may also be used by partnerships and group associations, and even solo optometrists may find it profitable to maintain full-service branch offices with employed personnel. Optometrists may obtain multiple franchise locations from a parent optical corporation. Finally, optometrists employed by a chain firm may practice at more than one office location. While the manner in which optometrists practice at more than one location differs, optometrists opting for any of these forms of practice are subject to restrictions on branch offices.

b. Nature of Restrictions

Many states have adopted regulatory schemes that limit

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130 Even if a branch office only offers limited services, it must conform to state requirements concerning minimum equipment and examination standards. See supra Section II.B.1.c.ii., "Standards of Practice."

Board refuses to issue a branch office permit for an office until that office is fully equipped and able to provide optometric services.[140] Without this permit, optometrists cannot open the branch office and must assume the additional financial risk of having their permit application denied.[141] This use of a permit requirement may make the opening of branch offices a practical impossibility for some providers.

Other states require optometrists to register every branch office location with the state board.[142] These regulations may be designed to ensure that the owner of a branch office is held accountable for the services offered at distant locations, or to facilitate sanitation or equipment inspections. However, the record does not indicate that registration requirements are enforced in a manner that impedes branch office development.

While most proponents of branch office restrictions justified them as necessary to maintain quality of care, some

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140 Id.

141 In one instance, the Board did not arrange to inspect a proposed branch office to determine its adequacy for a number of months, and on another occassion refused to issue a permit for nearly eleven months after the branch office had passed its Board inspection. The Board apparently failed to inform branch office applicants of the criteria relied on by the Board in determining whether to issue a branch office permit. Id. According to the NAOO, the Board has changed the criteria for branch offices when dealing with applicants for branch offices located next door to commercial optical firms, and has asked optometrists to close such offices without explanation or formal hearings. Id.

142 See, e.g., Alaska, Arkansas, Delaware, Florida, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Mississippi, Nevada, W. Virginia, Wyoming, S. Carolina, N. Carolina.

proponents of such restrictions in Okalahoma -- including the State Board of Examiners in Optometry -- justified them as necessary in order to protect full-time optometrists in small communities and graduating optometry students from the threat of competition by potential part-time branch offices of optometrists practicing in other communities.[143]

c. Effects of Restrictions on Commercial and Volume Practices

i. Effect on Volume

Branch office restrictions may prevent entrepreneurial individual optometrists from increasing the size of their practices.[144] A typical situation may be where an optometrist wishes to expand his or her practice to three or four locations. These restrictions may also prevent optometrists from developing chain firms. Optometrists may well be in the best position to begin these firms due to their professional expertise. Yet these restrictions could stifle talented, entrepreneurial optometrists from developing effective chains.[145]

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[143] See L. Oxford, Executive Secretary, Oklahoma Optometric Association, Tr. 2559; Letter from J. Johnson, Oklahoma State Board of Optometry, to Senator Taylor, January 9, 1984, G-19.

[144] NAOO Comment at p. 60. Since restrictions apply directly to the number of offices an optometrist may control, they do not necessarily restrict the number of offices that may be operated by a lay entity.

[145] Some licensed optometrists, including Dr. Stanley Pearle of (footnote continued)

multiple office practice. Some states impose flat limitations on the number of offices optometrists may operate, usually restricting them to one or two branch offices.[131] These restrictions explicitly prevent optometrist from establishing even small chains.[132]

Some states do not directly restrict the number of offices, but instead require an optometrist to remain in personal attendance at all office locations.[133] These restrictions effectively prevent extensive branch office practice. For example, Nevada regulations define personal attendance to mean that the optometrist who owns the practice must be present during fifty percent of regular office hours.[134] They do not permit optometrists owning branch offices to satisfy the personal attendance requirement by employing other licensed optometrists to operate the branch office.[135] The result is that Nevada

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131 See, e.g., California, Idaho, Kansas, Kentucky, Maine, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania.

132 An exception is the New Jersey statute, which permits an optometrist to practice in two branch offices upon approval by the state board. N.J. Rev. Stat. §45.12-9. Dr. Leonard Strulowitz of the N.J. Board of Optometry testified, however, that an optometrist not only may practice under his own license in two branch offices, but may own and operate as many additional optometric practices as he wishes, provided the optometrist's license is not displayed at these additional locations. L. Strulowitz, Member, New Jersey Board, Tr. 35.

133 See, e.g., Arizona, California, Nevada, Oregon, Pennsylvania.

134 Nev. Admin. Code §636.210(1). See also Arizona.

135 Id. This requirement would appear to negate any quality justification for these restrictions, since the state is obviously not satisfied even when one of its own licensees (footnote continued)

optometrists cannot operate more than two full-time offices.

Some states provide that optometrists must obtain a permit in order to open a branch office,[136] requiring either proof that the additional offices conform to certain minimum standards,[137] or that there is a demonstrated need in the community for the new office.[138] These requirements can be enforced in substantially different ways in different states.

Permit requirements are used in some states to prevent or discourage optometrists from opening branch offices. For example, the record indicates that the Massachusetts permit requirement was used to discourage some optometrists from opening branch offices.[139] According to NAOO members, the Massachusetts

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maintains personal supervision over a branch office. See infra Section III.C.3.c.iii.(b)., "Branch Office Restrictions."

136 See, e.g., California, Massachusetts, New Jersey, North Carolina, Oklahoma, Pennsylvania, Tennessee.

137 See, e.g., Massachusetts, Mississippi, (requires filing floor plan with the Board), Pennsylvania, Tennesse.

138 See, e.g., New Jersey ("public interest" standard), Pennsylvania, Okalahoma. A demonstrated need requirement seems clearly anticompetitive. If some optometrists already serve a regional area, potential competitors would not be "needed".

139 See NAOO Comment at p. 66 and Appendix V; R. Feldman, President, Spectron, Inc., J-3. Similar charges were made by the NAOO concerning enforcement activities in Tennessee. See NAOO Comment, Appendix V.

Massachusetts regulation authorizes the state board to issue a branch office permit to an optometrist contingent on that optometrist's ability to provide adequate care. Mass. Admin. Code tit. 246, §5.04. These permits are required only for branch offices, and not for principal or single offices. The Board makes no determination of the optometrist's ability to provide adequate care at his or her principal office. NAOO Comment, Appendix V.

In addition, these restrictions create barriers to expansion by lay optometric firms.[146] They may prevent these optometric firms from employing or entering into other business relationships with an optometrist at more than the permitted number of locations.[147] Each office that the optometrist is scheduled to work in is considered a branch for purposes of these restrictions, so that firms cannot schedule an optometrist to practice in more than the permitted number of locations.[148] This may prevent these firms from efficiently distributing their optometrists to best meet the needs of the firms' various offices.

Finally, these restrictions prevent lay firms from providing multiple franchise locations to optometrists seeking to expand their practices as franchisees.[149] This may preclude the

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Pearle Vision Center, Dr. Steven Tuckerman of Tuckerman Optical, and Dr. James Ellis of Eyexam 2000, are responsible for founding major chain firms offering optometric services. See e.g., J. Ryan, Counsel, NAOO, J-48(c), S. Tuckerman, President, Tuckerman Optical, J-51(a).

146 Because no state currently permits lay employment but prohibits branch offices, branch office restrictions have not been used to limit the number of offices which a chain may operate.

147 NAOO Comment at p. 60.

148 Id.

149 These restrictions are imposed on the licensed franchisees, who are prohibited from operating more than the maximum number of offices. In at least one state, California, branch office restrictions have been held to apply to franchisors as well as franchisees. See NAOO Comment, Appendix L. The California Attorney General has held that the state's two-office limitation prohibits franchisor O.D.s from providing more than two franchises. California currently prohibits lay franchising completely, but in the absence of such restrictions, the branch (footnote continued)

franchisor from expanding through franchisees with proven track records.[150]

ii. Effect on Firms' Costs

Branch office restrictions increase firms' costs, thus hindering the development of more efficient practices. The record establishes that optometrists can use branch offices to achieve economies of scale and thereby reduce costs. These economies of scale are made possible when optometrists increase their volume of practice sufficiently to enable them to take advantage of volume purchasing discounts for equipment and materials, and reduced per office advertising costs.[151] Provided the optometrist is successful in attracting new patients, the effect of these volume-related efficiencies may be reduced per-patient costs.[152]

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office limitation could be applied to lay franchisors as well.

[150] NAOO Comment at p. 60.

[151] See supra Section III.B.1.c.ii., "Availability of Economies of Scale." When increasing volume by means of opening additional office locations, optometrists obviously increase their operating costs substantially by assuming the expenses of operating a new office. Profitability will increase only if the optometrist is able to generate sufficient revenues in excess of these new costs. While this may not happen in every instance, branch offices provide opportunities for this to occur.

An optometrist may also take advantage of pre-existing economies of scale by entering into a franchising agreement with an established chain. See supra Section III.C.B.1.b.iv., "Franchising." However, branch office restrictions would preclude that optometrist from personal expansion even through ownership of multiple franchises, thus still barring him or her from the opportunity for growth.

(footnote continued)

Branch offices also permit firms to decrease cost through more efficient management techniques. Because optometrists may hire additional staff to provide services in a multiple office practice, they have the flexibility to divide the time of this additional staff to meet the specific needs of the practice's various locations.[153] Branch offices also permit optometrists to use their own time more efficiently by concentrating on providing professional services while leaving other tasks, such as dispensing, to employees.[154] Restrictions on branch offices thus restrict the development of more cost-effective and efficient practices.

3. Restrictions on Mercantile Locations

a. Introduction

This section will examine state restrictions on the practice of optometry in mercantile locations. As used herein, the term

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[152] See infra Section III.C.2.d., "Other Evidence Regarding Price." Proponents of branch office restrictions have not objected specifically to the contention that these restrictions limit the size of optometric practice. However, they do generally contest the effect of high-volume practice on prices.

[153] See NAOO Comment at p. 60.

[154] See J. Kwoka, Professor, George Washington University, J-12(a) at p. 6. RRNA disputes the argument that large firms are better at management techniques, stating that some traditional optometrists hire personnel and utilize management efficiencies similar to larger firms. However, RRNA does not deny that these techniques may be utilized to greatest advantage in higher volume practice.

"mercantile location" refers to shopping malls and to retail establishments such as department stores and optical outlets. Thirty states impose one or more explicit mercantile location restrictions or impose barriers which effectively prohibit optometrists from practicing in such locations.[155] This section will first describe the restrictions involved. It will then examine the effects of the restrictions upon the formation of commercial and volume practices.

b. Nature of Restrictions

Twenty-five states impose one or more bans[156] that appear to explicitly prohibit the practice of optometry in mercantile locations.[157] The most common ban, found in fifteen states, explicitly prohibits optometrists from practicing in or leasing space from a retail establishment.[158] Six states apparently

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[155] For example, several states prohibit optometrists from leasing space on a percentage-of-revenue basis. See infra Section III.B.3.b., "Nature of Restrictions." This may effectively preclude optometrists from locating in shopping centers.

[156] Some states impose several different types of bans. Since many states impose multiple bans, the number of states described as employing particular restrictions will add up to more than twenty-three.

[157] Alaska, California, Delaware, Hawaii, Idaho, Kansas, Maine, Massachusetts, Michigan, Mississippi, Montana, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia and West Virginia.

[158] Alaska, Delaware, Hawaii, Kansas, Mississippi, Montana, Nevada, New Jersey, New Mexico, Oklahoma, Texas and West Virginia. South Carolina, Tennessee, and Virginia impose similar (footnote continued)

achieve the same result by prohibiting the practice of optometry in retail locations where goods other than those needed in the practice of optometry are sold.[159] One state prohibits branch offices in department, jewelry, or optical stores.[160] Ten states prohibit optometrists from leasing space from opticians,[161] and two forbid optometrists from locating their offices "in proximity" to optical dispensers.[162] On the other hand, one state permits optometrists to locate within opticianries, but prohibits other mercantile locations.[163]

Twelve states have adopted other restrictions that fall short of explicit bans, but that could be interpreted to prohibit

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restrictions, but except optometrists who were practicing in such locations before a certain date.

[159] Alaska, Delaware, Maine, Nevada, New Jersey, and North Carolina. All but Maine and North Carolina also have an outright ban. In those states, this ban appears to be redundant. This ban could even ban practicing in retail optical outlets if the sale of eyeglasses, which can be purchased from non-optometrists, were deemed unnecessary to the practice of optometry. The record does not disclose how this restriction is enforced, however.

[160] Pennsylvania. This statute does not, on its face, affect an optometrist's principal office. However, since Pennsylvania also requires that all optometrists' offices have separate doors from those used for other establishments, it would appear that optometrists are effectively precluded from locating main offices in such stores as well.

[161] California, Delaware, Massachusetts, Maine, Michigan, Rhode Island ("as an adjunct to ... an ophthalmic merchandising business (commonly known as 'opticians') ... through the device of a lease"), and Oklahoma. Three states evidently reach the same result by prohibiting opticians from providing office space to optometrists. Idaho, North Dakota, and South Dakota.

[162] California and Oklahoma.

[163] L. Strulewitz, Member, New Jersey Board, Tr. 31-32.

practice in mercantile locations. Three states prohibit optometrists from holding themselves out as opticians.[164] Four states prohibit practicing as a department, branch, or concession of a mercantile establishment.[165] Four states prohibit optometrists from locating in a manner that could give the impression to the public that they are affiliated with a commercial enterprise.[166] Two states prohibit optometrists from accepting referrals based on an optometrist's location.[167] Two states prohibit optometrists from "practicing in a store or office which does not conform to that used by the majority of professional men in the area".[168] While the record does not in

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[164] Delaware, North Carolina, and South Carolina. This could be construed to prevent an optometrist from "holding out" as an optician by practicing in an optician's shop.

[165] Colorado, Kansas, Montana, and Texas. These could be interpreted to prevent optometrists from locating in such establishments. Kansas, Montana, and Texas seperately prohibit all practice in such establishments, so this provision appears to be redundant in those states. The Colorado restriction is evidently not interpreted to preclude practice in such establishments. R. Alderete, Legislative Committee Chairman, Colorado Optometric Ass'n, Tr. 1721-22. See also Dixon v. Zick, 500 P.2d 130 (Colo. 1972). These states, together with California, Hawaii, Oregon, and Washington, also prohibit the optometrist from using signs that read "optical department" or "optometric department".

[166] Indiana, Kansas, Maine, and Oklahoma. The effect of these provisions is unclear. They could be interpreted as banning all practice in or near department stores or other retail establishments. At the other extreme, they could simply affect the types of signs permitted. The record does not disclose how they are actually interpreted.

[167] Idaho and Maine. These could be interpreted to prohibit an optometrist from accepting a referral from an optician from whom he or she leases space. This might effectively frustrate the purpose of practicing in such a location. It is not clear how these regulations are enforced, however.

(footnote continued)

all cases disclose how these restrictions are interpreted, it seems evident that they could be interpreted to ban practice other than in a traditional solo private practitioner's office.

At least nine states appear to restrict practice in shopping malls. Two states apparently prohibit shopping mall practices altogether.[169] At least eight states prohibit optometrists from leasing space under leases that require a percentage of revenue to be paid as rent.[170] These leases are known as percentage leases. Since percentage leases are ordinarily required in shopping center leases,[171] this restriction could make it difficult or impossible for optometrists to rent space in shopping centers.[172]

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168 Delaware. See also New Mexico.

169 Alaska and Rhode Island. While Rhode Island's prohibition does not mention shopping malls explicitly, it does bar optometrists from practicing in a building where over 50% of the remaining space is rented under percentage leases. Since such leases are almost universally used in shopping centers, J. Solish, Counsel, R.H. Teagle Corp., Tr. 1371; C. Callsen, NAOO, Tr. 353, the effect of this provision is to inhibit optometric practice in shopping centers. In Alaska, no such ban appears in statute or regulation. However, there is evidence that the Board enforces such a restriction. J. Ingalls, President, Western States Optical, J-54 at pp. 3-4.

170 Florida (Board opinion), Hawaii, Kansas, Massachusetts, Nevada (interpretation of fee-splitting ban, W. Van Patten, Secretary, Nevada Board, Tr. 2251-53), New Hampshire, North Dakota, and Rhode Island. In addition to Nevada, it is possible that other states that ban fee-splitting may also interpret that ban as prohibiting percentage leases.

171 J. Solish, Counsel, R.H. Teagle Corp., Tr. 1371; C. Callsen, NAOO, Tr. 353.

172 There is evidence that in at least one state, optometrists have been able to obtain shopping center leases without paying rent on a percentage basis because of the state law. C. Beier, President, Kansas Board, Tr. 2137.

Most states that prohibit optometrists from practicing in a retail establishment permit the optometrist to locate in or next to that business so long as there is a separate entrance to a public street or hallway.[173] This requirement, known as a "two-door" or "side-by-side" requirement, expressly appears in nine statutes or regulations.[174] In at least five other states the requirement apparently arises as an interpretation of or reaction to other restrictions.[175] In some of these states, a solid floor-to-ceiling partition without inter-connecting doors must separate the optician's and optometrist's offices.[176] In others, an internal door between the two establishments is permissible.[177] One state apparently finds an opaque internal wall between offices to be acceptable, but not a glass wall.[178] Six states require that an optometrist's premises be separate and distinct from a commercial establishment, but apparently do not require separate entrances.[179] At least one state requires the

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[173] Hawaii, Kentucky, Massachusetts, Mississippi, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, and Virginia.

[174] Hawaii, Kentucky, Massachusetts, Mississippi, Oklahoma, Pennsylvania, South Dakota, Texas, and Virginia.

[175] E.g., North Carolina (Tr. 2790); North Dakota (NACO Comment); Rhode Island (NAOO Comment); South Carolina NAOO Comment) and Tennessee (NAOO Comment). In many cases, two-door practice apparently occurs as a response to the prohibition against practicing in a mercantile establishment. As noted above, two states do not even permit optometrists to practice in proximity to opticians. California and Oklahoma.

[176] E.g., Texas.

[177] E.g., Massachusetts.

[178] R. Feldman, President, Spectron, Inc., Tr. 87.
(footnote continued)

optometrist to have a separate bathroom.[180]

On the other hand, five states' statutes expressly prohibit the State Board of Optometry from enacting restrictions on where an optometrist may practice.[181] Another fourteen have no statutes or regulations pertinent to the issue, and therefore presumably do not restrict practice in mercantile locations.[182]

c. Effects of Restrictions on Commercial and Volume Practices

Restrictions on practice in mercantile locations inhibit the formation of high-volume and commercial practices in two ways. First, mercantile locations, which are generally located in high-traffic areas, are important to help generate a high volume of patients. Second, such restrictions impose unnecessary floor space, construction, or personnel costs. These burdens fall on both optometric chain firms and on individual practitioners.

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179 California, Colorado, Maine, Montana, Oregon, and Washington.

180 California.

181 Arizona, Connecticut, Florida, Georgia, and Wisconsin.

182 Alabama, Arkansas, Illinois, Iowa, Louisiana, Maryland, Minnesota, Missouri, Nebraska, New York, Ohio, Utah, Vermont, and Wyoming.

i. Effect on Volume

In order for a high-volume optometric practice to develop successfully, it is important that the practice locate in a high traffic area that is convenient to consumers.[183] Such a location might be a department store, shopping mall, or a freestanding location near a mall.[184] In retail business generally, a good location is critical to the success of the business.[185] This is true of an optometric practice as well. Relative to other factors, location is one of the most important factors consumers consider in determining where to obtain optometric services, following quality and price of service.[186] High volume practices, as noted elsewhere, are generally able to achieve economies of scale in labor costs, equipment, material, rent, and utilities.[187]

Restrictions on locating in proximity to an optician may have the effect of reducing the level of consumer convenience that would otherwise be achieved by a mercantile location.[188] If

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183 NAOO Comment at p. 45; S. Tuckerman, President, Tuckerman Optical Co., J-51(a).

184 NAOO Comment at pp. 45-46 (citing Eyeglasses I Staff Report at pp. 140-44), J. Kwoka, Professor, George Washington Univ., J-12(a) at p. 4.

185 E.g., NAOO Comment at 45.

186 Eyeglasses I Staff Report, B-2-52-1, at pp.140-44.

187 See supra Section III.B.1.c.ii., "Availability of Economies of Scale."
(footnote continued)

an optometrist cannot offer "one-stop" convenience by locating near an optician, the potential volume would be reduced and firms may be deterred from entering the market.

ii. Effect on Construction and Rental Costs

The states that impose "two-door" restrictions impose a different set of costs on firms. In such states, practitioners must typically maintain separate entrances to a public street, corridor, or hallway for both its optical dispensary and the leased-out optometrist's office. This results in higher construction costs, requires more space and thus more rent, and increases frontage costs. These added costs may be passed on to consumers. They may deter optometric chain firms from entering the market, and prevent both firms and individual optometrists from achieving the volume that may result from practicing in an optical dispensary.

The NAOO estimates that the cost of constructing, equipping, and fixturing a two-door office is fifteen to twenty percent higher than for an equivalent one-door office.[189] This cost, which typically might amount to $10,000 per office, includes duplicating the heating, cooling, bathroom, waiting room, and other facilities. The direct and indirect costs of adding a

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188 J. Kwoka, Professor, George Washington Univ., J-12 at 4; J. Denning, President-elect, American Association of Retired Persons, Tr. 59.

189 NAOO Comment at p. 35.

second door to an existing office was reported in one case at $6,500.[190]

The need for duplicate facilities, such as bathrooms and waiting rooms, also leads to an increase in space requirments for two-door offices. One chain firm estimates that it requires ten percent more space for a two-door facility than a one-door store.[191] Using NAOO's estimate that 200 to 300 additional square feet are required for a two-door operation, the increased rental cost attributable to that requirement would be between $3,000 and $10,500 per year based on annual shopping center rents between $15 and $35 per square foot.[192]

Two-door operations necessarily require the optometrist's and optician's offices to be located side-by-side in relation to the street or hallway. In one-door operations, on the other hand, the optometrist is typically located towards the back of the shop. The two-door operation thus requires more frontage space than a one-door shop. This tends to increase costs, since frontage space commands a premium, and makes it difficult to find sufficiently wide spaces.[193]

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190 R. Feldman, President, Spectron, Inc., Tr. 95-96.

191 Letter from E. D. Butler to T. Latanich, NAOO Comment, App. R. This factor, of course, applies only in states that do not permit the sharing of facilities and inside connecting doors, such as Texas. It would not apply to states that permit them, such as Massachusetts.

192 NAOO Comment at p. 54.

193 J. Ellis, President, Eyexam 2000, J-48(c); R. Feldman, President, Spectron, Inc., Tr. 95-96.

Other costs increase with a two-door operation as well. Where a requirement that there be no interconnecting doors between the two offices[194] or that all phases of the practice be under the optometrist's exclusive control[195] bars the sharing of personnel, increased payroll costs result because of the need for separate receptionists and other supporting personnel.[196] Utility costs also increase costs by about ten percent, or $500 to $1,000 per year.[197]

A comparison of costs incurred and prices charged by firms operating in both one-door and two-door states suggests that payroll costs and consumer prices may be higher in two-door states than one-door states. One firm that operates in a one-door setting in Nebraska and in a two-door setting in North and South Dakota reported that total payroll costs were $5,666 higher, and examination fees were four dollars higher, in the states requiring the two-door facilities.[198] Another firm

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194 E.g., Texas.

195 E.g., Colorado.

196 NAOO Comment at p. 55.

197 NAOO Comment at pp. 54-55.

198 Letter from L. Joel, President, Duling Optical, to T. Latanich, Pearle Vision Services, NAOO Comment, App. S; NAOO Comment at 55-56. Duling's own payroll costs were $589 less in the two-door offices. However, 75% of the affiliated optometrists in the two-door state had to hire ancillary help at an average cost of $8,340 per year, whereas none of the optometrists in the one-door state had to do so. NAOO calculated the total additional payroll cost at $5,751. Staff, using the same data, found the total additional cost to be $5,666 (8,340 x .75-589). This data does not, however, take into consideration cost of living and other differentials that may exist between (footnote continued)

reported similar results in comparing its one-door operations in Ohio with its two-door operations in Pennsylvania and Virginia.[199]

4. Restrictions on Trade Name Usage

a. Introduction

This section discusses state restrictions on the use of trade names. At least 32 states impose prohibitions on the use of nondeceptive trade names by optometrists. The record indicates that such prohibitions suppress the dissemination of useful information and impede the growth of lower-cost commercial optometric practice.

b. Nature of Restrictions

Restrictions on trade names generally take one of three forms. First, in some states, optometrists are prohibited from practicing under trade names in virtually all circumstances. Eight states explicitly ban trade or corporate names.[200] Another twelve states prohibit an optometrist from practicing under a

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Nebraska and the Dakotas, which could affect those price differentials.

[199] NAOO Comment at p. 56. This firm, Pearle, did not supply specific documentation for its claim.

[200] Florida, Indiana, Mississippi, Montana, North Dakota, Pennsylvania, Virginia and Washington.

false or assumed name.[201] At least two of these states, and possibly more, interpret this restriction to prohibit the use of trade names.[202] An additional twenty-three states prohibit optometrists from practicing under a name other than the name appearing on their licenses.[203] At least six of these states interpret that restriction to prohibit trade names.[204]

Second, some states impose restrictions on trade name use. For example, California requires that all trade names contain the word "optometric" or "optometrist," and also requires that optometrists receive a permit from the Board in order to use a trade name.[205] These rules are significant to the extent that they may be interpreted to prevent use of nondeceptive trade names. For example, a chain firm with an established, recognized trade name, such as Pearle Vision Center or Sterling Optical, may be unable to offer optometric services in California without changing its name unless the optometric services are offered separately under a different, conforming name.[206]

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201 Arizona, California, Idaho, Indiana, Iowa, Kansas, Montana, New Jersey, Nevada, Oregon, Tennessee and Washington.

202 Indiana and Kansas. In New Jersey, trade names can be used if the optometrist's real name is cited as well.

203 Alabama, Arizona, Delaware, Florida, Hawaii, Illinois, Indiana, Kansas, Kentucky, Maine, Massachusetts, Nebraska, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, South Dakota, Tennessee, Utah, Virginia, West Virginia and Wisconsin.

204 Hawaii, Indiana, Kansas, Nebraska, New Jersey and Wisconsin.

205 Cal. Bus. & Prof. Code § 3125(b), (c).

206 See infra Section VI., "Recommendations." The potential impact on trade name use of permit requirements is less clear.

Third, at least nine states require that the names of all optometrists practicing under the trade name,[207] or at any advertised location of a trade name firm, [208] be disclosed in all advertisements. The record establishes that such requirements effectively prevent nondeceptive trade name advertising.

Evidence was presented showing that the cost of disclosing the names of all optometrists practicing under a trade name is so burdensome as to preclude the effective use of trade names under many circumstances.[209] The record establishes that these disclosure requirements, by creating the same burdens on chain firms advertisers as outright trade name bans, make nondeceptive trade name advertising impractical for the reasons discussed below.[210]

State laws requiring that the names of all optometrists at particularly advertised locations be disclosed in all advertisements for those locations have a similar effect. As with the more comprehensive disclosure laws, these regulations

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207 Five states require disclosure of the names of all optometrists practicing under a trade name. Cal. Admin. Code tit. 15, R. 1513; Ma. Admin. Code Tit. 236 §5.11; Mo. Rev. Stat. §336.200; Neb. Admin. R. 8.36 406 c); N.C. Admin. Code §42 E. 0202(2).

208 Four states require disclosure of the names of optometrists at particularly advertised locations. Ga. Admin. Comp. ch. 430-4-.01(2)(f); Miss. Admin. R. 23; Or. Rev. Stat §683.140(11); Va. Bd. Exam Opt. R. II(B).

209 NAOO Comment at pp.84-87; G. Black, Arkansas Retail Merchants Ass'n, D-1 at p. 2; P. Zeidman, Counsel, International Franchise Ass'n, Tr. 617-620; NAOO Panel, Tr. 538.

210 See infra Section III.B.4.c.ii., "Effects on Firms' Costs."

increase costs for advertisements that mention specific locations.[211] Because of these increased costs, this requirement may effectively prevent nondeceptive trade name usage in advertisements which list a number of specific locations. For example, this requirement would likely preclude trade name usage in a short broadcast advertising spot for even a small number of locations, yet such advertising may well be the most effective marketing tool for a given firm.

A common thread running through many of these state trade name regulatory schemes is that an optometrist's ability to practice under a trade name depends on the literal form of practice in which the optometrist engages. Some states maintain inconsistent regulatory schemes in which trade names are permitted for some practitioners and prohibited for others. One such inconsistency concerns the treatment of professional corporations as compared with other forms of practice. Some states permit professional corporations to use a corporate name while denying the use of trade names to optometrists in branch office practice, partnership arrangements, or franchises.[212] Finally, most states that ban trade names permit optometrists who are employed by other optometrists to practice under the name of

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211 NAOO Comment at pp. 84-87; G. Black, Arkansas Retail Merchants Ass'n, D-1 at p. 2; P. Zeidman, Counsel, International Franchise Ass'n, Tr. 617-620; NAOO Panel, Tr. 538.

212 See, e.g., Indiana, Oregon. Many states require that the name of a professional corporation contain the full or last names of the major optometrist shareholders, with other associated optometrists practicing under the corporate names.

their employer, provided their own name is disclosed at the practice location.[213] Although trade name bans were intended to prevent certain presumed abuses in these states, the record does not reveal any significant abusive or deceptive use of trade names actually occurring by the exempt providers.

c. Effects of Restrictions on Commercial and Volume Practices

i. Effect on Reputation

Record evidence indicates that the use of trade names is valuable to both buyers and sellers of optometric goods and services.[214] Over time, trade names come to embody the

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213 See, e.g., Mississippi, North Dakota, Pennsylvania, Virginia and Washington.

A similar inconsistency exists in Wisconsin, a state that permits lay employment of optometrists but prohibits optometric trade names. See Wis. Stat. §449. In Wisconsin, opticians may conduct business under trade names, and if they employ optometrists, these optometrists may, in effect, practice under the optician's name. The Wisconsin courts have determined that the Wisconsin Board of Optometry has no jurisdiction over opticians. Therefore, the Board cannot prohibit opticians who employ optometrists from advertising the availability of optometric services in trade name advertising. Feinberg v. Hasler, 217 N.W. 2d 334 (1974). Thus, Wisconsin creates the anomalous effect of permitting trade names for chain optical firms offering optometric care but not permitting them for independent optometrists.

214 See, e.g., J. Kwoka, Professor, George Washington University, J-12(a); C. Shapiro, "Premiums for High Quality Products as Returns to Reputations," The Quarterly Journal of Economics, Nov. 1983, J-12(e); S. Wiggins and W.J. Lane, "Quality Uncertainty, Search and Advertising," The American Economic Review, Dec. 1983, J-12(g); L. Benham, "Licensure, Brand Names (footnote continued)

provider's reputation concerning price and quality,[215] in that they reflect the cumulative experiences that prior consumers have had with a particular firm over a period of time.[216] For this reason, trade names may substantially reduce search costs to consumers. And, as a result, trade names become a valuable asset to firms.[217]

While proponents of trade name bans contend that trade names do not provide useful information to consumers,[218] the record

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and Commercial Practices as Sources of Quality Control in Medicine, G-21. Admittedly, some of this evidence analyzes the use of brand names for manufactured fungible goods rather than trade names for services performed by different individuals at different locations. However, both attempt to convey the same type of information concerning standardization of quality, and the effectiveness of both depends in large part on the quality control exercised by the parent firm and the combined experiences of consumers purchasing the firm's goods and services.

The economic analysis is buttressed by comments submitted by representatives of firms with extensive experience in using optometric trade names. See, e.g., NAOO Comment, H-78 at p. 70-75; P. Zeidman, Counsel, International Franchise Ass'n, Tr. 617-20; J. Ellis, President, Eyexam 2000, J-48 at p. 8. Trade name opponents, however, dispute that trade names accurately convey information concerning quality and the ability of trade name firms to provide standardized quality at different locations. See, e.g., Rebuttal statement of Robert R. Nathan Associates, Inc., addressing the statement of John E. Kwoka, Jr., K-4 at p. 15-22. These criticisms will be discussed at infra Section III.C.3.e.i.(a), 'Effects on Preventing Deception."

215 J. Kwoka, Professor, George Washington Univ., Tr. 497.

216 "Quality" does not necessarily mean highest quality so much as a recognized level of quality. A firm may have a valuable reputation for providing economical goods. For example, consumers would not expect a Chevette to be of the same "quality" as a Porsche. Rather, the name Chevette may convey reliability and economy rather than superlative performance.

217 J. Kwoka, Professor, George Washington Univ., J-12(a) at pp. 4-5.

218 Some proponents of trade names bans also state that trade (footnote continued)

established that consumer reliance on reputation can be beneficial in a number of ways. First, the quality reputation embodied in trade names would generally be based on the cumulative experiences of many consumers over an extended period of time.[219] Second, contrary to claims that consumers are deceived by quality reputation because they cannot judge quality, consumers can make at least some quality judgments on an individual basis.[220] For example, most consumers, although not technical experts, should be able to tell whether a new eyeglass prescription or contact lens fitting enables them to see better or provides more comfort.[221] One would expect these subjective assessments of quality to be at least as strongly associated with the word-of-mouth reputation often relied on by traditional

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names prevent consumers from relying on the reputation of individual optometrists in selecting a practitioner. See, e.g., G. Easton, President-elect, AOA, Tr. 144-145; M. Coble, Kansas Optometrist, H-143; C. Shearer, Indiana Optometrist, H-153, p. 4. They fail to explain, however, why consumers could not continue to rely on personal reputation, and why the use of trade names is relevant to this argument. They also fail to explain why consumers should rely on the quality reputation of individual optometrists and not on that of trade name firms.

219 J. Kwoka, Professor, George Washington Univ., Tr. 502-503.

220 Rebuttal statement of California Optometric Association, K-12 at p. 20; RRNA Rebuttal, K-4 at p. 17.

Neither COA or RRNA provide evidence demonstrating the consumers' inability to judge quality. Consumers consider quality as a primary factor in selecting an optometrist. Eyes I Staff Report, B-2-52-1, p. 140. Yet if COA and RRNA are correct, then not even the traditional means of selecting a provider, such as word of mouth, provide consumers with information adequate to make an educated choice. In short, even if consumers cannot judge quality, use of trade names should be no more harmful than other means of selection.

221 Rebuttal statement of R. Bond, Associate Director, Bureau of Economics, K-18 at p. 18, fn. 8.

practitioners as with trade name reputation. Finally, there is no suggestion that, quality aside, consumers cannot rely on trade name reputation for price information.

Because of the value of trade names to both consumers and to firms, restrictions on their use hinder the growth and development of optometric firms.

ii. Effects on Firms' Costs

Trade name bans impede the formation and growth of optometric chain firms and large-scale commercial practices. Although chain firms are not absolutely barred from entering all markets where trade name are prohibited,[222] commercial providers have stated that trade names bans greatly increase the costs of doing business in these markets, reduce profits, and hinder efforts to gain acceptance by third-party payers.[223]

Trade name bans also impede chain firm advertising of optometric services.[224] Trade names make possible advertising

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222 See NAOO Comment, pp. 74-75.

223 Id. See also, M. Newman, O.D., H-90 at p. 2; G. Black, Arkansas Retail Merchants Assn., D-1 at p. 1-2; D. Staten, Nevada Optometrist, J-27 at p. 4. For similar reasons, these bans may also prevent smaller entrepreneurs from establishing commercial practices.

224 Price advertising by chain firms may also be deterred by different restrictions. In many states, the chain's or franchisor's effort to get lessees or franchisees to agree on the price for optometric services, even if only to facilitate regional advertising, would constitute interference with professional judgment, thus violating those states' bans on (footnote continued)

for multiple locations that may otherwise be prohibitively expensive if the names of all individual optometrists in a firm had to be used, or if individual practice locations had to be advertised separately under different names. Large firms can advertise many locations under one trade name. This enables them to spread their advertising costs over the entire firm, while their individual outlets benefit from widespread advertising campaigns.[225] However, in states banning trade names chain firms may not be able to take full advantage of these economies of scale.[226]

According to the commercial firms that engage in large scale advertising for optometric services, the costs imposed by trade names bans are substantial.[227] For example, the NAOO has estimated the cost savings of multiple location advertising that trade names permit.[228] In analyzing the print and broadcast

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corporate employment. In those instances, the significance of a trade name ban may be secondary. See Conversation between G. Jensen, FTC staff, and F. Rozak, Vice President, Cole National Corp., July 8, 1980, B-11-9 at p. 1.

225 NAOO Comment at pp. 70-74; P. Zeidman, Counsel, International Franchise Ass'n, J-14 at p. 21; D. Staten, J-27 at p. 4.

226 These restrictions not only affect large optometric chains, but also impact on smaller firms or individuals seeking to associate with a group practice or open a branch office. For these smaller entrepreneurs, the inability to spread advertising costs among their various locations may reduce their incentive to expand their practices or enter into business associations with other practices.

227 See, e.g., NAOO Comment at p. 72; J. Ellis, President, Eyexam 2000, J-48(c) at p. 8.

228 NAOO Comment at pp. 71-74.

advertising costs of a typical marketing program, the NAOO noted substantial per-office cost savings for a combined advertising campaign over advertising for individual locations.[229] In fact, the expense of some forms of advertising, such as broadcast advertising, may well be prohibitive to single offices or firms who must list the names of all of its optometrists and may require the combined resources of multiple locations under a single name to be cost effective.

Trade name bans also may increase non-advertising costs, especially for optometrists practicing in a franchising relationship. Because they may not be permitted to advertise optometric services under a trade name, potential franchisees may be required to establish separate offices for the sale of optical goods and the sale of professional services in order to advertise optical goods under the franchisor's trade name.[230]

5. Aggregate Effect of Restrictions on the Formation of Commercial Practices.

The evidence discussed above demonstrates that each of the restrictions prevent or restrict the development of commercial optometric practices, including large-volume and more-efficient,

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[229] Id. According to Dr. Ellis of Eyexam 2000, the cost differential to his Chicago locations in print advertising alone would necessitate a price increase of $6.00 per examination if Eyexam 2000 were required to advertise each location separately. J. Ellis, President, Eyexam 2000, J-48(c) at p. 48.

[230] NAOO Comment, at pp. 72-74.

low-cost practices. Thus, they reduce the number of such firms in the market and restrict competition.

Further, the restrictions often are enacted in combination, and generally work in combination to hinder the market entry of such providers. For example, at least 26 states have at least three of the restrictions at issue here.[231] Since each restriction increases the difficulty of chains and other providers to enter the market, or to expand and achieve high-volume, the restrictions have a cumulative impact; while one type of restriction may not be sufficient to prevent the formation of optometric chain firms or volume practices, a combination of several restrictions may well be. Thus, the analysis of the impact of individual restrictions above tends to underestimate the combined effect.

In addition to hindering competition from optometric firms the restrictions also hinder the development of chain optical firms, and other optical practices. As discussed above, the restrictions make it more difficult for optical companies to offer eye exams. Where it is unprofitable to offer eye exams, optical firms may choose not to enter the market at all; without access to prescriptions generated by an associated optometrist, the firm's sale of eyeglasses may be unprofitable at some locations. Thus, the restrictions also hinder the development of chain optical outlets.

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231 See chart infra pp. 33-46.

The conclusion that the restrictions reduce the number of commercial firms is further buttressed by evidence indicating that there are many markets throughout the country with few if any large chain firms. The evidence indicates that in some states -- all with restrictive laws -- none of the largest chains offer eye exams or do business at all, or there is little if any, commercial practice.[232] In many other states, the number of chains is limited.[233]

In conclusion, the evidence clearly demonstrates that the restrictions, singly or in combination, limit the number of

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[232] See, Lists submitted by Sterling Optical, Pearle Health Services, Cole National Corp., and Precision Lens Crafters, J-74 and J-75; C. Beier, President, Kansas Board of Optometry, Tr. 2124-25, (no commercial optometrists in Kansas); Comment of J. Crum, Kansas Optometrist, H-20 at p. 1 (optometrists in Kansas do not practice in commercial settings); J. Ingalls, President, Western States Optical, J-54 at pp. 3-4 (experience in Alaska) and Tr. 2184-86 (restrictions prevent expansion into small towns); P. Beale, Member, Maine Board of Optometry, Tr. 765 (few, if any, commercial firms in Maine); A. Johnson, Asst. Attorney General, State of Wyoming, Tr. 1995-96, (no optometrist practicing in commercial settings); K. Eldred, Secretary, Wyoming Board, Tr. 2004, 2007 (no for-profit corporations or commercial optometrists providing eye care in state); L. Zuern, Member, North Dakota Board, Tr. 1558, 1566, 1575.

No evidence contrary to these conclusions was presented for the record. Nathan stated that the five cities classified in the BE Study as "restrictive" now have chain firms offering eye exams. RRNA Rebuttal Statement, K-1 at p. 5. We have been unable to find any express claim in their testimony or statements that there are now no cities or markets without chain firms. See, e.g., RRNA Study, J-66(a), Vol. I, Ex. 1, p. 43; RRNA Rebuttal Statement, K-2 at p. 5. However, by stating that the BE Study's "restrictive" markets now have chain firms offering eye exams, they may be seeking to imply that chain firms offer eye exams in all markets. See also L. Strulowitz, Member, New Jersey Board, J-1 (New Jersey laws have not restrained growth of chains). This is contradicted by the evidence discussed above.

[233] See, supra, note 232.

commercial optometric providers in the market.

C. Effects Of Commercial Practice Restrictions On Consumers

1. Survey Evidence

In the following sections, we describe the three major surveys which were submitted for the rulemaking record. These surveys, which examined either the effects of commercial practice restrictions or the differences between commercial and noncommercial providers, were placed on the rulemaking record along with background and supporting documentation; at least one of the survey's authors testified and underwent cross-examination; and the studies were subjected to extensive analysis.[234]

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[234] A fourth survey was submitted by the California Optometric Association (COA) and was conducted on its behalf. This survey is entitled "A Consumer Study of Optometric Practices in Metro-Atlanta Area," J-67(a). E. Elliot, O.D., of the AOA and the COA, was made available to testify and answer questions about the Atlanta survey. However, he was not one of the study authors. Further, the comments and evidence about the Atlanta survey methodology were much more limited than the other three. Several additional studies were placed on the rulemaking record in the form of published articles. Background and supporting documentation regarding these studies was not placed on the rulemaking record and the studies' authors were not made available for questioning. Therefore, these studies cannot be fully evaluated. They will be discussed in the sections dealing with the issues to which they related, such as infra Sections III.C.2., "Price Effects of Commercial Practice Restrictions," and III.C.3., "Quality Effects of Commercial Practice Restrictions."

a. BE Study

i. Introduction

In 1980 FTC Staff published the results of a comprehensive study designed to measure the effects of commercial practice restrictions. The study, entitled "Staff Report on Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry," hereinafter referred to as the "BE Study", was conducted by the Commission's Bureau of Economics.[235]

The Study data showed that prices were 18% higher for eye exams and eyeglasses in markets without chain firms than in markets with chain firms.[236] The data also showed that the overall level of quality of eye care was not lower in markets with chain firms. The data on accuracy of the prescriptions, accuracy and workmanship of eyeglasses, the extent of unnecessary prescribing and the thoroughness of eye exams all showed that there was no difference in quality between markets with chain firms and those without chain firms. The Study thus indicates

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[235] B-2-31. The study was prepared by Drs. Ronald Bond, John Kwoka, John Phelon and Ira Taylor Whitten, of the FTC's Bureau of Economics. The Study was initiated in 1977, well before the Commission started to consider this rulemaking proceeding.

[236] While the Study was designed to examine both the effects of advertising and of chain firms, the results discussed in this staff report relate only to the effects of chain firms. This point is discussed more fully in Appendix A.

that restrictions on chain firms raise prices to consumers without providing any quality-related benefits.

ii. Methodology

In order to obtain expert advice on the quality aspects of the Study, BE Staff secured the assistance of the College of Optometry of the State University of New York, the Pennsylvania College of Optometry, and the Director of the Optometric Service of the Veterans Administration. These colleges and persons served as expert consultants in designing and conducting the Study.

In the Study, nineteen trained survey researchers,[237] posing as ordinary consumers, purchased eye exams and eyeglasses from optometrists in 12 different markets across the country.[238] Over

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237 With two exceptions, the survey subjects had relatively routine visual problems. Subjects fell into three groups:

(1) "blurred" - 15 visually healthy but myopic individuals, some with astigmatism, aged 40-51 who went to their eye appointments without their eyeglasses;

(2) "20/20" - 5 individuals aged 26-36 who went to theirappointments wearing eyeglasses which adequately corrected their vision problems (in order to test, among other things, the extent of unnecessary prescribing); and

(3) "binocular" - two subjects who had a vision problem which is relatively more difficult to correct, and who went to appointments wearing eyeglasses that did not correct their problem.

BE Study p. 43-44.

238 BE defined the relevant geographical market as Standard Metropolitan Statistical Areas (SMSA's). The 12 SMSA's in the (footnote continued)

400 eye exams and 231 eyeglasses were purchased.[239]

To provide a basis for comparison between restrictive and nonrestrictive markets, the survey subjects visited a range of competitive and regulatory environments. Cities were classified as markets where advertising was present if there was advertising of eyeglasses or eye exams in the newspapers or in the Yellow Pages.[240] Cities were classified as markets with commercial practice if eye examinations were available from large interstate

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survey were:

Little Rock, Arkansas
Knoxville, Tennessee
Providence, Rhode Island
Columbia, South Carolina
Winston-Salem, North Carolina
Milwaukee, Wisconsin
Columbus, Ohio
Portland, Oregon
Baltimore, Maryland
Minneapolis, Minnesota
Seattle, Washington
Washington, D.C.

BE Study at page 41.

In our discussion of the BE study we use the term "markets" rather than "SMSA's.

[239] Eyeglasses were not purchased in all cases because: a) the "20/20" subjects were instructed not to buy eyeglasses, even if they were recommended by the examining optometrist; and (b) sometimes new eyeglasses were not prescribed for the binocular subjects. The rest of the difference between number of eye examinations and pairs of eyeglasses purchased is explained by loss of eyeglasses shipped in the mail (4 or 5 pairs) and the fact that all eyeglasses purchased in Milwaukee (approximately 12) were not counted because the eyeglasses were mailed after the optometrists who prepared them discovered the purpose of the examinations thereby introducing the question of bias.

[240] No attempt was made to measure radio or television advertising. It is likely that most radio and television advertisers would also advertise in the newspapers and the Yellow Pages.

optical firms.[241]

Since price and quality may be affected by a number of factors other than the presence of chain firms, BE staff used multivariate regression analysis to analyze the data. This technique is the standard economic tool for dealing with situations where the variables under study may be affected by a number of factors. Multivariate regression analysis allows one to control for such other factors to ensure that they do not influence the results. In the BE price analysis, multivariate analysis was used to attempt to control for: (1) differences across markets in advertising, (2) differences across markets in the supply of optometrists; (3) differences across markets in the demand for optometric services; and (4) differences across subjects in prescriptive needs. Each of these factors might affect price, independent of the presence of chain firms. The price data were also adjusted for differences in the cost-of-living among cities.[242]

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241 Chain firms generally offer eye exams either through optometrists they employ or through optometrists leasing space from them.

The "most restrictive" markets in the study had neither advertising nor chain firms; in addition, restrictive laws such as those at issue in this proceeding existed in these markets. Cities were classified as "least restrictive" if advertising and chain firms were present. In the least restrictive cities there was price advertising of eyeglasses and at least nonprice advertising of eye exams.

242 BE Study at pp. 48-55, 91-93.

iii. Price Results

The total package price of the eye exam and eyeglasses purchased by the subjects formed the basis for the price analysis.[243]

The Study found that the prices charged for eye exams and eyeglasses were 18% higher in markets without chain firms. While the Study showed that the lowest price providers were the chain firms themselves,[244] it also showed that the presence of chain firms in a market resulted in lower prices throughout the market. Optometrists who practiced in the traditional manner charged prices that were significantly lower in markets where they faced competition from chain firms than in markets where they did not. The following table shows these findings.

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[243] This amount includes any dispensing fees, as well as charges for glaucoma tests or any other exam procedures which were priced separately. In order to minimize variation in the eyeglasses frames, subjects were instructed to purchase a particular unisex metal frame, if possible. BE Study at p. 46.

[244] Within the nonrestrictive market, optometrists were divided into the following three types of categories: (1) traditional, non-advertising, noncommercial optometrists in either solo practice or standard group practice; (2) advertisers not associated with large chain firms, including solo practitioners, as well as local optical firms; and (3) optometrists associated with large chain optical firms, either by leasing office space or by virtue of an employment relationship. In restrictive markets, all optometrists were nonadvertisers and nonchains. (There was also a small group of "on-site" advertisers who had large signs or window displays and who were treated as a separate group throughout the analysis). BE Study at pp. 40-41.

Table 1

Estimates of Average Prices
Charged for Examination and Eyeglasses[245]

	markets without chains	markets with chains
All Optometrists (market average)	83.35	70.72
nonadvertisers[246]		73.44
advertisers		63.57
chain firms		61.37

The BE Study also found that prices were lower at any given quality level in markets with chain firms compared to markets without chains. To examine this issue, the study looked at price variations holding quality constant.[247] As an example, the BE Study compared the cost of eyeglasses plus an eye exam of a typical quality level. The estimates showed that optometrists in

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245 The figures in this chart are not actual prices found in actual markets but are estimated prices derived from a multivariate regression analysis which held constant advertising and other variables which could affect price. The derivation of these figures and the assumptions relied upon are explained more fully in the Rebuttal Statement of R. Bond, K-18, and the Letter of R. Bond to J. Greenan, Presiding Officer, May 29, 1985, J-76. See, e.g., K-18 at Table A-3 and accompanying explanation.

246 These figures exclude optometrists who advertise on site.

247 To conduct this analysis, BE looked at price variations for exams with a given "thoroughness index." The development of the thoroughness index is discussed in infra Section III.C.1.a.iv., "Quality Results."

restrictive markets had the highest average price -- $94.00 in 1977; traditional optometrists in nonrestrictive markets had a lower price -- $73.00 in 1977 dollars; and chain firms in nonrestrictve markets had the lowest prices -- $63.00.[248] The Study found that for any given level of quality prices were lower in nonrestrictive markets and that chain firms had the lowest prices.

iv. Quality Results

In an attempt to obtain a comprehensive assessment of the quality implications of commercial practice restrictions, the BE Study compared four dimensions of quality in markets with chain firms and markets without chain firms: (1) the accuracy of the eyeglass prescriptions, (2) the accuracy and workmanship of the eyeglasses, (3) the extent of unnecessary prescribing, and (4) the thoroughness of the eye exam. The Study found no statistically significant difference in quality between these markets. The following table presents these results.

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248 BE Study at pp. 23-25.

Table 2

Estimates of Quality[249]

Quality Measure	Markets without Chains	Markets with Chains
Average Thoroughness of Eye Exam[250]	58.5	61.6
% of Accurate Prescriptions	82	88
% of Accurate Eyeglasses	85	87
% of Eyeglasses of Adequate Workmanship	82	92
% of O.D.'s Prescribing Unnecessarily	32	12

In measuring these aspects of quality, steps were taken to obtain an accurate and unbiased assessment. In order to assess the accuracy of the eyeglass prescriptions, both consulting colleges of optometry performed eye examinations on each survey subject before the subjects went into the field. The resulting prescriptions became the "baseline" prescriptions for judging the accuracy of the prescriptions written by each of the optometrists in the survey.[251] In order to avoid bias, each school judged the

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249 The estimates in the Table are derived from a multivariate analysis that corrected for possibly important determinants of quality other than the presence of large chain optical firms. See BE Study at pp. 8, 15, 18, 19 and 21.

250 This number results from the FTC Index of thoroughness. The NAOO index yielded similar results. See BE Study, pp. 8-14.

251 BE Study at pp. 44-45.

prescriptions obtained during the survey independently in comparison to the baseline prescription without knowing the type of optometrist which had been visited.[252]

In determining the accuracy of the eyeglasses, the two schools of optometry evaluated the eyeglasses purchased from each optometrist in comparison to each optometrist's written prescription,[253] without knowing the type of provider involved. The schools also examined the eyeglasses for workmanship - for example, whether there were scratches on the lenses, whether there were any significant imperfections in the lenses, whether the lenses were edged and mounted well and whether the frames were of acceptable materials and workmanship.[254] In order to avoid bias, identifying names and brands were covered on the

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[252] BE Study pp. 14, 72.

The optometrists at the optometry schools used their clinical judgment in determing whether the subject prescriptions were accurate in comparison to the baseline prescription.

[253] Lenses were read by an automatic lensometer and were then compared to the prescriptions written by the examining optometrists. This was doen even if the prescription itself was judged inadequate in comparison to the benchmark prescription because the issue under scrutiny here was whether the optometrist could accurately fill a prescription.

In judging the accuracy of the eyeglasses, the consultants used two different procedures. In one, they determined whether the lenses met the 1972 ANSI Z80.1 standards, which establish tolerances for lenses. Secondly, the consultants used their own clinical judgement to evaluate the eyeglasses for accuracy. BE Study pp. 75-76.

[254] BE Study pp. 14-20, 78-79. Although problems in workmanship may be caused by the optical laboratory, it is generally agreed that the optometrist is responsible for checking these aspects and rejecting eyeglasses with poor workmanship.

eyeglasses so that the consulting optometrists would not know which type of provider had sold the eyeglasses.

In order to assess the extent of unnecessary prescribing, one group of subjects arrived at their examinations wearing prescriptions which the consulting optometrists believed to be appropriate.[255] If the surveyed optometrists nonetheless recommended new eyeglasses they were classified as engaging in unnecessary prescribing.[256]

The results showed that there was no difference in markets with regard to accuracy of prescriptions, accuracy and workmanship of eyeglasses and extent of unnecessary prescribing. In addition, there was no difference between chain firms and traditional practitioners on these aspects of quality.

The fourth measure of quality, thoroughness of the eye exam, was used to assess the relative ability of optometrists in restrictive and nonrestrictive markets to detect visual problems and signs of eye disease or problems which might require medical attention.[257] The quality measure assessed whether optometrists

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255 These patients were instructed to inform the optometrists that they wanted new eyeglasses only if a new pair would "really make a difference" in their vision.

256 Overprescribing was defined in two ways. The first included all observations where the optometrists recommended a new prescription. The second included only observations where the optometrists had derived the correct prescription, thus excluded instances where the optometrists made an error in deriving the prescription, and therefore, determined that new glasses were needed in comparison to this erroneous prescription. BE Study at p. 20.

(footnote continued)

performed specific procedures which must be used in order to detect pathologies and treat complex visual problems.

To ensure that the survey researchers were familiar with the procedures that are part of a thorough eye exam, they were trained for a week at the two colleges of optometry to identify such procedures.[258] After each eye examination in the survey, subjects completed debriefing forms on which they noted whether or not optometrists had performed a detailed list of eye exam procedures and components. In order to develop an overall index of thoroughness for each optometrist, the FTC consultant at the Veterans Administration, in consultation with the schools of optometry, developed a quality index assigning weights to each procedure or component of an exam which reflected the importance of that procedure or component.[259]

Several steps were taken to guard against bias. Before being reviewed by the consultants, the debriefing forms were purged of data identifying the optometrists The possibility of bias was also further reduced by the use of two different indices of thoroughness, one developed by the FTC consultants, the other by NAOO. The results using each of the two indices were highly correlated, suggesting that the results are basically insensitive

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257 If signs of ocular disease or other problem are detected, the patient is ordinarily referred to an ophthalmologist for further treatment.

258 BE Study at pp. 44-45.

259 Each optometrist received a score ranging from zero to 100, depending upon which tests he or she performed.

to the weighting system used.[260]

The thoroughness data showed that examinations purchased in markets with chain firms and in markets without chain firms were, on average, of about equal thoroughness. Also, the percentage of optometrists offering more or less-thorough exams was substantially similar in the two types of markets.

The BE Study found substantial variation in thoroughness of exam within both restrictive and non-restrictive markets,[261] and the variation within one type of market was substantially similar to the variation in the other type of market. Thus, within each type of market, substantial percentages of the exam scores were found to be much higher and much lower than the averages. In nonrestrictive cities, a higher percentage of less-thorough examinations tended to be purchased from advertising optometrists and chains, while traditional optometrists tended, on average, to perform more thorough exams. In restrictive cities, both less-thorough and more-thorough exams were available from at least as large a percentage of optometrists as in nonrestrictive markets. Since advertising and chain practice was prohibited in these cities, however, all optometrists necessarily practiced in a traditional manner.

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260 BE Study at pp. 6-7, 68-69.

261 Substantial variation was found within each optometric group as well, so that, for example very thorough exams were found among some chain firms and much less thorough exams were found among some private optometrists in nonrestrictive markets. BE Study at pp. 63-68.

Neither the BE Study nor the record as a whole indicates whether the less-thorough exams which were found in both types of markets are "inadequate." This is a judgment for the market or for state regulatory bodies. The BE Study does indicate, however, that if some commercial firms are giving exams deemed "inadequate" because they are not thorough enough, then an equal percentage of optometrists in restrictive markets are giving such "inadequate" exams. Thus, the BE Study indicates that the restrictive laws do not accomplish the stated objective of eliminating less-thorough or "inadequate" exams from the market.

v. Comments and Criticism Concerning the Study

Many commenters, including individual optometrists, state board officials and association officials, stated their opinion that the BE Study was invalid, either by raising general objections or by providing specific reasons. Some commenters stated their approval of the Study.[262] The most lengthy and detailed of the comments about the Study was provided by Robert R. Nathan and Associates (hereinafter Nathan), a firm of private consulting economists hired in this proceeding by the AOA. Nathan submitted detailed, lengthy and, in part, highly technical, comments which criticized virtually every aspect of the BE Study.[263] Below, we discuss the most frequently-mentioned

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[262] NAOO Comment at p. 20; H. Snyder, West Coast Director, Consumers Union of the U.S., J-24(a) at p. 1.

[263] Robert R. Nathan and Assoc., consulting economists, (footnote continued)

comments about the methodology of the study, and the record evidence on these points. Appendix A to the Report contains a more detailed discussion of additional, more technical, aspects of the methodology of the BE Study and of the record evidence.[264]

The record indicates that none of the comments provide valid reasons for not relying on the BE Study. The record indicates that the Study and the analysis of the data were carried out in accordance with sound survey and statistical techniques and that there is no reason to believe that the results were affected by any systematic bias. Thus, the record indicates that the BE Study is reliable.

Commenters raised a number of concerns about the methodology of the BE Study. One, some commenters stated that the Study cannot be used to estimate the independent effects of advertising and of chain firms.[265] These commenters noted, for example, that the most restrictive cities in the Study had neither advertising nor chain firms and that the least restrictive cities had both.[266] They also stated that the BE Report did not discuss the

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J-66(a). Before Nathan had conducted a thorough evaluation of the Studies, they agreed to demonstrate their deficiencies and to develop economically sound reasoning to support the position of the AOA. Letter from J. Gunn, Nathan and Assoc., to A. Bucar, President, AOA, Dec. 13, 1984, K-22 Appendix A (Attachment to Rebuttal Statement of R. Kinscheck).

264 Because of their technical nature, the Nathan comments are discussed and responded to by Dr. Ronald Bond, FTC economist, at Rebuttal Statement of R. Bond, K-18.

265 See, e.g., Nathan study at Vol. I, Ex. 1, at pp. 32, 38-39, 47; AOA Comment, at p. 24.

266 See, e.g., Nathan study at Vol. I, Ex. 1, at pp. 31-32; (footnote continued)

independent effects of chain firms.

Contrary to these assertions, however, the Report did discuss the independent effects of chain firms and of advertising on quality; the Study reported that neither advertising nor chain firms had any effect upon quality in a market. The quality results reported in the Study were based on a comparison of markets with chain firms and markets without chain firms.[267]

While the Report did not discuss the independent effects of chain firms and advertising upon price, the Study was designed to examine these effects separately.[268] The separate effects of chain firms were derived by performing a simple calculation on the BE Study's underlying data.[269] Essentially, data from five markets with chain firms and seven markets without chain firms were analyzed using a regression equation which held constant the effects of advertising.[270]

Comment of Cal. Ass'n. of Dispensing Opticians, H-112 at p. 8; AOA Comment, at p. 24.

267 See, BE Study at pp. 60-62. This was done because the presence of advertising in a market was found to have no effect upon quality.

268 R. Bond, FTC economist, Tr. 466. Rebuttal Statement of R. Bond, K-18 at p. 5. The BE Study reported the combined effects because this was of primary interest at the time. R. Bond, Tr. 465-66.

269 See, Letter from R. Bond, FTC economist to J. Greenan, Presiding Officer, May 29, 1985, J-76; Rebuttal Statement of R. Bond, FTC economist at 5 and App. A. See also, R. Bond, Tr. 465; J. Kwoka, Professor, George Washington Univ., Tr. 500-01. Dr. Kwoka, a coauthor of the BE Study, stated his agreement with Dr. Bond's conclusions and methods of analysis. J. Kwoka, J-12(a) at p. 9 and Tr. 500-01.

270 For more detail, see Rebuttal Statement of R. Bond, FTC (footnote continued)

Two, some commenters stated that the study is obsolete because advertising of eye exams and eyeglasses is now nearly universal and that the price benefits found in the Study have already accrued to society as a result of this increase in advertising.[271] While it is clearly true that advertising is now more prevalent in many markets than at the time the Study was conducted, this does not affect the validity of the Study results, for a number of reasons. First, since the Study measured the independent effects of chain firms, changes in advertising are largely irrelevant and would not alter the results regarding chain firms.[272]

Second, even if an increase in advertising drives down the prices of all optometrists, there is no reason to assume that it would eliminate the price difference between commercial and noncommercial optometrists or between markets with chain firms and markets without.[273] In fact, the BE Study,[274] as well as

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economist, K-18 at p. 5 and Appendix A; Letter from Dr. R. Bond to J. Greenan, Presiding officer, May 29, 1985, J-76.

271 See, e.g., Nathan study at Vol. I, Ex. 1, pp. 34-41; AOA Comment at p. 24; R. Freese, President, California Optical Laboratories Ass'n, H-61 at p. 5; K. Van Arsdall, Indiana Optometrist, H-97 at p. 2; C. Shearer, Indiana Optometrist, H-153 at p. 2; A. Gorz, President, Wisconsin Optometric Association, J-25 at p. 5; M. Tiernan, California Ass'n of Dispensing Opticians, J-30 at pp. 9-10; J. Scholles, Ohio Optometrist, J-31 at p. 4; W. Van Patten, Secretary Nevada Board, J-56 at p. 1.

272 See, Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 5.

273 See, Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 5-7.

274 BE Study at p. 5. No test was conducted to determine whether this difference was statistically significant. However, (footnote continued)

other survey evidence,[275] showed that chain firms charged substantially less than the average price for all optometrists in market where there was advertising. In fact, an increase in advertising may well widen the price gap between these groups since chain firms may be better able to take advantage of the economies of scale associated with advertising.[276] The evidence indicates that there is indeed a larger price difference between commercial and noncommercial firms in markets with a higher incidence of advertising than in markets with less advertising.[277]

A third criticism raised about the BE study methodology was a claim that the BE Study is no longer valid because the five cities labeled as "restrictive" in that Study now have chain firms offering eye exams, implying that, as a result, the Study results are no longer relevant.[278]

This claim, raised by Nathan, the consulting firm hired by the AOA, should be rejected. Despite Nathan's claim, the record

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since the difference was substantial, it is likely to be statistically significant.

275 See infra Sections III.C.1.b., "Contact Lens Study" and III.C.2.c.ii., "Atlanta Study."

276 See, Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 5-6.

277 See infra Section III.C.2., "Price Effects of Commercial Practice Restrictions."

278 Nathan study, Vol. I, Ex. 1, at p. 43; Nathan Rebuttal Statement, K-2 at pp. 3-6. Nathan also states that these cities now have advertising. This point is not a valid criticism of the Study since, as explained, the Study examined the independent effects of chain firms.

does not clearly establish that large chains now provide eye exams in all five of the cities classified as "restrictive."[279] However, even if Nathan's claim were true, this would in no way invalidate the BE Study results for several reasons. One, although there apparently are some chain firms in some of these markets, restrictions do exist in these markets which hinder competition from such firms.[280] Therefore, there may well be fewer such firms and higher prices than in the absence of such restrictions. Two, the BE Study was intended to present a national picture of the effects of commercial practice restrictions. Twelve SMSA's were used in the analysis from such diverse areas of the country as Providence, Rhode Island; Knoxville, Tennessee; Portland, Oregon and Milwaukee, Wisconsin. All twelve SMSA's were incorporated in the regression analysis used to derive the price and quality effects of commercial practice.[281] Thus, even if conditions have now changed in the specific cities incorporated in the Study as "restrictive", this would not affect the applicability of the Study results to other markets throughout the country. The evidence indicates that there are currently many markets with

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279 Only one of the three large chains does business in Providence, Columbia, and Greensboro-Highpoint. A fourth, smaller chain does business in Knoxville. None of the largest chains do business in Little Rock. See, Lists submitted by Pearle Health Service, Cole National, Sterling Optical and Eyexam 2000 to Presiding Officer, J-74, J-75.

280 See chart at pp. 33-46.

281 Nathan's assertion that only the least and most restrictive cities were used in the price analysis is simply wrong. See, Nathan Rebuttal Statement, K-2 at p. 3.

restrictions on optometric chain firms.[282]

A fourth concern about the study methodology was that the survey subjects had relatively routine visual problems which required only the most basic level of skills. These commenters argued that the study should have been performed using subjects with more complex conditions.[283] While the BE Study used subjects that had relatively routine visual conditions, the study examined whether or not optometrists performed a large number of tests and procedures that would have detected more complex problems. The record evidence suggests that the results of the study would not have been different had the study included subjects with more complex visual conditions.[284]

Five, many commenters stated that the eye exam procedures which were included in the FTC thoroughness index represented a minimum level of quality which one would expect all optometrists

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[282] See chart at pp. 33-45. See supra note 232.

[283] Nathan study, Vol. I, Ex. 1 at pp. 76-79; AOA Comment at p 27; California Optometric Ass'n Comment, J-67(a) at pp. 3, 5-7; Statement of Southern California College of Optometry Panel, J-41(a) at pp. 4-5, 6; J. O'Connor, Indiana Optometrist, H-108 at p. 1; J. Crum, Kansas Optometrist, H-20 at p. 3; N. Otte, Indiana Optometrist, H-36; M. Raymon, California Optometrist, H-39 at p. 2; D. Robbins, Indiana Optometrist, H-59 at p. 3; W. Garton, Kansas Optometrist, H-70; L. Harris, Kansas Optometrist, H-71 at p. 5; R. Peach, Indiana Optometrist, H-73 at p. 1; B. Prokop, Kansas Optometrist, H-83 at p. 1; R. Fisher, Kansas Optometrist, H-60 at pp. 1-2; R. Szabo, Indiana Optometrist, H-94 at p. 1; M. Pickel, Indiana Optometrist, H-96 at p. 2; K. Arsdall, Indiana Optometrist, H-97 at p. 1; L. Zuern, Member, North Dakota Board of Optometry, J-40 at p. 2.

[284] See Appendix A for a more complete discussion of this point along with citations to the record evidence.

to perform.[285] Commenters claimed that, for this reason, differences in quality were unlikely to be found.[286]

To the contrary, the thoroughness index included over 20 eye tests, as well as specific points concerning case history, diagnosis and the subjective reaction of the patient.[287] Further, many optometrists, including noncommercial optometrists, did not perform all of the procedures.[288] For example, nonadvertising optometrists in restrictive markets had an average score of 58.8 out of a possible 100 on the FTC Index. If the index were a mere minimum one would expect a-higher score.[289] Thus, the record indicates that the procedures included were not a mere minimum, but constituted at least a thorough routine eye exam and probably went beyond this.[290]

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285 See, e.g., Nathan study, Vol. I, Ex. 1 at pp. 134-35; Statement of Southern California College of Optometry Panel, J-41(a) at p. 12; Comment of R. Fisher, Kansas Optometrist, H-60 at p. 1.

286 Statement of Southern California College of Optometry Panel, J-41(a) at pp. 4-5; Statement of California Optometric Ass'n Panel, J-67(a) at pp. 6-7.

287 See, BE Study at pp. 95-112 for a list of all the procedures and issues included in the thoroughness index.

288 BE Study at p. 8.

289 See Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 9-10.

290 Moreover, the methodology of the Nathan New York City Survey supports these conclusions. The record establishes that the procedures which optometrists would use to detect the eye conditions used in the Nathan survey were included in the BE Study's Index of thoroughness. Compare NAOO panel, Tr. 1959, 2075-77 and BE Study at pp. 98-102. Thus, the procedures in the BE study thoroughness index, if performed competently, would have led to the detection of the conditions in the Nathan survey. (footnote continued)

Six, several commenters noted that the BE Study's "unadjusted" price data showed higher prices in the least restrictive cities than in the most restrictive cities, implying that these data should have been used.[291] There is absolutely no valid basis for any claim that unadjusted price data should be used in comparing prices across cities. As we discussed earlier, the price data were adjusted to account for differences in the cost-of-living. Sound economic analysis demands that cost-of-living adjustments be made.[292]

In summary, the record discloses no credible arguments or evidence showing that the BE Study is invalid. To the contrary, the record indicates that the methodology of the BE Study is sound and in accord with proper survey and statistical techniques. Thus, the record indicates that the BE Study provides reliable evidence regarding the effects of chain firms

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This refutes the contention that the tests included constituted only a bare minimum.

[291] See, e.g., AOA Comment, H-81 at p. 30; L. Semes, Optometrist, Univ. of Alabama, F-3; W. Kirby, Indiana Optometrist, H-107; D. Robbins, Indiana Optometrist, H-59 at p. 4; L. Harris, Kansas Optometrist, H-71 at p. 6; K. Arsdall, Indiana Optometrist, H-97 at p. 2; R. Ireland, Indiana Optometrist, H-151 at p. 2; C. Shearer, Indiana Optometrist, H-153 at p. 2; W. Erxleben, Counsel, Washington State Optometric Ass'n, J-35 at p. 1; D. Conner, Director, Department of Legal Affairs, Indiana Optometric Ass'n, Tr. 672.

[292] Nathan concurred in this conclusion, stating that cost-of-living adjustments must be made, but that the particular cost-of-living adjustments used in the BE Study are invalid. Nathan study, Vol. I, Ex. 1 at pp. 97-98. See Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 12-13 for a complete discussion of this issue. Moreover, calculations performed by Dr. Bond using alternative cost-of-living indices yielded substantially similar conclusions. See, Rebuttal Statement of R. Bond, K-18 at p. 13.

upon price and quality in a market.[293]

vi. Conclusion

The BE Study shows that prices were significantly lower in markets with chain firms than in markets without chain firms, for all types of optometrists and at all levels of quality. Examining the accuracy of prescriptions, accuracy and workmanship of eyeglasses, the extent of unnecessary prescribing and the thoroughness of eye exams, the Study also found that there was no difference in quality between markets with chain firms and markets without chain firms. Although there was a wide variation in exam thoroughness in each type of markets, the percentage of optometrists with less-thorough exams and with more-thorough exams were substantially similar in markets with chain firms and in markets without such firms. Since each of the restrictions at issue in this proceeding hinders or restricts the development of chain firms, the BE Study provides persuasive evidence that the restrictions increase consumer prices throughout the market without increasing the quality of care in the market.

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[293] In infra section III.C.1.c., "Nathan New York City Survey," we discuss the Nathan New York City survey and its relationship to the BE Study. The Atlanta Survey, and its relationship to the BE Study, is discussed infra in sections III.C.2., "Price Effects of Commercial Practice Restrictions," and III.C.3., "Quality Effects of Commercial Practice Restrictions." Additional comments and evidence concerning specific issues such as the price and quality of chain firms, and the relationship of this evidence to the BE Study are discussed in those sections.

b. Contact Lens Study

i. Introduction

In 1983, the FTC Staff published its second major study of eye care price and quality, "A Comparative Analysis of Cosmetic Contact Lens Fitting by Ophthalmologists, Optometrists, and Opticians," hereinafter referred to as Contact Lens Study. This Study provided additional information on the effects of restrictions on commercial optometric practice by examining the price and quality of cosmetic contact lens[294] fitting between commercial optometrists -- optometrists who were associated with chain optical firms, used trade names, or practiced in commercial locations -- and other fitters. It found that, on average, commercial optometrists fitted cosmetic contact lenses at least as well as other fitters, but charged significantly lower prices, providing evidence that restrictions on such providers raise prices to consumers without any increase in quality.

In order to obtain expertise in defining and evaluating quality of eye care, staff obtained the assistance of the major eye care professional organizations — the American Academy of Ophthalmology, the American Optometric Association and the Opticians Association of America[295] — in designing and

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294 "Cosmetic" contact lenses refer to lenses worn instead of eyeglasses for cosmetic reasons as opposed to lenses worn for therapeutic or medical reasons.
(footnote continued)

conducting the survey. On balance the record supports a conclusion that the representatives of all three organizations reached a consensus regarding the methodology to be used in the study.[296]

By using consumer mail panels,[297] staff identified a

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295 Contact Lens Study at pp. 17-18.

296 See, G. Hailey, FTC staff attorney, J-6(a) at p. 2 and Tr. 199-200, 221-222; Letter from FTC staff to Dr. Dabezies, M.D., Feb. 2, 1979 ("[i]t looks as if all the involved groups will be in virtually total agreement on the significant aspects of the contact lens wearers study.") The agreement of the Optician's Association has never been in dispute. See, e.g., Letter from F. Sanning, President, Southern Optical Co., to G. Hailey, FTC, Feb. 21, 1979; Comment of D. Klauer, Opticians Ass'n of America, H-80 at p. 31. The agreement of the representative of the American Academy of Ophthalmology (AAO), was also clear. After receiving the "second round" or final modifications to the proposed methodology, Dr. Dabezies, M.D., of the Contact Lens Association of Ophthalmologists, and also of the AAO, made the following comments about the methodology:

> In general I am personally satisfied with the second round modifications. Jan. 29, 1979 letter to G. Hailey, B-5-13.
>
> I would again like to compliment the FTC on the very objective manner in which the study has been structured. May 12, 1979 letter to G. Hailey and T. Latanich, B-5-12.

The third group, the American Optometric Association (AOA), claimed, after reviewing the results of the Study, that they never agreed with the methodology and pointed to a Dec. 20, 1978 letter from Dr. Hunter, AOA, to Gary Hailey, FTC, wherein the AOA expressed serious reservations about the survey. Letter from R. Averill, AOA, to J. Bromberg, FTC, Jan. 13, 1983, B-5-2. See also, G. Hailey, Staff attorney, FTC, Tr. 225 and J-6(d). However, this letter was written at an earlier stage in the ongoing discussions and before the methodology was finalized. In its response to the final methodology that was circulated to the groups, AOA did not state any objections. Letter from Earle Hunter, AOA, to Gary Hailey, FTC, March 5, 1979. (A minor point concerning a one-to-four grading scale was mentioned. This suggestion was adopted).

(footnote continued)

representative sample of consumers who had been fitted for contact lenses within the past three years and who were still wearing their lenses. From this group, five hundred and two consumers were identified who agreed to participate in the survey. The survey subjects were located in 18 urban areas across the country.[298]

Staff classified the original contact lens fitters of these consumers into four groups: commercial optometrists, traditional optometrists, ophthalmologists and opticians.[299] As described below, in order to assess the relative ability of the fitter

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[297] Mail panels are developed by market research firms that survey thousands of individuals who have agreed in advance to respond to mail questionnaires or telephone interviews from the firm. Each firm's panel is demographically balanced to ensure that it is representative of the population as a whole.

[298] The urban areas chosen were Atlanta, Boston, Chicago, Cincinnati, Cleveland, Detroit, Houston, Kansas City, Los Angeles, Minneapolis/St. Paul, Nashville, Phoenix, Pittsburgh, Rochester (New York), St. Louis, San Diego, San Francisco, and Winston-Salem/Greensboro.

[299] The original purpose of the study was to compare the quality of cosmetic contact lens fitting among ophthalmologists, optometrists and opticians. Subsequently, Staff decided to classify the optometrists further into commercial and non-commercial.

Each of the 502 subjects filled out a questionnaire providing, among other facts, the name and address of the person who had fitted the lenses that they were wearing. Staff then sent a questionnaire to the fitters, the primary purpose of which was to obtain information to enable the staff to determine whether the subject had been fitted by an ophthalmologist, optometrist or optician. Staff used additional information in the Yellow Pages and the Blue Book of Optometry, a nationwide directory of optometrists, to determine whether an optometrist fitter was commercial or noncommercial. There was also a group of fitters that could not be classified. Detailed information about how the classifications were made is contained in Appendix B.

groups to properly fit contact lenses, survey examiners assessed the eye health of each of these subjects, looking for eye conditions commonly associated with improper contact lens fitting. The data collected in the survey was used to make comparisons of price and quality among these four types of providers.

ii. Procedures for Assessing Quality

In order to assess the relative ability of each provider group to fit contact lenses, the association representatives and staff agreed that an ophthalmologist, an optometrist, and an optician[300] should examine the eyes of each study subject for the presence of potentially pathological conditions which are commonly associated with improper contact lens fitting.[301] The association representatives also agreed upon the appropriate procedures to use and standards to apply in examining the eyes of the study subjects. In order to obtain an unbiased assessment, each of the three examiners would independently evaluate each subject s eyes without knowing what type of provider had originally fit the patient's lens.

The examiners looked for the presence of seven potentially

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[300] The opticians did not perform refractions on the subjects.

[301] The association representatives also identified qualified members of their respective professions who were willing to serve as field examiners and helped to locate well-equipped clinical facilities where the field examinations could be conducted.

pathological conditions. These included epithelial and microcystic edema (intercellular accumulation of fluids which causes the cornea to swell); corneal staining (abrasions or lesions on the cornea); corneal neovascularization (impingement of blood vessels into the normally avascular cornea); corneal striae (ridges or furrows on the cornea); injection ("bloodshot" eyes) and corneal distortion or warpage (irregularity in the curvatures of the cornea).[302]

For each subject, each of these conditions was graded on a scale of zero to four,[303] corresponding to pictures in an illustrated grading manual that had been designed by the group representatives. The grading manual was used to minimize inconsistencies in grading.

The findings of the examiners for each of the seven conditions for each eye were used to create a summary quality score for each subject, which would indicate the overall health of the subject's eyes. Since all of the seven conditions are not necessarily equally serious, in computing the scores, weights were assigned by the consultants to each condition based on the relative severity of that condition.[304] The summary quality

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[302] The subjects were also tested for visual acuity to determine whether their prescriptions were adequate. Contact Lens Study at pp. 20-21. Also, subjects' lenses were examined to determine their physical condition and cleanliness.

[303] "Zero" indicated no presence of the eye problem. "Four" indicated the most severe condition. One of the conditions was graded on a scale of zero to three.

[304] An unweighted summary quality score was also calculated. (footnote continued)

scores take into account all seven of the potentially pathological conditions simultaneously.

In addition to analyzing the summary quality scores, the study also examined the relative presence of each of the seven eye conditions individually. A "higher quality" score was assigned if the examination revealed that a particular condition was totally absent. A "low quality" score was assigned if the examination revealed that a particular condition was present to any degree.

In order to compare quality among the different providers, differences in the quality scores were computed for commercial optometrists, noncommercial optometrists, ophthalmologists and opticians. The multiple regression estimation technique was used, so that account was taken of a number of factors other than fitter competence that could have affected the relative health of the study subjects' eyes, and consequently, of the quality scores. These additional factors included the wearers' age, sex, and wearing habits, and the condition of the lenses.

iii. Quality Results

A comparison of the summary quality scores showed little difference among the provider groups and showed that commercial optometrists fitted cosmetic contact lenses at least as well as

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The results of the analysis using the unweighted scores did not differ appreciably from those which used the weighted scores.

the other fitter groups - noncommercial optometrists, ophthalmologists and opticians. This pattern was observed for both hard and soft lenses, which were analyzed separately. The results of looking individually at the presence or absence of each eye condition were fully consistent with the results based on the summary quality measure. In all seven of the eye condition categories, the commercial optometrists displayed quality levels at least as high as those of the other provider groups.[305]

iv. Procedures for Obtaining Price Information

Price information was obtained from the subjects who had their eyes examined during the survey. Prior to the exam, FTC Staff interviewed the patients and asked them: (1) how much they paid for their lenses; (2) whether that amount included the eye exam, follow-up care, the initial care kit and insurance and, if any of these items were not included, (3) what was the additional charge for the item. 388 of the 435 wearers utilized in the quality-of-fit analysis were able to answer all the questions concerning cost.

The price information was used to establish a uniform package price. The package price included the following items:

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[305] On three of the eye conditions, the commercial optometrists performed better than the noncommercial optometrists at the 10% significance level. This means that the difference was marginally significant.

the contact lenses, the eye exam, follow-up care, and the initial lens care kit.[306] The final price figures were then adjusted by a cost of living index computed for each of the 18 cities in the sample, and for each year within the 1975-1979 period.

v. Price Results

The results showed that commercial optometrists charged significantly lower prices than the other provider groups. The following chart shows the average price of each provider group, for hard and soft lenses.

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306 Contact Lens Study at pp. C-1 thru C-3. If a subject indicated that he or she did not know if a particular item was included and no additional price was given, it was assumed that the item was included in the quoted price.

AVERAGE ESTIMATED PRICES[307]

PROVIDER GROUP	AVERAGE PRICE (standard error)	
	Hard Lenses	Soft Lenses
OPHTHALMOLOGISTS	182.39 (7.6)	234.42 (9.1)
OPTICIANS	160.97 (8.1)	205.40 (11.6)
NON-COMMERCIAL OPTOMETRISTS	153.88 (6.6)	195.26 (6.6)
COMMERCIAL OPTOMETRISTS	119.18 (8.0)	158.75 (11.3)

The results showed that commercial optometrists charged prices that were on average 20% lower than non-commercial optometrists and over 30% lower than ophthalmologists.[308] These differences were statistically significant.

Two additional tests were conducted by BE Staff on the Contact Lens data which demonstrated that these price differences were, in fact, associated with commercial firms and were not due

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[307] J. Mulholland, FTC economist, J-19(a) at Table A-3 p. 14. These averages are not actual prices in actual markets but are estimated prices derived from the regression analysis used in the Study. Contact Lens Study at pp. C-3 through C-5.

[308] Since ophthalmologists are trained to perform medical evaluations of the eyes and optometrists are not, any cost comparison between optometrists and ophthalmologists may reflect a difference in the service provided.

to the effects of advertising or other market forces that could also affect prices. Thus these tests corroborated the general findings of the Study that commercial optometrists charged less than noncommercial optometrists.[309]

The tests looked at specific markets or years within which these markets forces were believed to be relatively constant. The first alternative test was based on purchases made in the four cities with the highest percentage of commercial fits.[310] Since commercial optometry relies heavily on advertising to attract its clientele, these cities were likely to be relatively free of advertising constraints. The second test was based on purchases made in 1979 for all cities in the sample.[311] It is

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309 See J. Mulholland, FTC economist, J-19(a) at pp. 7-9, which explains in detail the additional tests which BE staff performed to control for the effect of other variables which could have affected price. See also, J. Mulholland, Tr. 794-95.

Initially, the study's price finding was qualified, in the Report, due to the inability to control fully for certain factors other than type of fitter which may have influenced prices. Contact Lens Study at p. C-1. As a result of the additional tests this qualification can now be removed.

Nevertheless, some commenters stated that part or all of the price difference found in the Study may be attributable to factors other than commercial firms, specifically, an increase in price advertising since the Bates case, or an increase in competition from manufacturers of lenses. Nathan study, J-66(a) at p. 32; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) pp. 5, 20; AOA Comment at p. 47; J. Scholles, Ohio Optometrist, AOA, J-31 at p. 4.

310 This test was discussed in the Contact Lens Report, at pp. C-9 thru C-13.

311 This test was performed by BE Staff subsequent to the publication of the Contact Lens Report and was first reported in Dr. Mulholland's Statement. J. Mulholland, FTC economist, J-19(a) pp. 8-9.

highly likely that advertising existed in all markets by that year.[312]

The results of these two alternative tests support the general finding of the Contact Lens Study that commercial optometrists charged lower prices than the other provider groups. For both the subsamples, commercial optometrists were again found to charge significantly lower prices than non-commercial optometrists and the other provider groups.[313] What is particularly important is the cumulative effect of the tests performed, all of which strongly and unequivocably point to the same result -- that commercial optometrists charge less than noncommercial optometrists.

vi. Comments about the Study

Many comments were filed about the Contact Lens Study methodology. Many commenters stated that the Contact Lens Study is invalid. The most lengthy and technical of these was that of Robert R. Nathan and Associates (hereinafter Nathan), an economic

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312 In 1977 the Supreme Court ruled that lawyers have a First Amendment right to advertise. Bates v. State Bar of Arizona, 433 U.S. 350 (1977). Further, in 1978, the FTC's Eyeglasses I Rule went into effect, eliminating state prohibitions on advertising of ophthalmic goods and services. 16 C.F.R. Part 456.

313 The one difference between these results and those based on the full sample occurred for opticians: while commercial optometrists were still recorded as charging lower prices, the estimated difference between commercial optometrists and opticians was not always statistically significant. See J. Mulholland, FTC economist, J-19(a) at p. 8.

consulting firm hired in this proceeding by the AOA.[314]

In this section, we discuss the most frequently-repeated comments concerning the methodology of the study and provide a summary of the record evidence on these points. In Appendix B we discuss additional more technical points concerning the Contact Lens Study methodology.[315]

None of the comments provide a basis for rejecting the compelling evidence that the Study is valid and reliable. Thus, the evidence indicates that the Contact Lens Study provides reliable evidence.

Some commenters stated their approval of the methodology of the Contact Lens Study. For example, Professor Lee Benham, an independent expert on professional regulation,[316] stated that the Study may be the most careful examination which has been conducted of the relationship between commercial and noncommercial sources of care.[317] Concerning the criticisms

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314 Nathan Study, Vol. I, Ex. 2.

315 Because of the highly technical nature of the regression analysis used in the Study, some of the comments are responded to in more detail in the Statement of Dr. Joseph Mulholland, FTC economist, and one of the primary authors of the Report, J-19(a), and in Dr. Mulholland's Rebuttal Statement, K-23.

316 Professor Benham of Washington University, has conducted extensive independent research into the effects of various restrictions in the health care field. See, e.g., Benham and Benham, Regulating Through The Professions: A Perspective on Information Control, 18 J. L. & Econ. 421 (1975) B-2-29.

317 See, Licensure, Branch Names and Commercial Practices as a Source of Quality Control in Medicine, L. Benham, G-21 at pp. 23-24; Rebuttal Statement of L. Benham, Professor, Washington (footnote continued)

which have been raised about the study, he stated that it is not sufficient simply to articulate arguments but that specific reasons must be given as to why bias enters in a particular way. He stated that no convincing evidence has been presented to suggest that the study was sytematically biased.[318]

Several commenters criticized the study. One, some stated that it examined only current contact lens wearers and not former wearers or "drop-outs" -- people who had attempted to wear lenses in the past and then ceased wearing them. Commenters stated that, as a result, the Study examined only patients who had been successfully fitted with lenses and not those who had been unsuccessfully fitted and had to cease wearing the lenses because of the fitters' incompetence.[319] Thus, they stated that the Contact Lens Study failed to assess an important measure of quality, namely, the extent to which optometrists provide long term successful contact lens fits, particularly for difficult or

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University, K-17 at p. 2.

318 Rebuttal Statement of L. Benham, Professor, Washington Univ., K-17 at p. 2.

319 AOA Comment at pp. 38-39; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at p. 6; J. Kennedy, Minnesota Optometrist, J-26 at pp. 4-5; Statement of Southern California College of Optometry Panel, J-41(a) at p. 24; Rebuttal of F. Aron, Director of Statistical Research, AOA, K-7 at p. 2; Comment of American Academy of Ophthalmology, H-79 at p. 1; M. Helton, California Consumer, J-32 at pp. 3-4; Statement of Califonria Optometric Ass'n Panel, J-67 at p. 3; G. Easton, President-elect, AOA, Tr. 147; J. Crum, Kansas Optometrist, H-20 at p. 5; R. Wolter, Indiana Optometrist, H-52 at p. 1; W. Garton, Kansas Optometrist, H-70; L. Harris, Kansas Optometrist, H-71 at p. 7; D. Reynolds, Kansas Optometrist, H-77 at p. 2; R. Reinecke, Secretary for Governmental Relations, American Academy of Ophthalmology, H-79 at p. 1; R. Szabo, Indiana Optometrist, H-94 at p. 2.

hard-to-fit patients.

While it is true that the study examined only current wearers,[320] it is not true that these wearers were all successful wearers. Thus, while the Study did not directly address the "drop-out" rate question, it does provide evidence suggesting that commercial optometrists do not have a higher "drop-out" rate than noncommercial optometrists. The record evidence shows that many of the study subjects were experiencing problems with their lenses as reflected either by the existence of pathological eye conditions or by discomfort associated with wearing lenses.[321] Thus, if commercial optometrists were indeed less able to provide successful lens fittings, the study should have shown more eye problems and more discomfort among study subjects fitted by commercial optometrists.[322] This was not the case, however. The study found that there was no statistically significant difference between the patients of commercial and noncommercial

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320 As explained further in Appendix B, the consultants could suggest no method of evaluating the quality of fit of persons who were no longer wearing their lenses.

321 See e.g., J. Kennedy, Minnesota Optometrist, J-26 at p. 5. For example, Dr. Kennedy, an AOA witness, a contact lens expert and one of the study examiners, stated that one patient in the Study could barely wear her lenses at all because of discomfort associated with the lenses. Tr. 1144. See also the plots of individual eye condition scores against weartime in the Statement of J. Mulholland, FTC Economist, J-19(a) at Attachment B. These plots reveal the number of subjects with each type of pathology.

322 Not all problems associated with improper fitting necessarily lead the patient to cease wearing the lenses; some problems would not cause sufficient discomfort to cause all patients to cease wearing the lenses. See, J. Kennedy, Minnesota Optometrist, J-26 at p. 5 and Tr. 1148.

optometrists in the existence of the pathologic eye conditions and in discomfort associated with lens wear.[323]

Two, some commenters stated that the study results are invalid because most of the subject's had not worn their lenses for four hours on the day of the exam. These commenters stated that eye conditions associated with improper fitting would not be fully detected unless patients had worn the lenses for at least four hours on the day of the exam.[324] They argued that all

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[323] Rebuttal Statement of J. Mulholland, FTC economist, K-23 at pp. 10-11.

[324] Nathan study, Vol. I, Ex. 2, at pp. 18-19, 26-27; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at p. 12; J. Kennedy, Minnesota Optometrist, J-26 at p. 8; D. Sullins, Tennessee Optometrist, AOA Trustee, J-39 at p. 10; G. Easton, President-elect, AOA, Tr. 148; D. McBride, President, Montana Optometric Ass'n, Tr. 2273. Commenters cited a number of factors in support of this argument. AOA and Nathan pointed out that the Contact Lens Study data show significant decreases in the summary quality scores as weartime on the day of the exam increases. Specifically, Nathan pointed out that the average quality score for subjects with a weartime greater than four hours was significantly lower than the average for subjects with less than four hours. Nathan study, Vol. I, Ex. 2, p. 25.

This evidence does not show, however, that a four-hour weartime was necessary. Even if eye conditions get progressively worse as weartime increases, a minimum weartime would not be necessary for the study as long as eye conditions show up shortly after insertion of the lenses and a variable for weartime is included in the regression analysis. Such a variable was included in the Study's regression analysis and ensures that differences in weartime among subjects do not affect the outcome of the survey. For a further discussion of this point see the Rebuttal Statement of J. Mulholland, FTC economist, K-23 at pp. 5-6.

Commenters also cited to the optometric literature and clinical practice to show that, in follow-up examinations of contact lens patients, it is generally adviseable to examine patients after four hours of weartime on the day of the exam to ensure that any and all problems have reached their maximum level. Letter to Chairman Miller, FTC, from Richard Averill, (footnote continued)

subjects who had not worn their lenses for at least four hours should be excluded from the study and that the remaining group is too small for meaningful analysis.[325]

Despite the claims of these commenters, the record does not support a conclusion that failure to include a four-hour wear time invalidates the study results. One, as indicated, all the study consultants -- i.e., the representatives of the three major professional eye care associations, including the AOA, reached a consensus regarding the appropriate methodology for the study. Further, the representative of the American Association of Ophthalmology stated his explicit approval of the study methodology.[326] This constitutes convincing evidence that the study methodology is valid.

Second, even if testimony of AOA witnesses and other commenters is assumed to be accurate, the record reveals that they claim that weartime on the day of the exam is relevant for only some of the less severe eye conditions in the study.[327]

AOA, July 19, 1983, B-5-9 at pp. 11-12; J. Kennedy, Minnesota Optometrist, J-26 at p. 8.

325 Nathan study, Vol. I, Ex. 2, at pp. 18-19, 26-27; AOA Comment, H-81 at p. 45. B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at p. 12; J. Kennedy, Minnesota Optometrist, J-26 at p. 8. On the other hand, Professor Lee Benham of Washington University, an independent expert who is familiar with the Contact Lens Study, stated that no evidence has been presented to show that the Study results were affected by the failure to require a four-hour weartime for all subjects. Rebuttal Statement of L. Benham, Professor, Washington University, K-17 at p. 2.

326 See supra note 296.

327 See, e.g., J. Kennedy, Minnesota Optometrist, Tr. 1140-47, (footnote continued)

According to the statement of these witnesses many of the more severe eye conditions in the study -- including microsystic edema, corneal staining, corneal distortion and neovascularization -- are problems of a more long standing nature which take days or weeks to develop and equal lengths of time to disappear and thus, for which weartime on the day of the exam would not be relevant.[328] Thus, if commercial optometrists in general had a lower ability to fit contact lenses, one would expect commercial optometrists in the Study to have had significantly lower quality scores than noncommercial optometrists for at least these more severe conditions. However, Study data reveal that commercial optometrists performed at least as well as, if not better than, noncommercial optometrists not only on these conditions but on all seven of the individual eye condition scores in the Study.[329] It appears, therefore, that

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J-26 at pp. 9-11; Southern California School of Optometry Panel, Tr. 1693-94. See also, Rebuttal Statement of J. Mulholland, FTC economist, K-23 at pp. 4-7, Table 2 and Appendix A, for more detail regarding these points and for citations to specific testimony.

328 Thus, while it would be important that subjects had worn their lenses sometime prior to the day of the exam, weartime on the day of the exam was not deemed relevant for these four conditions. See, e.g., J. Kennedy, Minnesota Optometrist, Tr. 1140-47; Southern California School of Optometry Panel, Tr. 1693-94.

That length of weartime is irrelevant for most of the eye conditions in the study seems to be confirmed by the CLS data which shows that there are only two eye conditions for which quality scores decrease significantly as weartime increases - central corneal clouding and corneal staining, for hard contact lenses. For soft lenses, there are no eye conditions for which quality scores decrease significantly as weartime increases. This seems to indicate that weartime is not relevant for most of the eye conditions in the study. Rebuttal Statement of J. Mulholland, FTC economist, K-23 at pp. 6-7.
(footnote continued)

even if the commenters are assumed to be correct, and some of the eye conditions require a minimum weartime, this did not effect the result of the survey.

A third concern about the study methodology was raised by commenters who implied that the study results are invalid when they stated that the eye conditions examined in the study are not necessarily caused by fitter incompetence but could have been caused by other factors such as eye trauma.[330] These commenters objected to the fact that the examiners were instructed not to determine whether the eye problems were caused by fitter incompetence, as opposed to other factors.[331]

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[329] There appears to be no reason why commercial optometrists would tend to misfit their patients in ways that would cause only those eye problems which require a minimum weartime for detection.

[330] Nathan study, Vol. I, Ex. 2 at p. 24; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 4, 10, 13; J. Kennedy, Minnesota Optometrist, J-26 at pp. 5, 12; Statement of Southern California College of Optometry Panel, J-41(a) at pp. 19-20. Factors mentioned included such things as whether or not the subject was taking medication or birth control pills; the patient's adherence to lens care, wearing and follow-up visit instructions; the intervention of non-contact lens related eye disease or trauma; and whether the original fitter had completed the fitting process and considered the patient a successful fit.

[331] Some commenters suggested that the three examiners for each patient should have been allowed to obtain in-depth information concerning the subjects' prior medical history and history of eye problems, prior contact lens wear, use of medication and subjective reaction to the lenses in order to determine the source of the eye condition. B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 13, 17; Nathan study, Vol, I, Ex. 2 p. 24; J. Kennedy, Minnesota Optometrist, J-26 at p. 12. It is ironic that Nathan criticized our use of the one to four grading system as too subjective, id. at p. 15, yet suggested an even more subjective approach.

In order to obtain as objective a measure of quality as possible, examiners were instructed to assess only the relative physical presence of the seven potential eye problems.[332] A determination of the cause of an eye problem is very difficult, if not impossible, in individual cases, and such a methodology would have introduced a great deal of uncertainty and subjectivity into the study.[333] There is no reason to believe that any of these other factors varied systematically depending upon whether the subject was fitted by a commercial or noncommercial optometrist and therefore there is no reason to believe that the results of the study were affected by the fact that these factors were not considered.[334]

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[332] Examiners were not to evaluate the lens on the eye, take a medical history, question the patient, or attempt to make any judgments about whether improper fitting had taken place. G. Hailey, FTC attorney, Tr. 248.

[333] The long list of factors raised by the commenters emphasizes the difficulty of determining whether, in any given instance, contact lens problems are the fault of the fitter or are caused by circumstances beyond the fitter's control.

The better approach is to incorporate such other factors into the regression analysis, where possible, as control variables. Further, the important step is to include those variables that might affect the outcome - i.e., that are expected to vary between fitter groups. For example, although the use of medication may have affected the existence of the eye conditions, (and this was not included in the Study), the Study results would only be affected if use of medication was systematically different among patients of commercial optometrists compared to patients of noncommercial optometrists.

[334] It is significant that none of the commenters alleged any bias with regard to the failure to include these other factors in the Study. See, e.g., Nathan study, Vol. I, Ex. 2 at p. 24; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13 at pp. 4, 13. For example, one of these commenters, Dr. Barresi, could suggest in his testimony no reason why any of these factors would vary depending upon fitter (footnote continued)

Four, some commenters also stated that the study focused only on cosmetic contact lens fits, or "simple" cases, and excluded more difficult-to-fit patients, implying that the results might have been different if more difficult patients had been included.[335]

Noncosmetic or therapeutic lenses, which are fit for medical reasons such as cataract surgery, were not included in the study. The survey consultants advised that different quality standards would apply to these lenses, and also, that patients wearing such lenses constitute only a very small percentage of total patients.[336] Moreover, many optometrists, both commercial and private, may not fit therapeutic lenses but may refer patients needing such lenses to specialists. Including such lenses in the Study would have been impractical and also was not essential because of the small number of such fits and because they are usually handled by specialists. Extended wear lenses

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group. Tr. 577.

335 See, e.g., AOA Comment at p. 36; Nathan study, Vol. I, Ex. 2 p. 13; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at p. 7; J. Kennedy, Minnesota Optometrist, J-26 at p. 13; J. Scholles, Ohio Optometrist, AOA trustee, J-31 at p. 6; M. Helton, California Consumer, J-32 at pp. 2-3; W. Sullins, Tennessee Optometrist, AOA trustee, J-39 at pp. 1-6; C. Beier, President, Kansas Board of Optometry, J-52 at p. 3; N. Otte, Indiana Optometrist, H-36 at p. 1; L. Harris, Kansas Optometrist, H-71; K. Arsdall, Indiana Optometrist, H-97 at p. 2; W. Kirby, Indiana Optometrist, H-107 at p. 2; E. O'Connor, Indiana Optometrist, H-108 at p. 1; T. Vail, Illinois Optometrist, H-115 at p. 4; J. Kintner, Indiana Optometrist, H-117 at p. 2; E. Zaranka, Indiana Optometrist, H-127; L. Asper, California Optometrist, H-148; R. Ireland, Indiana Optometrist, H-151 at p. 2. See also, Comment of American Academy of Ophthalmology, H-79.

336 G. Hailey, FTC attorney, Tr. 206-07.

and several other new specialized lens types could not have been included in the study since they were not available at the time.

Further, the comment that the study included only simple cases and excluded all difficult-to-fit patients is not correct. A significant number of cosmetic contact lens wearers may experience problems adapting to their lenses during the fitting process or may have unusual visual problems. Since the survey was based on a representative sample of cosmetic contact lens wearers, it is likely that some of the study patients experienced fitting problems or had complex visual problems.

Five, some commenters noted that the price data collected is based on consumers' recall of the prices that they paid, at times, several years in the past.[337] No biased is alleged, however, and there appears to be no reason why consumers would systematically recall paying lower prices at commercial firms than at noncommercial firms. Thus, even if there is some random error in the price data for both commercial and noncommercial optometrists, it would not affect the price differences which were found.

Six, some commenters objected to the method used in the Study to classify optometrists as commercial or noncommercial and stated that many of the classifications were not correct.[338]

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337 Nathan study, Vol. I, Ex. 2 at pp. 14, 15 and 27.

338 AOA Comment at p. 38; Rebuttal Statement of RRNA, K-6 at pp. 8-9, 13-16; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 2-3.

Nevertheless, the record indicates that the Study results are reliable.[339] One, staff was conservative in making the classifications; only fitters who were clearly commercial or clearly private was classified as such; other were placed in the "unknown" category. Two, while making the classification, staff was not aware of how the fitter had scored on the price or quality criteria. Thus, while differences of opinion may exist regarding some of the classifications, there is no reason to believe that there is any bias in the study's classifications or that the results were affected by any alleged errors.

In summary, the record discloses no valid reason why the Contact Lens Study should not be relied upon. The record indicates that the Contact Lens Study is indeed reliable.

vii. Conclusion

The Contact Lens Study indicates that commercial optometrists fit cosmetic contact lenses at least as well as noncommercial optometrists and other provider groups but charge significantly lower prices. Since each of the restrictions at issue in this proceeding hinders the development of commercial practices and restricts competition in the marketplace, the study provides persuasive evidence that the restrictions raise prices to consumers without increasing quality.

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339 See Appendix B for a more complete discussion, with citations.

c. Nathan New York City Survey

i. Introduction

A third survey was conducted by Robert R. Nathan and Associates (hereinafter Nathan) in conjunction with the AOA. Nathan is an economic consulting firm hired by the AOA for this proceeding. In this survey, test subjects with a variety of eye conditions obtained eye examinations from a sample of commercial and noncommercial optometrists in New York City. The purpose of the survey was to determine whether commercial and noncommercial practitioners differed in their ability to detect the eye conditions of the subjects. Nathan reported that 32 percent of the commercial optometrists and 60 percent of the private optometrists detected the eye conditions. According to Nathan, these results showed that eye examinations in New York City given in commercial practice environments tended to be less comprehensive and lower in quality than those given in private practice settings. Nathan also stated that these findings so "radically contradict"[340] the findings of the BE Study that the BE Study should not be relied upon.

As explained more fully below,[341] the record demonstrates that the results of the Nathan survey are unreliable because

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340 Nathan study, Vol. I, Ex. 3, p. 5.

341 See Appendix C for a complete discussion.

Nathan failed to employ generally accepted and recommended survey practice in order to guard against bias. The record indicates that the procedures used created a significant potential that the bias of AOA representatives who were substantially involved in the survey could have affected the results. This renders the Study unreliable.[342]

Further, the results of the Nathan survey, as reported, do not contradict the results of the BE Study. The Nathan survey, since it examined only a nonrestrictive market, does not contradict the central finding of the BE Study -- that there was no difference in quality between markets with chain firms and market without such firms.

ii. Description of the Nathan Survey

The Nathan firm was retained by the AOA in December 1984 to present evidence in this proceeding. Nathan agreed to "demonstrate the statistical deficiencies" of the FTC Studies, to develop "economically sound reasoning to support and advance the positions" of the AOA, and to design and conduct a reliable survey to provide information concerning "price/quality relationships" between commercial and noncommercial optometrists.[343] The survey was conducted during the week of May

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342 The record does not establish whether or not the AOA representatives or the study results were, in fact, biased.

343 Letter from J. Gunn, President, Robert R. Nathan and Assoc., to A. Bucar, O.D., President, AOA, Dec. 13, 1984, K-22, Appendix (footnote continued)

13-18, 1985. The survey examined quality but Nathan did not report any price data.

To conduct the survey, Nathan and AOA representatives selected a pool of 11 survey subjects with a variety of eye conditions, including anisocoria (pupils of differing size), vertical eye muscle imbalance (improper eye alignment), astigmatism (corneal irregularity), and retinal abnormalities (holes, spots, scarring or hemorrhaging of the back of the eye).[344] According to Nathan, these conditions were chosen because they would require a variety of procedures for detection and would be readily detectable only in a thorough exam.[345]

These survey subjects had their eyes examined by private and commercial optometrists in the three New York City boroughs of Manhattan, Queens and Brooklyn. Survey subjects visited a total of 105 optometrists; 53 in commercial settings and 52 in private settings.[346]

AOA representatives developed the sample frame -- i.e., the list of commercial and private optometrists from which the optometrists in the survey were selected. AOA representatives who were familiar with optometrists in the boroughs of Queens, Manhattan and Brooklyn classified optometrists in these three New

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A (attachment to Rebuttal Statement of R. Kinscheck).

344 Nathan study, Vol. I, Ex. 3, pp. 2-3.

345 Nathan study, Vol. I, Ex. 3, p. 3; A. Cahill, Economist, Nathan and Assoc., Tr. 2705-07.

346 Nathan study, Vol. I, Ex. 3, p. 4.

York boroughs into the following categories: private practices,[347] commercial practices,[348] retired or out of business, and status unknown.[349] The private practices and the commercial practices were then listed in random order and eye examinations for survey subjects were assigned based on this order.

Subjects were instructed to fill out a debriefing sheet after each eye exam, indicating, among other things, what the optometrist told them about their eye condition. Survey subjects were also orally debriefed after one or two exams by a Nathan staff member and an AOA staff optometrist. Based on the written debriefing sheets and the oral debriefing, the Nathan staff member and AOA representative determined whether each optometrist had passed or failed.[350] The representatives who conducted the debriefing were aware at the time this determination took place of the identity of the optometrist, and whether the practice was commercial or noncommercial.[351]

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[347] Private practices were defined to include all practices that were optometrist owned and had three or fewer locations. Nathan study, Vol. III, p. A-1.

[348] Commercial practices were defined to include all optometrists employed by lay entities and all chains with five or more locations. Nathan study, Vol. III, p. A-1.

[349] Nathan study, Vol. I, Ex. 3, pp. 5-7. See further discussions at infra Appendix C. A large group were classified as unknown.

[350] Nathan study, Vol. I, Ex. 3, pp. 14-15; A. Cahill, Economist, Nathan and Assoc., Tr. 2745, 2802.

[351] Nathan study, A. Cahill, Economist, Nathan and Assoc., Tr. 2791-93.

The stated criteria for determining whether or not an optometrist had passed was whether the optometrist performed certain tests that would detect the eye condition and whether the optometrist discussed the subjects' problem with them. The only exception to this approach was for patients with astigmatism; there the stated criterion was to examine the prescription to determine whether the optometrist had detected the astigmatism.[352]

Nathan reported that 60 percent of the private optometrists and 32 percent of the commercial optometrists detected the problems. These differences were found to be statistically significant.[353] Nathan thus concluded that private practitioners are more likely than commercial optometrists to detect more complex vision problems.

The survey also collected data on the percent of optometrists who took a medical history as a part of the eye exam and on the length of the eye exams. This data was based on the survey subjects' responses. Nathan reported that 73 percent of the eye exams taken in private practice included questions about the patient's medical history, while 47 percent of the exams taken in commercial settings included a medical history. These differences were found to be statistically significant. Nathan also reported that the average length of an eye exam in a private

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352 Nathan study, Vol. I, Ex. 3, pp. 15-16.

353 Nathan study, Vol. I, Ex. 3, p. 17. Nathan reported that they were significant at the 99% confidence level.

practice was 31 minutes, while the average length in a commercial practice was slightly less than 14 minutes. These differences were also found to be statistically significant.[354]

iii. Evaluation of the Survey

Extensive comments were filed about the methodology of the Nathan survey including evaluations by several survey experts. In this section we summarize the record evidence concerning the methodology of the survey.[355] In Appendix C of this report we present a more detailed analysis of the record evidence regarding the methodology.

The record demonstrates that Nathan failed to employ generally accepted and recommended research practice in order to guard against bias affecting the results. The procedures used created a substantial danger that the bias of the AOA representatives who had substantial involvement in the survey may have influenced the results.[356]

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354 Nathan study, Vol. I, Ex. 3, p. 18.

355 This discussion is based on information contained in the Nathan hearing exhibit, on information which was revealed during the cross-examination of members of the Nathan firm, on data gathered independently by FTC staff, and on evaluations by several survey experts.

356 This conclusion is supported by record evidence summarized below and described in more detail in Appendix C. It is supported by the opinion of expert witnesses, including the FTC consultant and several totally independent experts, as discussed below.

Two areas are particularly subject to this problem. First, AOA representatives had sole responsibility for construction of the sample frames, i.e. the lists of private and of commercial optometrists in the three New York boroughs. No independent persons participated in this task. Nathan did not utilize adequate procedures to avoid the possibility of bias affecting the construction of the sample frames.[357]

Further, evidence developed by FTC staff tends to suggest that bias may have affected the development of the sample frames. Based on a review of the New York City telephone directory "Yellow Pages" and other sources, FTC staff determined that AOA representatives left out of the private sample frame a large number of optometrists who appear to clearly fit Nathan's definition of private optometrists, indicating that the total sample frame should have been around 40% larger than the frame Nathan used.[358] Nathan classified these optometrists as "unknown," but the record does not disclose why they were

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[357] See infra Appendix C for a complete citation to the record evidence supporting this conclusion, including testimony of the Nathan panel and evidence of survey experts.

[358] Concentrating on the borough of Queens, FTC staff identified 14 optometrists located in Queens who appear to be clearly private optometrists. Since there were 35 private optometrists from Queens in Nathan's private sample frame, this suggests that the total sample frame should have been around 40% larger than the frame Nathan used. In selecting these 14 optometrists, staff left out all questionable or doubtful optometrists, leaving 14 optometrists who appeared beyond question to be privates. For a more complete description of this process, and supporting documentation, see, Rebuttal Statement of J. Mulholland and R. Kinscheck, FTC staff, K-21 at pp. 1-5 and Appendices A and B thereto.

classified as "unknown."[359] Although it cannot be said that the result of the survey would have been different had these omitted optometrists been included, this unexplained omission clearly raises a significant possibility that the sample frames may have been unrepresentative and possibly biased against commercial firms.

Second, an AOA staff optometrist participated in the debriefing of the patients and graded some of the debriefing forms with knowledge of whether the surveyed optometrists were

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[359] The omission of this group of optometrists was never explained by Nathan or AOA representatives despite requests for clarification. The Nathan witness panel could not answer additional questions on this point. See, S. Schneider, Economist, Nathan and Assoc., Tr. 2819. AOA counsel also made it abundantly clear that AOA would present no additional witnesses who might have answered questions about the classification scheme. See, e.g., Remarks of AOA counsel, Tr. 980-86. See also, AOA's Motion In Opposition to NAOO's motion to compel the Appearance of a Witness and the Production of Documents, Aug. 9, 1985, A-36. (NAOO filed several motions to compel the appearance of several witnesses related to the Nathan New York City Survey. See, Motion of NAOO to compel the Appearance of a Witness, A-32, Amended Motion of NAOO to Compel the Appearance of a Witness and Production of Documents, A-34, and Motion of NAOO to Compel the Appearance of a Witness and Production of Documents, A-35. AOA opposed all of these motions. AOA's Response in Opposition to NAOO's Motion to Compel the Appearance of a Witness and Production of Documents, A-36. The motions were denied by the Presiding Officer. Presiding Officer's Order No. 10, A-31).

By memo dated Sept. 6, 1985, from FTC staff to the Presiding Officer, staff requested that the AOA make certain witnesses available to answer questions about Nathan's classification scheme. The Presiding Officer declined to transmit this request to the AOA; however, FTC staff send an information copy to AOA counsel. By letter of Sept. 13, 1985, from AOA counsel to FTC staff, AOA counsel made clear that they would refuse to honor staff's request. See, Memo to Presiding Officer from FTC staff, Sept. 6, 1985, and, Letter from D. B. MacGuineas, AOA counsel, to FTC staff, Sept. 13, 1985, K-22, Appendix E (attachment to Rebuttal Statement of R. Kinscheck).

commercial or noncommercial. Further, the procedures used by Nathan afforded this AOA optometrist a great deal of opportunity to exercise any bias he may have had. He filled in crucial information on some of the debriefing forms and had to make judgment calls to determine whether the optometrist passed or failed.[360] These procedures created such a serious possibility that bias may have affected the results that they render the results unreliable.

A number of survey and marketing experts, including an FTC consultant and several independent experts, submitted their evaluation of the Nathan survey for the record.[361] These experts were unanimous in their opinion that the nature of the involvement of the AOA representatives in the study and the procedures used resulted in a significant danger of bias in the results. For example, according to Dr. Gary Ford, an FTC market research consultant, the Nathan survey is "essentially useless" because of Nathan's failure to guard against bias.[362] Professor

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360 See the more extensive discussion in Appendix C. The record does not establish that the AOA optometrist was, in fact, biased.

361 These included, Dr. Gary Ford, an FTC consultant who is a Professor of Marketing in the Kogod College of Business Administration at the American University; Dr. Thomas Maronick, Ph.D., Director of the FTC's Impact Evaluation Unit; Dr. James Begun, Associate Professor, Virginia Commonwealth University; Dr. Lee Benham, Professor, Washington University; and Dr. Alan Beckenstein, Professor, University of Virginia and Consultant to NAOO.

362 Rebuttal Statement of G. Ford, Professor, American Univ., K-20 at pp. 3, 9. Dr. Thomas Maronick, head of the FTC's Impact Evaluation Unit, stated that, for the same reasons, the Nathan study is of "questionable validity and reliability and great caution must be used in ascribing any weight to the findings." (footnote continued)

Begun, of the Medical College of Virginia, and an independent researcher in this area, stated that "the results of this study are suspect due to the involvement of self-interested parties in the design and data collection phases," and that reasonable efforts were not taken to avoid bias.[363] Professor Lee Benham, Ph.D., an independent researcher at Washington University, noted that the potential for systematic bias was introduced as a result of AOA involvement.[364]

iv. Relationship to the BE Study

Nathan stated that the findings of their survey "radically contradict" the conclusions of the BE Study, and therefore that the BE Study should not be relied upon. Nathan's assertion should be rejected not only for the reasons discussed above -- i.e., that the results are unreliable -- but also because the results, as reported, do not contradict the BE Study.[365]

Rebuttal Statement of T. Maronick, Ph.D., FTC Staff, K-19 at p. 1.

363 Memorandum from J. Begun, Ph.D., to R. Morrison, Commission of Health Regulatory Bds., Commonwealth of Virginia, July 18, 1985, K-1, Ex. 12 at p. 2 (attachment to NAOO Rebuttal Statement).

364 Rebuttal Statement of L. Benham, Professor, Washington University, K-17 at p. 2. According to Dr. Alan Beckenstein, a marketing and economics consultant for NAOO, "the Nathan study deviates so far from reasonable standards of objectivity that it should suffer the fate of being ignored." Rebuttal Statement of NAOO, K-1, Appendix A, p. A-2.

365 In fact, Nathan does not claim to have examined the effects of commercial practice restrictions. Nathan study, Vol. I, Ex. 3, pp. 1-5; S. Schneider, Economist, Nathan and Assoc., Tr. 2748, 2822. Nathan's stated purpose was to determine whether the (footnote continued)

In explaining how the Nathan survey results contradict those of the BE Study, Nathan stated that if the BE Study were correct, then the Nathan study should have shown no difference between the results of eye exams given by commercial firms and by private optometrists.[366]

Nathan's assertion reflects a misunderstanding of the findings of the BE Study. The key finding of the BE Study was that there was no difference between markets in the quality of eye care. The BE Study found that in nonrestrictive markets, chain firms provided less-thorough exams than noncommercial optometrists. It also found, however, that an equal percentage of optometrists in restrictive markets provided less-thorough exams and consequently that there was no difference between restrictive and nonrestrictive markets in the average thoroughness of exams.

The Nathan survey findings, as reported, do not contradict these BE findings. A finding in a nonrestrictive market like New York that commercial optometrists provide less-thorough exams or detect pathologies less frequently than private optometrists does not refute the BE Study findings on exam thoroughness.

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results of the BE Study would have differed if patients with less common vision problems had been used.

366 Nathan study, Vol. I, Ex. 3, p. 3. On cross-examination, the Nathan representative responsible for the survey was asked why the Nathan survey contradicted the BE Study. She stated "our outcome procedure agrees with the BE Study's process procedure. However, our outcome procedure disagrees with the BE Study's outcome procedure." A. Cahill, Economist, Nathan and Assoc., Tr. 2826. See Appendix A for a further discussion of the distinction between "input" and "output" measures.

Moreover, unlike the BE Study, the Nathan survey failed to go a step further and examine restrictive markets. The BE Study suggests that a survey such as Nathan's, if properly conducted in restrictive and nonrestrictive markets, would have found an equal percentage of optometrists in each type of markets who failed to detect the eye conditions. The Nathan survey was not designed, however, to address the key issue in the BE Study -- the quality differences between markets, and therefore cannot refute the central BE finding.

v. Conclusion

The record indicates that Nathan failed to follow generally accepted and recommended techniques to guard against bias, thus rendering the results of their study unreliable. For example, Nathan permitted AOA representatives to have sole responsibility for construction of the sample frames -- the lists of private and commercial optometrists. Further an AOA representative was allowed to debrief patients, fill in crucial information on debriefing sheets, and grade debriefing forms, all while the AOA representative was aware of whether the survey optometrists were commercial or private. As a result of these procedures, there is such a substantial possibility of bias that the results cannot be relied upon.

Further, the Nathan study results, as reported, do not contradict the BE Study. By failing to study restrictive as well as nonrestrictive markets, Nathan failed to address the crucial

issue in this proceeding -- the effects of commercial practice restrictions.

2. Price Effects of Commercial Practice Restrictions

a. Introduction

The record evidence demonstrates that commercial practice restrictions raise prices to consumers. Convincing, systematic survey evidence indicates that competition from chain firms lowers prices throughout the market for all types of providers and at all quality levels. In addition, extensive evidence on the record, including survey evidence, demonstrates that commercial providers, particularly chain firms and large-volume practices, charge significantly lower prices than non-commercial optometrists. Thus, state restrictions on the development of such firms reduce consumer access to low-cost providers, reduce consumers' freedom of choice, and reduce competition in the marketplace, resulting in higher prices. No valid survey evidence or other persuasive evidence was presented for the record that contradicts these findings.

b. The Issues

Chain firms and other commercial providers have traditionally positioned themselves as a low-cost alternative to noncommercial practitioners, and several studies have shown this

to be true.[367]

Despite the evidence, a few commenters stated that commercial firms do not charge lower prices.[368] Commenters stated that such firms have costs not faced by private practitioners, such as advertising fees, higher rents, dividends to stockholders and the cost of additional branch offices, which must be passed on to consumers.[369] Some commenters stated that, while chains may have lower fees now, they will eventually monopolize the markets and raise prices.[370] Some commenters stated that when all aspects of quality are considered, commercial optometric firms do not have lower prices.[371] Some commenters accused chain firms of "bait and switch" tactics, stating that the actual prices of commercial firms are higher than the advertised prices.[372]

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367 These studies are discussed elsewhere.

368 Rebuttal Statement of the California Optometric Ass'n, K-12 at pp. 5-8; A. Modesto, New York Optometrist, H-13; P. Slaton, Minnesota Optometrist, H-18; D. Robbins, Indiana Optometrist, H-59 at p. 3; M. Downey, Kentucky Optometrist, H-22.

369 N. Otte, Indiana Optometrist, H-36 at p. 1; Rebuttal Statement of the California Optometric Ass'n, K-12 at pp. 7-8.

370 J. Izydorek, Indiana Optometrist, H-130 at p. 2; M. Gainer, Georgia Optometrist, H-35 at pp. 1-2; N. Otte, Indiana Optometrist, H-36 at p. 1; A. Modesto, New York Optometrist, H-13.

371 See e.g., B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 21-23; D. Weigel, Indiana Optometrist, H-46; New Jersey Board of Optometry, J-01 at p. 3; J. Moye, Mississippi Optometrist, Tr. 3001.

372 R. Szabo, Indiana Optometrist, H-94 at p. 2; D. Robbins, Indiana Optometrist, H-59 at p. 7; L. Zuern, Member, North Dakota Board of Optometry, Tr. 1556-57.

c. Study Evidence

i. BE and Contact Lens Studies

Together, the two FTC-sponsored studies examined the major areas of eye care handled on a daily basis by most optometrists. The BE Study examined the cost of an eye exam and eyeglasses and the Contact Lens Study examined the cost of cosmetic contact lens fitting services.

These studies provide important evidence that state restrictions which prevent or hinder the development of optometric chain firms and other commercial optometrists raise prices to consumers. The BE Study found that prices were significantly lower in markets with chain firms; all types of providers, including traditional as well as commercial, charged lower prices in markets with chain firms and prices were lower at all levels of quality. The lowest priced providers were the chain firms themselves. The Contact Lens Study corroborates these findings.[373] It found that commercial firms charged less

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373 "Commercial Optometrists," as defined in the Contact Lens Study, were not identical to "chain firms" as used in the BE Study. The BE Study's "chain firms" were large interstate optical firms which offered eye exams. The Contact Lens Study's "commercial optometrists" included, in addition to such chains, smaller chains and optical companies, as well as optometrist-owned practices that had a number of attributes of commercial practice. See Appendix B, "Methodology of the Contact Lens Study," for a further discussion of the definition of "commercial practice."

than noncommercial firms, suggesting that restrictions on such firms, by limiting competition, are likely to raise prices throughout the market and deny consumers access to a low-cost alternative.

The Contact Lens Study also, in effect, updates the BE Study since it provides price data for a market environment in which advertising was more prevalent. The Contact Lens Study data, which covered 1977 through 1979, showed that the price difference between commercial and noncommercial optometrists was greater in 1979 than for the earlier years.[374] Since advertising was widely prohibited in earlier years and more widely utilized by 1979,[375] this widening price gap may well indicate that the price effects of commercial practice are greater in a market where advertising is more prevalent than in a market where it is restricted. It is likely that one reason for this is that commercial firms can take better advantage of advertising to generate economies of scale than traditional optometrists, and thus can lower their prices more.

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374 J. Mulholland, FTC economist, J-19(a) at pp. 9-15. These figures compare the 1979 Contact Lens Study data to the Contact Lens Study data from 1977 and 1978.

375 The Supreme Court ruled in 1977 that total bans on price advertising by lawyers violated the First Amendment. Bates v. State Bar of Arizona, 433 U.S. 350 (1977). The Commission's Eyeglasses I Rule, 16 C.F.R. Part 456, eliminating total bans on ophthalmic price advertising, was also in effect in 1979.

ii. Atlanta Survey

Additional evidence indicating that commercial optometric firms charge lower prices comes from a 1982-83 survey, submitted for the rulemaking record by the California Optometric Association (COA).[376] In this survey, which was conducted on behalf of the COA in metropolitan Atlanta, Georgia, five investigators obtained thirty eye examinations and eyeglasses, ten from each of three groups of optometrists: "corporate," "private commercial" and "private professional."[377] The survey compared the accuracy of prescriptions, the accuracy of eyeglasses, the cost of eye exams and the "mark-up," as defined, on frames and lenses among these three provider groups.[378]

In the survey "corporate" practice was defined to include optometrists affiliated with a corporate chain. Since corporate employment was not permitted in Georgia in the years in question, the "corporate" optometrists were not employed by the chains but apparently leased space from them. The "private commercial" optometrists had some attributes of a commercial practice, such

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376 Consumer Stucy of Optometric Practices in Metro-Atlanta Area, J-67(a) (Attachment to Statement of Califonria Optometric Ass'n) (hereinafter Atlanta Survey). The Study was conducted by John H. Thomas and Associates, Atlanta, Georgia.

377 Id. at p. 4.

378 The quality findings are discussed at infra section III.C.3.i.b., "Atlanta Study." The "mark-up" analysis is discussed at infra section III.C.2.c.iv., "Contrary Survey Evidence."

as a commercial location or advertising but were not affiliated with a chain. The "private professional" optometrists included optometrists who seldom, if ever advertised and who practiced in a "traditional manner."[379]

The study compared the cost of eye examinations among the three optometric groups.[380] The results showed that "corporate" practices charged significantly less than "private professional" and "private commercial" as a group -- $30.00 versus $40.75.[381] These results confirm the price findings of the BE and Contact Lens Studies that commercial firms charge less than noncommercial optometrists. Further, by providing data for 1982-83, a time period when advertising was more prevalent than at the time of

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379 Atlanta Survey, J-67(a), supra note 376, at p. 4. These optometrists generally practiced in one location, seldom if ever advertised and were not affiliated with any other entity.

380 Id. at p. 22. The raw data collected in the study appear to be valid, although there is insufficient evidence on the record to conclusively determine that they are in fact, valid. Very little comment or criticism exists on the record regarding the Atlanta survey. Since the study author was not made available for cross-examination, extensive questionings about the study execution was not possible. (Dr. Elliot of the COA was available to answer questions about the study but he was not one of the study authors).

At infra section III.C.2.c.iv., "Contrary Survey Evidence," we discuss methodological flaws in the Atlanta survey's "mark-up" analysis. The problems relate to the way in which the raw data was analyzed and the conclusions drawn from the data. Here and in infra section III.C.3.c.i., we discuss other findings of the Atlanta survey. The evidence available reveals no apparent flaws in the analysis of these data.

381 Id. at pp. 27, 29, 35. The "private commercial" practices charged $37.60. No statistical test was done to determine whether this result was significantly different from the average prices of the other two groups.

the BE Study, it confirms that the price differences exist despite increases in advertising.

iii. Other Studies

Further survey information tending to confirm the BE and Contact Lens Study price conclusions was supplied by NAOO. Since Nathan, in their New York City survey,[382] did not report any price data, NAOO collected price data in the summer of 1985 from each of the optometrists who had been included in Nathan's survey. The NAOO-collected data revealed that, on average, the private practitioners in Nathan's survey charged $33.22 for eye examinations and the commercial firms charged $13.51.[383] These NAOO findings corroborate and update the BE and Contact Lens Study findings -- that commercial firms charge lower prices; nevertheless, they may be biased since the AOA developed the lists of commercial and private optometrists from which the survey optometrists were selected. As a result, it cannot be ruled out that the sample may have been skewed to include higher quality private optometrists.[384] If the sample was skewed, then this could have biased the NAOO price findings as well as Nathan's quality results.[385]

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382 See discussion at supra section III.C.1.c., "Nathan New York City Survey.

383 Rebuttal Statement of NAOO, K-1 at p. 19.

384 See supra Section III.C.1.c., "Nathan New York City Survey." There is less clear evidence to suggest that the list of commercial optometrists may be skewed.
(footnote continued)

Earlier studies which examined the impact of commercial practice restrictions also tend to confirm the conclusion that commercial practice restrictions significantly increase costs to consumers. A study by Professors Lee and Alexandra Benham, based on 1970 data, found significantly higher prices in restrictive states.[386] In determining whether or not a market was restrictive, the Benhams looked at the number of eyeglasses purchased from commercial firms and at the reported difficulty which commercial firms experienced in entering a market.[387] This methodology does not eliminate the effects of restrictions on advertising since such restrictions would affect the number of firms in the market and the firm's difficulty in entering the market. The Benhams' found that in 1970 prices of eyeglasses were between 25% and 33% higher in restrictive states than in nonrestrictive states.[388]

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385 It also appears that a person associated with NAOO, and thus possibly biased, collected the price data. See, Rebuttal Statement of NAOO, K-1 at Appendix 11. However, since the data collected by this person was objective price information and no interpretation of the data was performed by this person, it appears that the possibility of bias from this source in the data collection is unlikely.

386 Benham and Benham, Regulating Through The Professions: A Perspective on Information Control. 18 J.L. & Econ. 421 (1975), B-2-29.

387 Professors Benham and Benham developed two measures of restrictiveness. One was developed by surveying several large commercial firms to obtain their assessment of the difficultly which commercial firms had in entering and operating in a state for reasons other than competition with existing commercial firms. The Benhams' second measure of restrictiveness was based on the proportion of individuals who purchased their eyeglasses from commercial sources rather than from private optometrists or ophthalmologists. Id. at pp. 439-440.

(footnote continued)

iv. Contrary Survey Evidence

Some limited survey evidence was presented for the record, which, according to proponents of the restrictions, showed that commercial firms do not charge less or even charge more than noncommercial optometrists. What follows is a discussion of those surveys and why they do not support the stated conclusions.

(a) Atlanta Survey

According to COA the Atlanta Study's[389] findings on "mark-ups" cast doubt on the price conclusions of the BE and Contact Lens Study.[390] The study compared the percentage "mark-up" for

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388 Id. Professor James Begun, and F. Feldman have also conducted a number of studies to assess the impact on price and quality of "professionalism" and state laws regulating "professionalism." J. Begun, "Professionalism and the Public Interest: Price and Quality in Optometry." (Ph. D. dissertation, University of North Carolina, June 1977), B-2-30; J. Begun, "The Consequences of Professionalization for Health Services Delivery: Evidence from Optometry," 20 J. of Health and Social Behavior 376-386 (Dec. 1979), B-4-1; J. Begun and R. Feldman, "A Social and Economic Analysis of Professional Regulation in Optometry," Aug. 31, 1979, B-4-2. While this is important, groundbreaking work, and generally supports the notion that laws requiring "professional" practice increase prices, it is not directly relevant to the issues in this proceeding. One reason is that these studies looked at the aggregate effect of laws governing continuing education, commercial practice, and advertising, and did not isolate the effect of each. Additional reasons are detailed in a memo by Joe Mulholland, Bureau of Economics, FTC, February 29, 1985, G-18.

389 See discussion at infra Section III.C.2.ii., "Atlanta Study" for a description of the Atlanta Survey.

390 Atlanta Survey, J-67(a), supra note 376 at p. 4.

materials among the three optometric groups. This "mark-up" percentage was not obtained by examining the actual mark-up of the firms. Rather, it was defined as the difference between the single-item wholesale price of frames and lenses (excluding volume discounts) as shown in frame catalogues and the retail price charged by the firms.[391] The results showed no statistically significant difference in the "mark-up", as defined, between "corporate" practice, on the one hand, and "private professional" and "private commercial" on the other.[392]

According to the COA, this shows that "alleged corporate efficiencies (e.g. savings through volume purchasing) were not being passed on to consumers" because all the provider groups had equivalent "mark-ups", as defined, on materials.[393] Apparently, the comparison of "mark-up" percentages, as defined, was intended to allow inferences to be made about the relative prices charged by the optometric provider groups, and to demonstrate that chain firms do not pass along to consumers cost savings which may accrue from volume-discount purchasing.[394] Apparently, COA was implying that, because "corporate" practices did not have a lower "mark-up" as defined, they did not have lower consumer prices.

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391 Atlanta Survey, J-67(a), supra note 376, at p. 18.

392 Id. at pp. 29, 34.

393 Letter from A. Freid, President, California Optometric Ass'n, dated April 13, 1983, J-67(a), (attachment to Statement of California Optometric Ass'n).

394 E. Elliot, President, California Optometric Ass'n, Tr. 2895.

However, the "mark-up" data in the Atlanta survey provides no useful insight into the relative prices charged by the provider groups. Considering the small sample size[395] -- only 10 observations from each provider group -- inferences about price based on "mark-ups" would only be valid if there was little variation in the wholesale cost of the frames and lenses or if actual mark-ups[396] did not vary appreciably among different types of eyeglasses. Neither of these conditions were met.

First, similar frames and lenses were not purchased from the surveyed optometrists in the Study. Instead, survey subjects were allowed to select whatever frame they wanted,[397] with the apparent result that the sample frames varied widely in wholesale cost.[398]

Second, there is a wide variation in actual mark-ups of frames and lenses. According to the evidence, there can be significant variation between mark-ups on different frames sold by a firm, depending on the type of product, competitive

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[395] The small sample size is not necessarily a problem in itself. The problem here is created by the variability in wholesale cost and the variability in actual mark-up among the frames and lenses, in conjunction with the small sample size.

[396] The actual mark-up is the difference between the retail price to consumers and the actual wholesale price paid by the firm including any volume or other discounts.

[397] Atlanta Survey, J-67(a), supra note 376 at pp. 11-12.

[398] Id. at p. 19. If, in the study, subjects had purchased relatively similar frames and lenses from all the optometrists, then, mathematically, it would have been true that an equivalent "mark-up", as defined, would equate with equivalent prices to consumers.

situation, and other factors.[399]

Since the subjects bought frames that varied widely in their wholesale cost, and there is an apparent large variation in mark-ups, the resulting averages for each group depend very heavily on the particular lens/frame combinations purchased. A different set of purchases may well have provided an appreciably different set of results. This being the case, the "mark-up" information provided in the Atlanta survey provides little useful insight into the prices charged by different provider groups.[400]

COA also pointed to the Atlanta survey results showing that the cost-per-examination minute was higher for "corporate" practices than for "private professional" practices.[401] No tests were performed to determine whether this difference was statistically significant.

Calculations of cost-per-minute does not address the key

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399 Letter from J. Ritchie, Counsel, NAOO, to R. Kinscheck, FTC, Sept. 12, 1985, K-21, Appendix E (Attachment to Rebuttal Statement of Joe Mulholland and R. Kinscheck); Rebuttal Statement of NAOO, K-1 at p. C-4. Similarly, the Atlanta survey itself indicated a wide variation in mark-ups. Atlanta survey, J-67(a), supra note 376 at p. 19.

400 The variability in mark-up percentages was a prime reason why in the BE study subjects were instructed to purchase a similar type of product from each optometrist. In this way the study could analyze the main focus of interest to consumers and policymakers - prices.

401 Letter from A. Freid, President, COA, April 13, 1983, J-67(a), (attachment to Statement of COA); Statement of California Optometric Ass'n Panel, J-67(a) at p. 4. Cost was lowest for "private commercial" practices. Atlanta Survey, J-67(a), supra note 376 at p. 26.

questions of whether different provider groups charge more for a given level of quality. Even if commercial practices charged more per minute this does not mean that they charged more for a given quality exam. In order to address this issue, the Atlanta survey would have had to devise a better measure of quality than length of exam, which, by itself means very little. For example, in the BE Study an "index" of exam thoroughness was developed which took into account various tests and procedures and weighted each depending on its relative importance. Using this index, the BE Study found that chain firms charged the lowest prices for an exam of a given thoroughness.

(b) 20/20 and Optometric Management Surveys

Nathan and Associates, the consulting firm hired by the AOA, pointed to two trade press surveys which they stated revealed that vision care firms actually charge higher prices than nonchain optometrists.[402] The first trade press survey was conducted by 20/20 Magazine in 1984. The results showed that average billings for eye exams, eyeglasses and contact lenses were higher for high volume optometric practices -- those with sales greater than $200,000 a year -- than low volume practices -- those with less than $200,000 in annual sales. The record does not reveal whether this difference was statistically

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[402] Nathan study, Vol. I, Ex. 1, p. 125. "Vision care firms" means chain firms.

significant.

No conclusion about the relative prices of chain and nonchain practices can be drawn from this data. Nathan's conclusion that 20/20's definition of high volume and low volume is roughly equivalent to chain optometric firms and nonchain optometrists, respectively, is unsupported. It appears that Nathan's only support for this inference is the fact that most of the large chains have annual sales greater than $200,000 per annum. However, while it may be true that most of the large chains have annual sales over $200,000, many private optometrists and traditional group practices do also.[403] A letter from the editor of 20/20 Magazine stated that the data cannot be used to distinguish chain firms from traditional optometrists.[404]

Moreoever, the data permits no conclusions about relative prices to consumers. The 20/20 data compares "average billings" which does not necessarily equate to prices for equivalent goods and services. For example, larger average billings could have resulted from the sale of more or better merchandise such as designer frames, multiple pairs of glasses or tinted lenses.[405] In contrast to the BE and Contact Lens Survey, the 20/20 survey

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403 See, e.g., J. Kennedy, Minnesota Optometrist, Tr. 1156 (practice grosses $600,000 per year), Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 15 n. 6.

404 Letter from J. Stone, Editor of 20/20 Magazine, to J. Mulholland, FTC, K-18, Appendix C (Appendix to Rebuttal Statement of Ronald Bond, Economist, FTC).

405 Id.

did not compare a uniform package of goods and services. Thus, the 20/20 data cannot be used to compare average prices for high and low volume firms.

Nathan cited a second survey reported in Optometric Management in 1981, which found that "group incorporated" practices charged higher fees than "solo" practitioners for eye exams, eyeglasses and contact lenses.[406] Despite Nathan's assertion to the contrary, however, no conclusions about the relative prices of chain firms can be drawn from this data.[407] The "group incorporated" practices included many traditional optometrists. Chain firms made up, at most, only a small percentage of the sample; fully 92 percent of the total sample were in independent practice.[408]

v. Criticism of the Studies' Price Findings

Many commenters disputed the studies' finding of price benefits to consumers by stating that different levels of quality

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406 Nathan study, Vol. I, Ex. 1 p. 60.

407 Neither can any conclusions about commercial optometrists generally be drawn from this data, since many traditional optometrists were included in "group incorporated."

408 The survey was mailed to practicing optometrists. Thus, the only way chains were represented in the sample was via the optometrists they employed. But such respondents made up less than eight percent of the sample. See, Rebuttal Statement of R. Bond, K-18 at p. 15, citing Optometric Management, Jan. 1981 p. 19. Moreover, it is not clear how commercial optometrists, such as those leasing from or employed by chain firms, were categorized, or if they were included at all.

or of services were being compared.[409] Thus, they implied that commercial firms do not charge less than non-commercial optometrists for a given level of quality or service. While the quality findings of the Studies, as well as other evidence on quality is discussed elsewhere, it is important to note here that both the BE and the Contact Lens Study found that the cited cost-savings resulted with no diminution in quality. The BE Study found that at any level of quality prices were lower in nonrestrictive markets and chain firms had the lowest prices.[410] The Contact Lens Study found that there was no difference in quality between commercial and noncommercial optometrists.[411] Thus, the assertions that different quality was being compared is contradicted by the results of the studies.[412]

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409 See e.g., Nathan study, Vol. I, Ex. 1, pp. 84-93, Vol. I, Ex. 2 pp. 29-30; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 7-8, 20-24; R. Peach, Indiana Optometrist, H-73 at p. 2; J. Saul, Florida Optometrist, H-93 at p. 4; J. Kintner, Indiana Optometrist, H-117 at pp. 7-8; C. Beier, President, Kansas Board of Optometry, J-52 at p. 5.

410 BE Study pp. 23-25.

411 Nathan also stated that the eyeglasses in the BE Study were not of a heterogeneous quality. Nathan study, Vol. I, Ex. 1 at pp. 84, 93. However, the BE Study methodology was designed to minimize variations in quality; subjects were instructed to purchase a particular unisex metal frame and the FTC consultants determined that, on average, there was no difference in quality of workmanship between the frames purchased at commercial firms and at noncommercial firms. See, Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 11-12. Dr. Bond's Rebuttal provides a further explanation for why Nathan's allegations should be rejected.

412 One assertion is not completely refuted by the Studies. Some commenters stated that noncommercial firms may take on harder cases, or more difficult patients, and that this may account for at least some of the price difference. Southern California College of Optometry Panel, J-41(a) at p. 23; B. (footnote continued)

Specifically, some commenters stated that consumers of commercial firms will pay more in the long run because of inferior eye care at these firms.[413] Thus, they stated that consumers of commercial firms will often be forced to pay for second visits to the commercial firm or to a private practitioner because the treatment they initially received was inadequate.[414] For example, commenters stated that contact lens patients who are not fitted adequately by commercial firms may have to seek care elsewhere, at additional cost.[415] Commenters

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Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 6-7, D. Robbins, Indiana Optometrist, H-59 at p. 1. No credible evidence on the record supports this assertion. Dr. Barresi submitted an article containing a description of a survey which he claimed showed that optical outlets are geared to simple cosmetic fits. J-13(a) at p. 7; "Following Contact Lens Trends," Feb. 1984 Contact Lens Forum, J-77. However, this survey provided insufficient information to allow comparisons to be made between commercial practices and noncommercial practices. Since Dr. Barresi submitted this article for the record after the close of the hearings, it was impossible to question him or obtain further information about how he believed this article supported his conclusion. Further, chain firm representatives denied they turn away difficult patients. See, e.g., J. Ellis, President, Eyexam 2000, J-48(c) at p. 4; M. Allmaras, Indiana Optometrist, J-51(b) at p. 2; B. Davis, Texas Optometrist, J-48(e) at p. 2; M. Albanese, Illinois Optometrist, Tr. 1920; R. Zaback, New Jersey Optometrist, NAOO, J-48(b) at p. 2; E.D. Butler, President, Precision Lens Crafters, Tr. 345. However, the Studies could not completely control for this possibility. There is also no evidence to indicate how large a percentage of the population such difficult patients represent; it is likely a small percentage, since it seems doubtful that chain firms would turn away large percentages of the population. Thus the Studies' price results clearly appear to be valid for large segments of the population.

413 See e.g., Nathan study, Vol. I, Ex. 1 at pp. 10, 86; J. Culver, Kansas Consumer, D-03; R. Wolter, Indiana Optometrist, H-52; A. Modesto, New York Optometrist, H-13.

414 See, e.g., Nathan study, Vol. I, Ex. 1 at pp. 10, 86; J. Culver, Kansas Consumer, D-03; R. Wolter, Indiana Optometrist, H-52; A. Modesto, New York Optometrist, H-13.

(footnote continued)

also stated that consumers of commercial firms will develop costly eye problems because of inadequate care at such firms.[416]

There is no record support for these claims, and, in fact, the available evidence refutes this contention. For example, since commercial firms were found to fit contact lenses at least as well as noncommercial practitioners, there is no reason to believe that contact lens consumers of commercial firms would need to seek more remedial care at additional cost. Also, since the BE Study found no difference in the quality of care between restrictive and non-restrictive markets, there is no reason to believe that consumers in markets with chain firms would need to seek more remedial care than consumers in markets without such firms.

Some commenters stated that commercial firms charge additional fees for remedial or follow-up care, for difficult patients or for other "extras", while private practitioners include such charges in their basic fees.[417] Thus, they argued, when all these "extras" are included, commercial firms do not charge less than private practitioners. There is no reliable

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[415] B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at p. 23; J. Kennedy, Minnesota Optometrist, J-26 at p. 3; R. Wolter, Indiana Optometrist, H-52.

[416] J. Crum, Kansas Optometrist, H-20 at p. 2; W. Van Patten, Secretary, Nevada Board of Optometry, J-56 at p. 2; J. Izydorek, Indiana Optometrist, H-130 at p. 2.

[417] B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 21-23; D. Weigel, Indiana Optometrist, H-46; L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 3; J. Moye, Mississippi Optometrist, Tr. 3001.

evidence, however, to support this charge. Further, the BE and Contact Lens Studies tend to refute this charge since a uniform package price was established.[418] While the studies did not necessarily take account of every conceivable "extra" charge, they did attempt to control for the major elements of eye exams and contact lens fitting. Further, commercial firms stated that they include the same amount of follow-up care in their basic prices as private practitioners.[419]

Nathan also disputes that the studies' price findings are currently valid by stating that, over time chain firms have abandoned their low-price policy, and are now attempting to generate goodwill by stressing quality in advertising.[420] Nathan stated that some of the chains currently do not advertise price but instead emphasize quality.[421] Nathan's argument is not valid for a number of reasons. First, contrary to Nathan's implication, the evidence does not indicate that a significant number of chain firms have abandoned price advertising.[422] In

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418 In the Contact Lens Study follow-up care was included and insurance fees were excluded from the package. Contact Lens Study, pages C-1 through C-3. In the BE Study, the price included any dispensing fees and charges for glaucoma tests or other procedures that were priced separately.

419 NAOO Panel, Tr. 1946-48, 2077-78.

420 Nathan study, Vol. I, Ex. 1, pp. 57-58.

421 Id.; Rebuttal Statement of Robert R. Nathan Assoc., K-4 at pp. 20-21.

422 Only one of the large chain firms indicated that it did not price advertise. Several firms stated that they did price advertise and did not characterize such advertisements as infrequent. NAOO Panel, Tr. 363-366. Further, it is virtually (footnote continued)

fact, Nathan elsewhere argues that there is now more price advertising than at the time of the BE Study.[423] Second, it is entirely possible that some chains may have been stressing quality at the time of the BE Study. Thus, Nathan presents no evidence of any change in advertising practices. Third, even if some of the chains are stressing quality this does not necessarily mean that they have higher prices relative to nonchain optometrists. Fourth, Nathan's argument appears to be predicated on the assumption that chains had just entered the market when the BE Study was performed in 1977, since they argued that as chain firms become more established market participants they abandon their low-price policy. In fact, however, in those markets in the BE Study with chain firms, these firms had been in those markets for many years. In conclusion, Nathan's argument merely amounts to unfounded speculation.

d. Other Evidence Regarding Price

i. Effects of Restrictions Generally

Other evidence on the record supports the conclusion that chain firms, and other large-scale commercial practices, charge

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impossible for chains to engage in price advertising of eye exams and optometric services in states which do not permit corporate employment since the chains generally cannot control or advertise the prices of services performed by optometrists leasing from them. This may well explain the lack of price advertising of eye exams in many instances.

423 Nathan study, Vol. I, Ex. 1, pp. 34-41.

lower prices, thus indicating that the presence of such firms in a market not only offers consumers a lower-cost alternative but also is likely to drive down prices through-out the market.

Conclusive evidence documents the existence of economies of scale available to chain firms and other large-scale optometric operations.[424] Economies of scale can be obtained in areas such as advertising, personnel and space utilization, cost of material and equipment.[425]

The existence of economies-of-scale indicates that large volume commercial firms have the capability of lowering prices to consumers without decreasing quality. This tends to corroborate the results of the BE and Contact Lens Studies. Some commenters stated that the cost-savings resulting from these economies-of-scale are not passed on to consumers.[426] While there is no evidence bearing directly on this point one way or another, economic theory suggests that such cost-saving would be passed on to consumers, at least in part. It is not relevant to consumers

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[424] The specific evidence regarding economies of scale is discussed more fully in supra Sections III.B.1.c.ii., "Availability of Economies of Scale," III.B.2.c.ii., "Effect on Firms' Costs," and III.B.4.c.ii., "Effect on Firms' Costs."

[425] In 1982, the California Department of Consumer Affairs estimated that the cost differences, attributable to economies of scale during the first 10 years of practice between an independent solo practitioner and a corporation could range from $12 to $13 per customer. Commercial Practices Restrictions in Optometry, State of California, Department of Consumer Affairs, 1982, J-24(b) at pp. 8-11, 13.

[426] See, e.g., Rebuttal Statement of California Optometric Ass'n, K-12 at pp. 7-8.

how much of the cost savings are passed on as long as the prices charged by commercial optometrists are lower. The Studies show that commercial firms do indeed charge less than traditional optometrists.

ii. Effects of Specific Restrictions

Evidence discussed in section III.B. indicates that each of the restrictions increases firms' cost of doing business. The costs, for example, of the "two-door" requirements -- which prohibit optometrists from locating inside mercantile establishments -- are well documented.[427] As another example, lay association and branch office restrictions increase firms' costs by preventing optometrists from taking advantage of economies of scale in equipment, material, advertising and managerial techniques.[428] Trade name bans significantly increase advertising costs to the point where some types of advertising may be prohibitively expensive.[429] All of these costs are likely to be passed on to consumers, at least in part.

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427 See, supra Section III.B.3.c.ii, "Effect on Construction and Rental Costs."

428 See, supra Sections III.B.1.c.ii, "Availability of Economies of Scale," and III.B.2.c.ii, "Effect on Firms' Costs."

429 See, supra Section III.B.4.c.ii, "Effect on Firms' Costs."

e. Other Costs to Consumers of Restrictions

i. Effect of Restrictions Generally

In addition to lower prices, consumers may obtain other benefits in markets with commercial firms. Clearly, consumer choice is enhanced in such markets; this is itself a benefit. Further, commercial firms may well offer a number of benefits which tend to reduce consumer costs. Such firms are likely to locate in areas such as shopping centers,[430] and to be available on weekends and evenings.[431] Some chain firms offer in-store laboratories to fabricate lenses, thus reducing the waiting period for lenses from several days or weeks to overnight.[432] Larger chain firms may also offer a much larger selection of eyeglass frames than is feasible for an individual optometrist.[433] By offering such potential consumer benefits, commercial firms may well force other optometrists to follow suit. Restrictions on commercial firms, by reducing these benefits, thus impose additional costs on consumers.

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430 See, NAOO Comment at p. 4; S. Tuckerman, President, Tuckerman Optical, J-51(a) at p. 3.

431 See, NAOO Comment at p. 3; NAOO Panel, Tr. 383-94; J. Ingells, President, Western States Optical, Tr. 2175. But see, Nathan Rebuttal Statement, K-4 at pp. 10-12.

432 NAOO Comment at p. 4; E.D. Butler, President, Precision Lens Crafters, Tr. 345-6.

433 NAOO Comment at pp. 3-4.

ii. Effects of Specific Restrictions

Some evidence focused specifically on the effects of trade name restrictions and mercantile location restrictions in increasing consumer search costs. As discussed more fully in section III.B.4.c.i., Restrictions on Trade Name Usage, the evidence indicates that trade names can provide valuable information to consumers and can assist consumers in making choices between providers of goods and services.[434] As a result, trade names may substantially reduce search costs to consumers. Further, bans on trade names, by restricting the ability of firms to advertise, also limit the information available to consumers.

Evidence indicated that increased search costs are also imposed on consumers by restrictions on mercantile locations. While difficult to quantify, consumers incur costs gathering information on price and quality through advertising, asking friends and relatives, and phoning and visiting outlets in person.[435] If optometric practices can be found in high-traffic areas that are otherwise frequented by consumers, consumer search cost is reduced.[436]

Similarly, mercantile locations reduce transportation

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434 J. Kwoka, Professor, George Washington Univ., J-12(a) at pp. 4-5.

435 J. Kwoka, Professor, George Washington, Univ., Tr. 515.

436 Id. at p. 497; NAOO Panel, J-12(a) at 4.

costs. Consumers can save time by combining trips to obtain optometric services with trips for other purposes. This can only happen, however, if practices are located near other consumer destinations such as in a shopping mall or department store. Accessibility of care is particularly important to elderly persons.[437]

f. Conclusion

Extensive evidence on the record demonstrates that commercial practice restrictions raise prices to consumers. The BE Study indicates that in markets with chain firms prices are lower for all providers and at all quality levels. The BE Study, the Contact Lens Study and the Atlanta survey indicate that commercial optometrists charge less than noncommercial optometrists. Evidence also indicates that large-volume practices such as chain firms can take advantage of economies-of-scale, thus enabling such firms to lower their prices without lowering quality. Evidence also indicates that each of the restrictions increases costs to consumers either directly or by increasing firms' cost of doing business. Proponents of the restrictions presented no credible evidence to the contrary. Thus, restrictions on commercial practice deny consumers access to low-cost providers, restrict consumers' freedom of choice and, by reducing competition, tend to raise prices throughout the

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437 J. Denning, President-elect, American Ass'n of Retired Persons, Tr. 53, 59.

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3. Quality Effects of Commercial Practice Restrictions

a. Introduction

The record evidence indicates that commercial practice restrictions reduce the overall quality of care in the market. In making this assessment, staff examined the impact of commercial practice restrictions on two aspects of the quality of eye care: (1) the effect of such restrictions on the quality of eye care for those who receive eye care, and (2) the extent to which such restrictions cause persons to forego or delay eye care because of the higher prices associated with the restrictions.

Regarding the first aspect of quality, the two FTC studies provide systematic and convincing evidence that consumers who receive eye care do not receive higher quality as a result of state restrictions on commercial practice. No reliable survey evidence was presented for the record which rebuts this conclusion. Other evidence on the record was anecdotal in nature, and thus, provides no basis for making systematic comparisons between markets.

Regarding the second aspect of quality, the evidence indicates that, as a result of higher prices associated with the restrictions on commercial practice, consumers tend to receive less frequent eye care in restrictive markets. This may result

in inadequate vision and uncorrected eye problems for such persons. The evidence regarding both of these factors is discussed more fully below.

b. The Issues

i. Arguments for Commercial Practice Restrictions

Commercial practice restrictions in general[438] have long been justified on the assumption that they are necessary to maintain high quality vision care.[439] Proponents of these restrictions argue that commercial firms provide lower-quality care because, in contrast to traditional optometrists,[440] their primary concern is profits.[441] For example, they state that

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438 Arguments dealing with specific restrictions are discussed in at infra Section III.C.3.c.iii., "Effects of Specific Restrictions."

439 L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 3; D. McBride, President Montana Optometric Ass'n, J-57 at p. 3; E. Kovanik, Kansas Ophthalmologist, H-129 at p. 1; M. Hattor, Kansas Optometrist, H-66; J. Brownlee, President Mississippi Optometric Ass'n, H-119; P. Moughan, Attorney, New Mexico Optometric Ass'n, H-121 at p. 1; H. Bumgardner, Kansas Optometrist, H-135 at p. 2; H. Glazier, President, Maryland Board of Optometry, J-21 at p. 1; J. Scholles, Ohio Optometrist, AOA trustee, J-31 at p. 5; J. Robinson, Secretary, North Carolina Board of Optometry, Tr. 2999; L. Powers, Kansas Optometrist, H-149 at p. 2; H. Smiley, President, Rhode Island Optometric Ass'n, H-47; J. McGracken, President, Kentucky Optometric Ass'n, H-57.

440 S. Schwartz, Kansas Optometrist, H-136 at p. 1; C. Beier, President, Kansas Board of Optometry, J-52 at pp. 2-3; M. Raymon, California Optometrist, H-39 at p. 2.

(footnote continued)

commerical firms, in an attempt to generate a high volume of patients, provide exams which are too short, and consequently that they provide inadequate exams,[442] fail to detect eye pathologies and make appropriate referrals to other medical specialists,[443] provide inadequate contact lens fitting,[444] and turn away patients with difficult problems who need extra time.[445] Proponents of the restrictions also stated that

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441 L. Zuern, Member, North Dakota Board of Optometry, J-40 at pp. 5-6; H. Bumgardner, Kansas Optometrist, H-135 at p. 2; J. Robinson, Secretary, North Carolina Board of Optometry, Tr. 2999; D. Reynolds, Kansas Optometrist, H-77 at p. 1; R. Lopez, Connecticut Optometrist, H-23.

442 K. Eldred, Secretary, Wyoming Board of Optometry, J-50(a) at p. 1; R. Saul, Florida Optometrist, H-93; R. Peach, Indiana Optometrist, H-73 at p. 1; L. Asper, Florida Optometrist, H-148 at p. 1; L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 3; H. Bumgardner, Kansas Optometrist, H-135 at p. 2; L. Powers, Kansas Optometrist, H-149 at p. 1; P. Barr, California Optometrist, H-156; J. Scholles, Ohio Optometrist, AOA trustee, J-31 at p. 4; D. Kuwabara, Chairman, Hawaii Board of Optometry Panel, J-34 at p. 3; Southern College of Optometry, Tr. 1612-14; E. Friedman, Texas Optometrist, Tr. 2398.

443 R. Huber, Tr. 1814-16; J. Crum, Kansas Optometrist, H-20 at p. 4; D. Reynolds, Kansas Optometrist, H-77 at p. 1; H. Glazier, President, Maryland Board of Optometry, J-21 at p. 2; L. Fry, Kansas Ophthalmologist, H-145; W. VanPatten, Secretary, Nevada Board of Optometry, J-56 at p. 2.

444 D. Robbins, Indiana Optometrist, H-59 at p. 4; Southern California College of Optometry Panel, J-41(a) at p. 23; B. Barresi, Professor, State Univ. of New York College of Optometry, J-13(a) at pp. 6-7; J. Crum, Kansas Optometrist, H-20 at p. 2; R. Wolter, Indiana Optometrist, H-52; R. Peach, Indiana Optometrist, H-73 at p. 2; K. Van Arsdall, Indiana Optometrist, H-97 at p. 2; J. Kintner, Indiana Optometrist, H-117 at p. 3; K. Eldred, Secrtary Wyoming Board of Optometry, J-50(a) at pp. 1-2; R. Grene, Kansas Ophthalmologist, J-64 at p. 3.

445 L. Semes, Professor, Univ. of Alabama-Birmingham School of Optometry, F-3; D. Conner, Legal Affairs, Director, Indiana Optometric Ass'n, Tr. 696-700; D. Weigel, Indiana Optometrist, H-46 at p. 1; Southern California College of Optometry Panel, J-41(a) at p. 23; D. Robbins, Indiana Optometrist, H-59; R. Saul, Florida Optometrist, H-93 at p. 1.

commercial firms provide poor quality or inaccurate[446] eyewear or unnecessary eyewear[447] in an attempt to generate additional profit. They state that traditional optometrists provide longer exams[448] and provide higher quality exams.[449]

Proponents of the restrictions also state that the presence of commercial firms will drive down quality throughout the market. According to this argument, traditional optometrists are forced to lower their quality in an attempt to compete with the commercial firms who provide lower prices and advertise heavily.[450]

Proponents of the restrictions rarely addressed the issue of consumer access to vision care. They did not discuss whether

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446 K. Eldred, Secretary, Wyoming Board of Optometry, J-50(a) at p. 1; D. Robbins, Indiana Optometrist, H-59 at p. 1; G. Funk, Optometrist, H-122 at p. 5; D. Kuwabara, Chairman, Hawaii Board of Optometry, J-34 at p. 3; C. Beier, President, Kansas Board of Optometry, J-52 at p. 8.

447 K. Eldred, Secretary, Wyoming Board of Optometry, J-50(a) at p. 1; L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 3; D. Kuwabara, Chairman, Hawaii Board of Optometry, J-34 at p. 3; J. Fallis, Past President, California Society of Ophthalmic Dispensers, Tr. 1487.

448 J. Izydorek, Indiana Optometrist, H-130 at p. 1; H. Bumgardner, Kansas Optometrist, H-135 at p. 2; H. Hanlen, Pennsylvania Optometrist, Tr. 2315-16; M. Raymon, California Optometrist, H-39 at p. 2.

449 J. Izydorek, Indiana Optometrist, H-130 at p. 1; E. Kovarik, Kansas Optometrist, H-129; J. Scholles, Ohio Optometrist, AOA trustee, J-31 at pp. 2-3; H. Hanlen, Pennsylvania Optometrist, Tr. 2315-16; J. Crum, Kansas Optometrist, H-20 at p. 1.

450 L. Lapierre, Kansas Optometrist, H-128 at p. 1; N. Otte, Indiana Optometrists, H-36 at p. 1; S. Gifford, Oklahoma Optometrist, H-100; G. Schmidt, Florida Optometrist, H-31 at p. 2.

consumers are delaying or foregoing the purchase of vision care because of the higher prices associated with the restrictions.[451]

ii. Arguments Against Commercial Practice Restrictions

Opponents of the restrictions stated that rather than maintaining quality, the restrictions harm consumers by increasing prices and decreasing the availability of vision care.[452] They stated that the restrictions at issue here do not deal with quality of care, but instead are aimed at restraining competition and protecting the economic interests of the traditional practitioners.[453] Thus, they view the laws as a form of economic protectionism which harms consumers.[454]

They state that all optometrists, private and commercial, face the same incentives: virtually all profit from the sale of services and of eyeglasses and lenses[455] and all must provide high quality care to the patient in order to be successful in the

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451 See infra footnote 599 and accompanying text.

452 Rebuttal Statement of NAOO, K-1 at p. 11; NAOO Comment, at pp. 1, 2; J. Kwoka, Professor, George Washington Univ., J-12 at p. 7; H. Snyder, West Coast, Director, Consumers Union, J-24 at p. 2; R. Moroff, New York Optometrist, J-51(d) at p. 1.

453 Rebuttal Statement of NAOO, K-1 at pp. 4, 11; W. Levy, President, New Mexico Ophthalmological Soc'y, E-31 (attachment to Comment of C. Chavez, Superintendant, New Mexico Regulation and Licensing Department).

454 Rebuttal Statement of NAOO, K-1 at pp. 4, 11 and 13.

455 NAOO Comment at pp. ii-iii, 33.

long-run.[456] They also state that all optometrists have the same academic background and face the same licensing requirements,[457] and that commercial firms provide high quality.[458]

Several commenters stressed that an important aspect of quality concerns the frequency with which consumers receive vision care.[459] They stated that in restrictive markets, some

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[456] Rebuttal Statement of NAOO, K-1 at p. 13; NAOO Comment at pp. ii-iii, 33; S. Tuckerman, President, Tuckerman Optical, J-51(a) at p. 2; J. Ingalls, President, Western States Optical, Tr. 1279-80.

[457] Statement of NAOO Panel, J-8 at p. 2.

[458] J. Ellis, President, Eyexam 2000, J-48(c) at p. 4; M. Allmaras, Indiana Optometrist, J-51(b) at p. 2; K. Fritz, West Virginia Ophthalmologist, J-51(c) at p. 1; B. Davis, Texas Optometrist, J-48(e) at p. 2;

The NAOO also stated that some of the so-called quality issues are, in reality, matters of personal choice for the consumer. NAOO stated that the primary functions of the optometrist are to correct visual anomalies through a refractive examination, to provide appropriate prescription lenses and to make a medical referral where pathology is suspected. Beyond that, according to NAOO, the patient should be free to select the level of services that he or she desires. For example, NAOO noted that some patients may prefer to develop a long-term relationship with one optometrist and make appointments well in advance. Other consumers may prefer the option of a walk-in appointment and will accept treatment from whichever optometrist is available at the time. According to NAOO, these are questions of patient choice and not of quality of care. NAOO Comment at pp. 5-7; Rebuttal Statement of NAOO, K-1 at pp. 7-8.

[459] J. Begun, Professor at the Medical College of Virginia, Virgina Commonwealth University, K-1, Exhibit 12 at p. 2 (attachment to Rebuttal Statement of NAOO); Rebuttal Statement of L. Benham, Professor, Washington University, K-17 at p. 2; A. Beckenstein, Professor, University of Virginia, K-1 at Appendix A at p. A-7 (attachment to Rebuttal Statement of NAOO); H. Snyder, West Coast Director, Consumers Union, J-24(a) at p. 2; J. Denning, President-elect, American Ass'n of Retired Persons, J-2 at pp. 1-2; J. Kwoka, Professor, George Washington Univ., J-12(a) at pp. 11-12.

consumers likely forego vision care while others may obtain it less frequently because of the higher prices associated with the restrictive laws.

c. Quality of Care for Consumers Who Receive Care

i. The Study Evidence

(a) BE and Contact Lens Studies

The most persuasive evidence on the quality issue -- the BE and Contact Lens Studies -- has already been discussed in detail above.[460] These studies indicate that commercial practice restrictions do not raise the overall level of quality in the market, for consumers who receive care.[461] The BE Study found that there was no difference in quality of eye care between markets with chain firms and markets without chain firms. The Contact Lens Study, which dealt with an additional important area of optometric care, found no difference between commercial and noncommercial optometrists in the quality of cosmetic contact lens fitting services. This study thus provides further support for the conclusion that the presence of commercial firms does not lower quality in the market.

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460 See supra Sections III.C.1.a., "BE Study," and III.C.1.b., "Contact Lens Study."

461 These studies do not expressly address the issue of access to eye care.

(b) Atlanta Study

Additional evidence regarding quality was presented by the Atlanta survey.[462] This survey compared the accurary of prescriptions and the accuracy of eyeglasses among three provider groups: "corporate", "private commercial" and "private professional."[463]

The survey evaluated the accuracy of the eyeglass prescriptions obtained by the survey subjects in comparison to benchmark examination results that had been derived for each survey subject by two optometrists, before the subjects went into the field.[464] No statistically significant difference in the variance of prescriptions from the benchmarks among the three optometric groups was found.[465]

The survey also evaluated the accuracy of the eyeglasses

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462 Atlanta Survey, supra note 376, J-67(a). The basic methodology of this survey and the price findings have been discussed above. See supra section III C.2.c.ii, "Atlanta Study."

463 There is no evidence to indicate that there are problems with the raw data collected in the survey or that these data were improperly analyzed in arriving at the study's quality results. The quality results appear valid on their face, although there is insufficient evidence on the record to conclude that they are, in fact, valid. See supra section III.C.2.c.ii, "Atlanta Study."

464 Id. at pp. 13-15. Information identifying the subject optometrists was removed from the prescriptions before they were evaluated.

465 Id. at pp. 29, 34.

obtained by the survey subjects by comparing them to the written prescriptions received by the subjects.[466] The survey found somewhat more deviation of the eyeglasses from the prescription among "corporate" practices than among "private professional" or "private commercial" practices; however, the difference was only marginally significant statistically.[467] Therefore, the quality results of the Atlanta survey tend to support the quality findings of the BE and Contact Lens, with a minor exception.[468]

(c) Contrary Survey Evidence

Some survey evidence was presented which was said to contradict the above-described BE and Contact Lens Study results

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466 Id. at pp. 15-17.

467 Id. at p. 29. In order to be considered significant, a difference must normally be significant at the 95% confidence level. The prescription results in the Atlanta Survey were significant at the 90% level, a lower level of significance, which means that there is less certainty that the difference is statistically significant.

468 NAOO presented additional evidence in support of the quality results of the BE and Contact Lens Studies. NAOO reanalyzed the underlying data of the Nathan New York City Survey. Rebuttal Statement of NAOO, K-1 at pp. 21-28. Using criteria for evaluating the survey optometrists and their prescriptions which NAOO believed to be more appropriate than the criteria used by Nathan, NAOO found no statistically significant difference in the quality of care between commercial and noncommercial optometrists.

A more thorough discussion of the difference between the NAOO criteria and those used by Nathan is found in Appendix C, Nathan Study Methodology. However, the results of the NAOO reanalysis must be viewed with caution. Since NAOO, an interested party in this proceeding, devised the quality measure and applied it to data which had already been collected, it is possible that bias may have affected the results.

regarding quality. Proponents of the restrictions rely heavily on the Nathan New York City Survey -- discussed more fully in section III.C.1.c. -- which, however, is not reliable because of serious methodological flaws in its design, and, which, in any case, does not contradict the BE Study findings.

Several commentors pointed to other data or informal surveys which they believed showed that there are quality justifications for commercial practice restrictions. For example, the results of an informal survey, conducted by a private optometrist, was offered to show that commercial optometrists have more contact lens "drop-outs," or unsuccessful wearers, than private optometrists.[469] In this informal survey, one hundred patients of a private optometrist, Dr. Morrison, filled out questionnaires. These patients had been fitted by other optometrists in the past and had unsuccessfully attempted to wear contact lenses. Based on their answers, Dr. Morrison found that the majority of these patients had previously sought "low-cost eyecare."

For several reasons, the Morrison survey cannot be used to determine whether commercial optometrists are less able to

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469 AOA Comment at pp. 40-41 and Appendix C thereto; J. Kennedy, Minnesota Optometrist, J-26 at pp. 3-4.

"Drop-outs" are patients who attempted to wear contact lenses but ceased wearing them. Contact lens patients may cease wearing their lenses for many reasons, including discomfort associated with lens wear. According to these commenters, a higher percentage of "drop-outs" indicates that the optometrists are less competent at fitting contact lenses.

provide successful contact lens fits than private optometrists, for several reasons. First, the survey provides no definition of the term "low-cost eyecare," and this term appears to include optometrists who are not "commercial optometrist." Second, the survey does not attempt to determine why the patients were unsuccessful fits. Patients may have ceased wearing their lenses for reasons unrelated to the fitting ability of their optometrist and this could have resulted in a bias in the data.[470] Thus, the survey data is too ambiguous and limited to provide a basis for any conclusion on whether commercial optometrists are less able to fit contact lenses adequately.

In addition, some commenters pointed to the Contact Lens Study data which showed that, in comparison to commercial optometrists, noncommercial optometrists, on average provided more follow-up care to their patients and instructed more patients on the importance of regular check-ups.[471] Some commenters stated that these results show that noncommercial optometrists provide higher quality eye care than commercial optometrists.[472] They stated that lack of follow-up care is a prime cause of contact lens fitting failures.[473]

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[470] For a further discussion of this point, see Appendix B, "Contact Lens Study Methodology." In addition, because of the informal nature of this survey, it is likely that appropriate survey techniques were not used to eliminate bias and to assure reliable and projectable results.

[471] These findings were not reported in the Contact Lens Study.

[472] Nathan study, Vol. I, Ex. 2 at pp. 38-40; AoA Comment at p. 42. See, also, J. Kennedy, Minnesota Optometrist, J-26 at p. 13; J. Crum, Kansas Optometrist, H-20 at p. 4.
(footnote continued)

The Contact Lens Study indicates, however, that the greater amount of follow-up care did not result in a difference in the ultimate quality received by consumers.[474] Follow-up care and regular check-ups are "inputs"--procedures which optometrists use to obtain a given "output", in this case, a quality contact lens fit. The Contact Lens Study directly measured the quality of the "output" -- the ultimate fit of the lenses. The Study found no difference in the ultimate quality of fit between commercial and noncommercial optometrists.

Calculations performed on the Contact Lens Study data also point to the potential pitfalls in relying on the number of follow-up visits as an indication of high quality.[475] An analysis of the Contact Lens Study data indicates that the number of follow-up visits was significantly negatively related to the quality outcome,[476] meaning that a greater number of follow-up visits was associated with more pathological eye conditions. This is consistent with the view that follow-up care is obtained more often by consumers who are experiencing problems. One possible explanation for this is that patients are returning for

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473 AOA Comment at pp. 41-42.

474 This does not mean that follow-up care is not important to ensure a high quality contact lens fit. It does indicate, however, that the number of follow-up visits cannot be used to assess the quality of fit.

475 These calculations were performed by Valerie Cheh, A Ph.D. student in economics. See, Rebuttal Statement of V. Cheh, Washington University, K-16.

476 Id. at pp. 1-2.

follow-up care because they are experiencing problems with their lenses. While these results cannot be said to provide a definitive analysis concerning the quality implications of follow-up care, they do illustrate the dangers of relying upon more follow-up care as an indication of high quality.

Finally, one commenter pointed to the results of the Atlanta Study which showed that "corporate" practices spent less time per examination than private practices.[477] However, even assuming this data has any statistical validity, it would be consistent with the results of the BE Study. The BE data showed that commercial practices gave shorter exams but that there were an equal percentage of shorter exams in both restrictive and nonrestrictive markets. Since the Atlanta survey examined only a market with chain firms and no market without chain firms, its results are incomplete and can say nothing about the differences between such markets and hence, about the effect of the restrictions at issue here.[478]

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477 "Private commercial" practices were found to have the longest exams. No statistical tests were performed to determine whether these differences were statistically significant. Atlanta Survey, J-67(a), supra note 376 at pp. 24, 29; Letter from A. Freid, California Optometrist Ass'n Panel, President, April 13, 1983, J-67(a) (attachment to Statement of California Optometrist Ass'n Panel); California Optometric Ass'n Panel, J-67(a) at p. 4.

Nathan also reported that their New York City data, based on the survey subjects' responses, showed that the eye exams given in private practice settings were statistically significantly longer than the eye exams given in commercial settings. Nathan study, Vol. I, Ex. 3 pp. 17-18. As explained in Appendix C, Nathan Survey Methodology, the Nathan data may well be biased against commercial firms.

(footnote continued)

In summary, the Studies, particularly the BE and Contact Lens Studies, clearly indicate that commercial practice does not lower the quality of care in the market. No valid survey evidence contradicts this conclusion.

ii. Other Evidence Regarding Effects of Restrictions in General

The record contains additional evidence, largely anecdotal in nature, on the question of how these restrictions impact on quality for those who receive care. Some of this evidence relates to commercial practice restrictions in general and will be discussed in this subpart. Some of this evidence relates to the effects of specific restrictions and will be discussed in subpart c.iii.

In total, this evidence about restrictions generally indicates that in some instances problems may have occurred at

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478 The issue of exam length has been raised repeated throughout this proceeding, with proponents of the restrictions arguing that commercial optometrists provide shorter, and hence lower quality exams, than noncommercial optometrists. There are two basic fallacies with this argument. First, although an analysis of the BE data indicated that there is a correlation between exam length and quality, J. Kwoka, Professor, George Washington Univ., J-12(a) at p. 10, the BE Study s "index" of exam thoroughness is a much better measure of quality. This "index" takes into account the procedures performed by the optometrist in an exam. Thus, exam length, by itself, cannot be viewed as an accurate gauge of quality. Second, and more importantly, the BE Study indicates that there is no difference between restrictive and nonrestrictive markets in the average length of exams. J. Kwoka, Professor, George Washington Univ., J-12(a) at p. 10. None of the evidence cited by the rule proponents even attempts to compare the two types of markets.

both commercial and traditional practices. It also indicates that some commercial firms and some private practitioners appear to provide very high quality. None of this evidence provides any information as to systematic differences between commercial and noncommercial firms and, more importantly, between restrictive and nonrestrictive markets. Only the studies, described above, provide such information.

(a) Evidence in Favor of the Restrictions

The first type of evidence offered in support of the restrictions consists of testimony by representatives of a few Boards of Optometry that they receive many more complaints about commercial firms than about noncommercial firms.[479] For example, the representative of the Maryland Board of Optometry testified that the Board received around 40 or 50 complaints per year and that roughly 85-90% involve commercial optometrists.[480]

This testimony must be viewed in conjunction with the testimony of other state board members who gave contrary evidence. For example, the President of the Ohio State Board of Optometry testified that the complaints received by that Board are in direct proportion to the percentage of each type of

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[479] H. Glazier, President, Maryland Board of Optometry, J-21 at p. 3; W. Van Patten, Secretary, Nevada Board of Optometry, J-56 at p. 1; E. Friedman, former Chairman, Texas Optometry Board, Tr. 2398.

[480] H. Glazier, President, Maryland Board of Optometry, J-21 at p. 3.

optometrist in the state.[481] A member of the Texas Board stated that the Board sends investigators into the field to check the quality of exams given by optometrists and has found no more violations of the basic competence requirements among commercial optometrists than among noncommercial optometrists.[482] This directly contradicts the testimony of a former Chairman of the Texas Optometry Board who has long been opposed to commercial practice.[483] Given the contradictory nature of this testimony, it is difficult to draw any conclusions from it.

In addition, much of the testimony that some state boards receive more complaints about commercial firms was unsubstantiated. Staff attempted to obtain copies of complaints or complaint logs in order to verify this information but was unable to obtain meaningful information.[484]

The relevance of this testimony, even if accurate, is also questionable, since no evidence was offered to indicate what percentage of these complaints dealt with legitimate quality of

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481 S. Tuckerman, President, Ohio State Board of Optometry, J-51(a) at p. 1.

482 B. Davis, Member, Texas Optometry Board, J-48(e) at pp. 1-2 and Tr. 1959.

483 E. Friedman, Former Chairman, Texas Optometry Board, Tr. 2398. This optometrist was involved in the lawsuit of Friedman v. Rogers, 440 U.S. 1 (1979).

484 One board refused to submit the requested information stating that the files were confidential. Other boards submitted information which was so incomplete that it could not be analyzed. Only one board, North Carolina, submitted usable data, but there was no data with which to compare it.

care concerns. In fact, some Board representatives admitted that a large number of the complaints dealt with advertising or fee disputes.[485] The evidence also suggests the possibility that many complaints against commercial firms may not have come from patients but were filed by competitors, suggesting that the complaints may not have concerned legitimate quality issues.[486] The record also contains some evidence suggesting that some Boards focus their enforcement efforts on commercial firms because of a general objection to the presence of such firms in their state.[487]

In addition, it may be significant that the majority of states with commercial practice did not testify in this proceeding. Many of these states submitted written comments but did not allege abuses by commercial firms.[488]

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485 See, e.g., H. Glazier, President, Maryland Board of Optometry, J-21 at p. 3, Tr. 903, 910; W. Van Patten, Secretary, Nevada Board of Optometry, J-56, pp. 1-2, Tr. 2263.

486 The complaint log submitted by the Optometry Board of North Carolina, a restrictive state, shows that many complaints were filed by competitors. See, Statistical Breakdown of North Carolina State Board of Examiners in Optometry Complaint Log, J-80.

487 See, e.g., Report by the Auditor General of California, June 1985, J-46(b) at p. 16; S. Tuckerman, President, Ohio State Board of Optometry, Tr. 2062; R. Feldman, President, Spectron, Inc., J-3(a) at pp. 1, 4-5.

488 See, e.g., G. Owen, Speaker of Michigan House of Representatives, E-3; L. Clarke, Executive Secretary, New York State Board of Optometry, E-6; S. Rimmiler, Executive Director, Missouri State Board of Optometry, E-9; B. Nichols, Secretary, Wisconsin Department of Regulation and Licensing, E-37. Some of these commenters supported promulgation of the proposed rule.

The second type of evidence offered in support of commercial practice restrictions consisted of testimony by approximately four former employees of commercial firms stating that poor quality eye care had been delivered by the firms for which they worked. For example, former employees of three or four firms testified that they had been ordered to use lenses which were in stock although they did not conform to the prescription, that poor quality lenses and frames were dispensed,[489] that optometrists were pressured to perform exams in 15 minutes,[490] that improper contact lens fitting was conducted[491] and that optometrists were pressured to prescribe unnecessary lenses.[492] Many of these reports concerned only one chain firm. This testimony, even if reliable, cannot show systematic abuses by commercial firms.

Third, many optometrists testified that they were aware of instances of poor quality at commercial firms based on reports and experiences of patients that they had treated after the patients had been treated at commercial firms,[493] or on reports

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489 T. Ray, Texas Optometrist, J-62; H. Woodring, California Optometrist, J-59 p. 3; G. Schwab, California Optometrist, J-63 p. 3; C. Dabb, Former California Optical employee, J-61.

490 H. Woodring, California Optometrist, J-59 p. 3; C. Dabb, Former California Optical employee, J-61. See also, F. Niemann, Counsel, Texas Optometric Assoc., Tr. 1014 (citing instance of optometrist allegedly forced to examine 50 patients per day.

491 C. Dabb, Former California Optical employee, J-61.

492 H. Woodring, California Optometrist, J-59 p. 3.

493 See e.g., L. Strulowitz, Member, New Jersey State Board of Optometry, Tr. 21-23; R. Fiegle, Kansas Optometrist, H-65 at p. (footnote continued)

from other optometrists who had been associated with such firms.[494] A few consumers testified that they had experienced problems at commercial firms.[495]

Even assuming that these witnesses are presenting an accurate account of particular circumstances, at most we can conclude that problems have occurred in some instances. Anecdotal evidence of this type, however, does not indicate that commercial firms systematically engage in more abuses than noncommercial optometrists. Moreover, this type of anecdotal evidence can provide no information on the differences between restrictive and nonrestrictive markets.

A fourth category of evidence consisted of statements, and, in some instances, supporting documentation, that abuses had occurred before the restrictive laws were enacted.[496] In many instances, this testimony referred to alleged abuses which occurred forty or fifty years ago when many of the restrictive

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2; J. Honaker, President, Kentucky Board of Optometry, J-17(a); D. Robbins, Indiana Optometrist, H-59 at pp. 1, 3-4; R. Wolten, Indiana Optometrist, H-52; R. Fiegel, Kansas Optometrist, H-65 at p. 2; R. Bauer, Indiana Optometrist, H-126 at p. 1.

494 D. Kuwabara, Chairman, Hawaii Board of Optometry, Tr. 1405-06; D. Weigel, Indiana Optometrist, H-46; D. Herriot, Kansas Optometrist, H-133 at p. 1; F. Niemann, Counsel, Texas Optometric Assoc., Tr. 1014 (citing deposition of Texas optometrist).

495 M. Harkins, Kansas Consumer, D-12.

496 Statement of California Optometric Association Panel, J-67(a) at pp. 8-9; K. Eldred, Secretary, Wyoming Board of Optometry, J-50(a) at pp. 1-2; T. Wheeler, Oregon Board of Optometry, J-55 at p. 2; N. Varnum, Secretary, Maine Board of Optometry, J-18(a); B. Prokop, Kansas Optometrist, H-83; J. Moye, Mississippi Optometrsit, Tr. 421.

laws were enacted. Much of this testimony consisted of statements that abuses had occurred with commercial firms with no specific citations to evidence.[497] This evidence has little probative value because of its anecdotal and nonspecific nature and because of its age.

(b) Evidence Against the Restrictions

Some evidence was presented indicating that potential quality-related problems are not exclusively associated with commercial practice and may exist with private optometrists in restrictive states as well. For example, one commercial optometrist testified about a number of private optometrists for whom he had worked who tried to pressure him into overprescribing eyeglasses.[498] Representatives of State Boards also stated that they received quality-related complaints about noncommercial practitioners.[499]

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497 See, e.g., T. Wheeler, Oregon Board of Optometry, J-55 at p. 2, Tr. 2205-06; K. Eldred, Secretary, Wyoming Board of Optometry, J-50(a) at p. 1; D. Kuwabara, Chairman, Hawaii Board of Optometry, Tr. 1403. But, see, "Optometry on Trial . . . Revisited," J. of the American Optometric Ass'n, Vol. 55, No. 7, July 1984, J-18(a), Enclosure B (Attachment to Statement of N. Varnum, Sec.-Tres., Maine Board of Optometry) (account of 1937 Reader's Digest survey of optometrists).

498 J. Ellis, President, Eyexam 2000, J-48(c) at p. 5 and Tr. 1921-22. See, also, R. Zaback, New York Optometrist, J-48(b) at p. 3; L. Strulowitz, Member, New Jersey State Board of Optometry, Tr. 40-42.

499 See, e.g., D. Kuwabara, Chairman, Hawaii Board of Optometry, Tr. 1407; L. Strulowitz, New Jersey Board of Optometry, Tr. 40.

Evidence was also presented showing the high quality optometric care offered by at least some commercial firms. For example, the evidence shows that the advertisement of one chain firm lists 16 different tests and procedures which are performed on every patient and asks "was your last eye exam this thorough?"[500] According to the testimony, the commercial firm determined, based on comparison shopping, that this eye exam is more thorough than the vast majority of exams in private practice,[501] and substantially more thorough than the minimum required by the law.[502]

In addition, several commercial optometrists testified that their firms have the most modern optometric equipment available, and that such equipment is often not found in private optometrists' offices.[503] Testimony also indicated that optometrists may be attracted to commercial firms because such firms stock a greater variety of contact lenses.[504] In addition, commercial optometrists testified that superior care is provided because optometrists can devote all of their time to providing eye exams while opticians and other support personnel handle

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500 Advertisement for Eyexam 2000, J-48(c), (attachment to Statement of J. Ellis, President, Eyexam 2000.

501 D. Butler, President, Precision Lens, Tr. 334.

502 J. Ellis, President, Eyexam 2000, J-48(c) at p. 3.

503 B. Davis, Texas Optometrist, J-48(e) at p. 2; J. Ellis, President, Eyexam 2000, J-48(c) at pp. 2-3; M. Albanese, Illinois Optometrist, J-48(c) at p. 2.

504 M. Albanese, Illinois Optometrist, Tr. 1919-20.

dispensing and other tasks.[505]

Many commercial optometrists testified that the majority of their patients come from referrals rather than advertising. This suggests that they are likely providing high quality, or at least that their patients believe they are.[506]

Finally, commercial firms testified about the quality control measures that they employ. For example, most commercial firms use a supervising optometrist to oversee patient complaints and monitor the quality of other optometrists to ensure that patient needs are being served.[507] Several commercial firms testified that they terminated employees, lessees or franchisees found to be providing substandard care.[508]

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505 M. Albanese, Illinois Optometrist, J-48(d) at p. 2.

One commercial optometrist testified that he specializes in problem contact lens patients and often takes patients who have not been accepted at private offices because of the difficulty of their problems. R. Zaback, New Jersey Optometrist, Tr. 1916. Another commercial optometrist testified that he treats patients with specialized problems which many optometrists do not treat. B. Davis, Texas Optometrist, Tr. 1945-46.

506 B. Davis, Texas Optometrist, Tr. 1952 (75% from referrals); J. Ellis, President, Eyexam 2000, Tr. 1952 (originally 100% from referrals, now 50%); R. Zaback, New Jersey Optometrist, Tr. 1952 (80% from referrals); S. Tuckerman, President, Tuckerman Optical, Tr. 2073-74 (100% from referrals); R. Moroff, New York Optometrist, Tr. 2073-74 (very large percentage).

507 M. Albanese, Illinois Optometrist, Tr. 1949; B. Davis, Texas Optometrist, Tr. 1950; R. Moroff, New York Optometrist, J-51(d) at p. 3; F. Rozak, Vice-President, Cole National, Tr. 331-32; A. Goodman, Vice-President, Sterling Optical, Tr. 335-37; J. Ellis, President, Eyexam 2000, J-48(c) at p. 4.

508 J. Ellis, President, Eyexam 2000, J-48(c) at p. 4; E.D. Butler, President, Precision Lens Crafters, Tr. 339; G. Schwab, California Optometrist, Tr. 2501-03.

The evidence also indicates that commercial firms can achieve a high volume of patients without providing "quickie" exams. Because commercial firms often hire or associate with several optometrists,[509] and utilize opticians and other support personnel, commercial optometrists may have more time to perform exams.[510]

NAOO stated that if there were indeed a correlation between the commercial practice of optometry and lower quality of care, that correlation should be reflected in higher malpractice premiums being charged to commercial optometrists.[511] The record indicates that insurance companies do not differentiate in malpractice premiums charged commercial and non-commercial optometrists.[512] While this could be accounted for by imprecision in insurer classification of optometrists, lack of insurer experience with optometric chain firms, and other factors,[513] this might also indicate that insurers have either found no difference between commercial and non-commercial optometrists in malpractice claims or loss experience or do not believe that an examination of that experience would lead to a

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509 R. Zaback, New Jersey Optometrist, J-48(b) at p. 2; B. Davis, Texas Optometrist, J-48(e) at p. 2.

510 S. Tuckerman, President, Tuckerman Optical, Tr. 2068; R. Zaback, New Jersey Optometrist, J-48(b) at p. 2.

511 NAOO Comment at p. 42.

512 Letter from Corroon & Black of Wisconsin to T. Latanich, H-78, App. O (Appendix to NAOO comment).

513 RRNA Rebuttal, K-5. See, also, R. Huber, California Attorney, Tr. 1820-21.

basis for differentiating premiums.

There is no doubt that commercial optometrists are faced with the same incentives to provide high quality as noncommerial optometrists. Neither private optometrists or commercial optometrists have a greater incentive to provide high quality. Private optometrists, like commercial firms, must earn a profit in order to stay in business and both types of practitions generate profits by selling eyewear. While some practitioners in each group may be tempted to cut-corners in order to generate short-term profits, practitioners in both groups must maintain a good reputation in order to attract and hold the loyalty of patients.[514] For this reason, it is not surprising that the evidence indicates that there is no difference in quality between

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514 J. Kwoka, Professor, George Washington, Univ., J-12(a) at p. 5. Both groups depend heavily on repeat business, and consequently need to maintain the goodwill of their customers E.D. Butler, President, Precision Lens Crafters, Tr. 333; J. Ellis, President, Eyexam 2000, Tr. 1938; J. Ingalls, President, Western States Optical, Tr. 2180, J-54 at p. 3. Cf. S. Tuckerman, President, Tuckerman Optical, Tr. 2073; R. Moroff, New York Optometrist, Tr. 2074; P. Zeidman, Counsel, International Franchise Ass'n, J-14 at p. 11, Tr. 600.

It has been suggested that firms can counteract the loss of goodwill as a result of decreased quality by massive advertising. While this may be true over the short run, over the long run the costs of extra advertising will affect the firms profitability.

Franchisors have an additional incentive to maintain high quality standards. The Lanham Trademark Act, 15 U.S.C. §1964 extends trademark protection to the franchisor's trade name only if the franchisor actively maintains the quality standards associated with the trade name. It is unlikely that a franchisor would risk the loss of copyright protection for its trade name by allowing quality standards to be abused. P. Zeidman, Counsel, International Franchise Ass'n, Tr. 599-600.

markets with chain firms and those without.

In conclusion, much of the anecdotal testimony, whether for or against restrictions in general, was presented by interested parties. At most, it suggests that some problems may have occurred at some commercial firms and also with some traditional practitioners. However, it can be concluded that some commercial optometrists and some noncommercial optometrists provide superior quality care. None of this anecdotal evidence demonstrates that there are any overall differences in quality between commercial and noncommercial optometrists, nor, more importantly, does it address quality differences between restrictive and nonrestrictive markets.

iii. Effects of Specific Restrictions

In this sub-section we discuss comments and evidence which focus on the effects of specific restrictions on the quality of care for those who receive care. Commenters alleged that each of the specific restrictions is needed to ensure quality of care; some cited anecdotal evidence in support of these claims. No systematic evidence was presented. Overall, the record does not contain any convincing evidence that the specific restrictions enhance the overall quality of care for whose who receive care.[515]

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[515] To the extent that problems are found to occur with either traditional practitioners or commercial practitioners, states remain free to address these problems. Many states currently (footnote continued)

(a) Lay Association Restrictions

(1) Interference with Professional Judgment

Many commentors and witnesses stated that permitting lay association would lead to interference with optometrists' professional judgment.[516] This rationale is offered for all types of lay association, including lay employment,[517] fee-

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have statutes apparently intended to address such specific problems. Several, for example, specify minmum examination procedures that must be performed. Others specify minimum equipment that must be present in the optometrist's office. Some specify patient records that must be maintained. Many require that cases of suspected pathology be referred to ophthalmologists. The states that impose these requirements are listed at supra section II.B.1.c.iii., "Standards of Practice." All states prohibit fraud and deception in the practice of optometry, and most prohibit capping and steering and kickbacks. See supra section II.B.1.c.iii., "Professional Conduct."

[516] E.g., J. Leopold, Kansas Optometrist, H-142; R. Bauer, Indiana Optometrist, H-126; M. Pickel, Indiana Optometrist, H-96; E. Waterman, Rhode Island Optometrist, H-103; C. Wong, California Optometrist, H-105; M. Crotts, Kansas Optometrist, H-43; M. Raymon, California Optometrist, H-39; G. Cole, President, New Hampshire Board of Optometry, E-50; E. Walker, Member, Florida Board of Optometry, E-36; R. Gross, Chairman, Pennsylvania Board of Optometry, E-42; C. Beier, Vice-President, Kansas Board of Optometry, E-45; E. Vinje, Attorney, North Dakota Board of Optometry, E-53 at p. 7; B. Wilson, Administrator, Oregon Board of Optometry, E-59; E. Herb, Colorado Optometrist, H-87 at pp. 3-4; H. White, President, Kansas Optometric Ass'n, H-84 at p. 2; B. Prokop, Kansas Ophthalmologist, H-83; J. Akers, Kansas Optometrist, H-85; L. Carson, Attorney, Florida Optometric Ass'n, H-88; F. Niemann, Attorney, Texas Optometric Ass'n, H-53; C. LoParo, Pennsylvania Optometrist, H-106; K. Nash, President, South Carolina Optometric Ass'n, H-56; L. Smith, Kansas Optometrist, H-54.

[517] E.g., Comment of R. Gross, Chairman, Pennsylvania Board of (footnote continued)

splitting,[518] and franchising.[519] Some commenters stated that they believed that lay association would lead to compensation schemes that encourage overprescription. Others maintained that inferior materials would be dispensed. Another comment was that the need to perform a large volume of examinations would lead to less thorough examinations.

Proponents of lay employment bans argue that the lay employee is particularly susceptible to interference because of the high degree of control inherent in the employment relationship.[520] Several commercial optometrists who currently lease space from commercial firms expressed fear that if they were employed by their current lessors, their employers would interfer with their judgment.[521]

Anecdotal evidence on the issue of interference with professional judgment is mixed. Two former lay-employed optometrists stated that they were required by lay employers to render sub-standard care.[522] Several optometrists in commercial

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Optometrical Examiners, E-42; J. Leopold, Kansas Optometrist, H-142.

518 E.g., A. Gorz, President, Wisconsin Optometric Ass'n. H-40.

519 E.g., M. Garner, Georgia Optometrist, H-35.

520 "[T]here is no greater degree of control which one person may lawfully exert upon another than under . . . employer/employee relationship." F. Niemann, Jr., Attorney, Texas Optometric Ass'n., J-23(a) at p. 8.

521 C. LoParo, Pennsylvania Optometrist, H-106; H. Krosschell, Massachusetts Optometrist, H-11; G. Schmidt, Florida Optometrist, H-31.

522 G. Schwab, California Optometrist, Tr. 2480-83; T. Ray, (footnote continued)

practice, on the other hand, maintain that by being freed from administrative tasks and dispensing chores, they are able to practice at least as high quality optometry as they could in private practice.[523]

No systematic evidence of interference with professional judgment by lay employers or associates was presented. In particular, there is virtually no evidence of interference from the eleven states that currently permit lay employment.[524]

(a). Effect on Overprescription

Opponents of lay association allege that lay-associated optometrists will be pressured to overprescribe in order to boost profits from the sale of eyewear.[525] Tactics that encourage

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Texas Optometrist, Tr. 2448-52. Several others made similar allegations, however, about employers who were optometrists. H. Woodring, California Optometrist, Tr. 2347-52; Attachments to Statement of F. Niemann, Attorney, Texas Optometric Ass'n, J-23(c),(e), & (f); J. Lovell, Kentucky Optometrist, K-9; G. Snyder, Maryland Optometrist, K-9.

523 E.g., R. Moroff, New York Optometrist, J-51(d); M. Allmaras, Indiana Optometrist, J-51(b) at p. 1 (discussing employment in Illinois).

524 If interference with professional judgment results from lay association, one would expect it to be most prevalent in states that permit lay employment. Lay employment is alleged to be the most intrusive form of lay association. F. Niemann, Attorney, Texas Optometric Ass'n, J-23(a) at p. 8. Only one instance of interference with professional judgment was presented from such a state. G. Schwab, California Optometrist, Tr. 2480-83 (discussing prior employment in Missouri). Dr. Schwab was employed by a lay franchisee of a national chain. However, it developed on cross-examination that the chain promptly terminated the franchisee upon Dr. Schwab's reporting the situation to chain officials. Tr. 2498-2503.

(footnote continued)

overprescription, they suggest, might take several forms: optometrists might be paid bonuses or commissions for eyewear prescribed,[526] be given prescription quotas, or if employed, simply be ordered to overprescribe in order to boost sales.[527]

There is no indication, however, that the profit motive leads lay-associated optometrists to overprescribe more than other optometrists do. As discussed above, independent optometrists are subject to the same incentives to overprescribe as lay-associated optometrists.[528] Any such temptation should, in general, be counterbalanced by the need of both firms and independent optometrists to maintain goodwill and patient satisfaction.

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525 E.g. Position Paper: Virginia Board of Optometry, E-68, Ex. I; A. Coe, California Optometrist, H-16; G. Cole, President, New Hampshire Board of Optometry, E-50. P. Brungardt, Kansas Optometrist, H-29. R. Stoddard, Maine Optometrist, E-61 (Attachment to letter from U.S. Senator W. Cohen).

526 See Initial Staff Report at p. 33 (citing H. Gould, B-2-52-13).

527 A. Coe, California Optometrist, H-16; W. Beeaker, President, Maine Optometric Ass'n., H-55; W. Kirby, Indiana Optometrist, H-107; H. Kroschell, Massachusetts Optometrist, H-11; J. Akers, Kansas Optometrist, H-85.

A variation on the concern about overprescription is that the lay-associated optometrist, aware of the corporate goal of selling eyewear, will come to view the patients' problems as refractive problems, requiring eyewear to correct, and not to consider alternative diagnoses. B. Wilson, Administrator, Oregon Board of Optometry, E-59; Cf. D. Vierling, Texas Optometrist, H-38. There is no evidence supporting this position. Even if true, however, non-commercial dispensing optometrists would be subject to the same influence.

528 J. Kwoka, Professor, George Washington Univ., J-12 at p. 8. See, supra, section III.C.3.c.ii.(b)., "Evidence Against the Restrictions." Unlike employed optometrists, private dispensing optometrists keep all of the profits from dispensing eyewear.

The record does not demonstrate that lay association is related to overprescription. To the extent that states view overprescription as a problem in the profession generally, their ability to regulate it in an appropriate manner will not be affected by the proposed rulemaking.

(b). Effect on Adequacy of Examinations

Proponents of commercial practice restrictions also claim that lay employers, franchisors, lessors, or partners will pressure the optometrist to see more patients than can be properly examined in a given period of time, resulting in inadequate or poor quality examinations.[529]

Of the anecdotes presented, few were related to lay association.[530] The few that were do not support a conclusion that inadequate examinations are inherent in lay associated practices. In one Missouri case, an employee of a lay franchisee of a national firm alleged that he was required to schedule examinations every fifteen minutes and accommodate walk-in

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[529] P. Brungardt, Kansas Optometrist, H-29; E. Brazing, Ohio Optometrist, H-33; E. Herb, Colorado Optometrist, H-87 at p. 5; R. Saul, Florida Optometrist, H-93; D. Weisel, Indiana Optometrist, H-46.

[530] The rest related to employers who were themselves optometrists. Attachments to Statement of F. Niemann, Attorney, Texas Optometric Ass'n, J-23(c)(e), & (f); H. Woodring, California Optometrist, Tr. 2347-52; J. Lovell, Kentucky Optometrist, K-9; G. Snyder, Maryland Optometrist, K-9.

business as well. When he complained about the situation to the franchisor, however, the franchisor promptly terminated the franchise.[531] Most of the other cases were from the same state,[532] and consist of selectively assembled, non-systematic anecdotes. As such, their probative value to the relationship between inadequate examinations and lay association is unclear. On the other hand, several optometrists who practice as corporate employees testified that they are not pressured to give less than thorough examinations by their employers and, in fact, they provided very high quality exams.[533] In sum, the anecdotal evidence suggests that some lay-associated optometrists give less thorough examinations than average, while others give more thorough examinations.

(c). Willingness to Handle Complex Cases

Proponents of restrictions on lay association also argue that optometrists are pressured to avoid more time consuming and complex cases and refer them out to other practitioners.[534] Some commercial optometrists dispute this, claiming that they perform

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531 G. Schwab, California Optometrist, Tr. 2498-2503.

532 T. Ray, Texas Optometrist; Attachments to Statement of F. Niemann, Counsel, Texas Optometric Ass'n, J-23(c),(e), & (f).

533 R. Moroff, New York Optometrist, J-51(d); M. Allmaras, Indiana Optometrist, J-51(b) at p.2.

534 K. Van Arsdall, Indiana Optometrist, H-97; Virginia Board of Optometry, Position Paper, E-68, Ex. I.

the full range of optometric services.[535] The record does not establish that lay-associated optometrists generally avoid complex cases. It also does not establish that referring complex cases to other qualified practitioners results in any identifiable consumer injury.

(d). Use of Untrained persons

A further objection raised by proponents of lay association restrictions is that when the optometrist is associated with a layperson, untrained personnel may be used to perform tasks, such as contact lens fitting or responding to medical questions, that should be left to a professional.[536] Most states have laws requiring that these acts be performed by licensed persons or under their supervision.[537] Although the record contains anecdotal allegations of practice by untrained persons,[538] there is no systematic evidence of a widespread problem. There is also no evidence that this problem is necessarily associated with

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535 E.g., A. Goodman, Vice President, Sterling Optical, Tr. 343-45; B. Davis, Texas Optometrist, Tr. 1915; R. Zaback, New Jersey Optometrist, Tr. 1916. Some commercial optometrists do not perform certain specialized services, but refer them to other practitioners. E.g., M. Allmaras, Illinois Optometrist, Tr. 2301-32.

536 H. White, President, Kansas Optometric Ass'n., H-84 at p. 2; C. Kissling, Kansas Optometrist, H-50; M. Downey, Kentucky Optometrist, H-22.

537 See supra section II.B.1.c.i., "Qualifications to Practice."

538 G. Schwab, California Optometrist, J-63 at p. 2; C. Dabb, Former California Optical Employee, J-61 at pp. 4-5.

commercial practice any more than it is with non-commercial practice. Indeed, the problem of untrained personnel fitting contact lenses was cited (without specific support) as a problem in at least one state that bans all forms of commercial practice.[539]

(e). Optometrist-patient Relationship

Lay association, according to proponents of restrictions, undermines the optometrist-patient relationship in at least three ways. First, it is claimed that the optometrist's loyalty will become divided between the patient and the employer,[540] and that the optometrist will tend to place the employer's interest above the patient's.[541] Second, it is claimed that patients will not know the identity of the optometrist who sees them, so the patients will be unclear as to who is responsible for the care delivered.[542] Third, it is alleged that if the patient complains to the state board, the board will not know which optometrist to investigate and, since boards do not have jurisdiction over

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539 H. White, President, Kansas Optometric Ass'n., H-84 at p. 2.

540 E.g., D. Crum, Kansas Optometrist, H-20; B. Prokop, Kansas Optometrist, H-83; R. Fiegel, Kansas Optometrist, H-65; E. Vinje, Attorney, North Dakota Board of Optometry, E-53 at p. 7; C. Wong, California Optometrist, H-105; H. Glazier, President, Maryland Board of Optometry, Tr. 900.

541 E.g., T. Hawks, Kansas Optometrist, H-75.

542 D. Bettis, Chairman, Consumer Relations Committee, Kansas Optometric Ass'n, H-30; N. Stigge, Kansas Optometrist, H-95.

corporate employers of optometrists, they will not be able to proceed against the corporations.[543] Fourth, it is claimed that continuity of care will suffer because of high-turnover among optometrists at lay-controlled establishments.[544] Finally, it is alleged that the resulting breakdown in the optometrist-patient relationship will result in inferior care and an increase in malpractice claims.[545]

The record does not support these claims. Virtually all come from states that prohibit lay association, and thus have no direct experience with the effects of permitting lay association.[546] States that permit lay association generally did not raise these concerns. No systematic evidence of such abuses was presented. The limited anecdotal evidence on both sides is inconclusive, with one former lay-employed optometrist claiming that a breakdown did occur,[547] while several current lay-associated optometrists stated that they enjoy good patient relationships.[548]

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543 L. Strulewitz, Member, New Jersey Board of Optometry, Tr. 36. D. Bettis, Chairman, Consumer Relations Committee, Kansas Optometric Ass'n, H-30; C. Beier, President, Kansas Board of Optometry, Tr. 2097; No reason is advanced why states could not regulate corporate employers of optometrists if they saw fit.

544 H. Glazier, President, Maryland Board of Optometry, Tr. 899-900.

545 R. Huber, California Attorney, J-45, pp. 3-9.

546 But see, H. Glazier, President, Maryland Board of Optometry, Tr. 905. Dr. Glazier defined as commercial optometrists anyone practicing under a trade name. Tr. 906. See, also, pp. 225-26, infra.

547 T. Ray, Texas Optometrist, Tr. 2449.
(footnote continued)

There are few complaints from states that permit lay association that patients or state boards have difficulty identifying the optometrists responsible for their care. There is no evidence that this problem is widespread or that it is associated with lay association. However, nothing in this rulemaking would prohibit states from requiring optometrists to identify themselves to patients if states find this to be a problem.[549]

(2) Effect on Quality Control and Goodwill

As discussed above, commercial firms, like individual optometrists, have strong incentives to maintain high quality standards.[550] The record indicates that firms maintain quality control programs to ensure that consistent standards are maintained.[551] One way in which firms may control quality is to

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548 E.g., R. Zaback, New Jersey Optometrist, Tr. 1914; M. Allmaras, Indiana Optometrist, J-51(b).

549 See, e.g., New York, which requires optometrists to wear name badges in commercial and multiple-optometrist facilities. N.Y. Reg., Tit. 8, Ch. 1, §29.2(a)(11). Other states require optometrists to give patients their names, addresses, and registration numbers. E.g., Alaska.

550 See, supra section III.C.3.c.ii, "Evidence Against the Restrictions."

551 F. Rozak, Vice President, Cole National Co., Tr. 330-32; A. Goodman, Vice President, Sterling Optical, Tr. 335; D. Loomis, Vice President, Pearle Vision Centers, Tr. 338. Cf. J. Solish, Attorney, R.H. Teagle Corp., Tr. 1369-70; M. Albanese, Illinois Optometrist, Tr. 1949 (firms controlled by optometrists).

send covert "shoppers" into the offices of employed and, in some instances, leasing optometrists to assess quality.[552] One large firm that leases space in department stores and then either employs optometrists or subleases to optometrists reports that customer complaints to the department stores are passed on to the firm, giving it an additional measure of quality control.[553]

Restrictions on lay association can actually hinder the quality control effort. Employed optometrists can be readily corrected or, if necessary, terminated should the quality of their work fall below standards. Where firms are forbidden from employing optometrists, they frequently lease space on or near their premises to independent optometrists. Quality control over leased optometrists' work is more difficult to exercise through the landlord-tenant relationship than through the employment relationship.[554] One firm that is required to lease space to optometrists in some states, although it would prefer to hire them, points out that it is more difficult to terminate substandard optometrists in a leasing situation than in an employment context.[555]

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552 A. Goodman, Vice President, Sterling Optical, Tr. 335-36; J. Solish, Attorney, R.H. Teagle, Corp., Tr. 1369-70.

553 F. Rozak, Vice President, Cole National Co., Tr. 332.

554 F. Rozak, Vice President, Cole National Co., Tr. 331.

555 E.D. Butler, President, Precision Lens Crafters, Tr. 334, 339-40.

(b) Branch Office Restrictions

Proponents of branch office restrictions claim that these restrictions are necessary to ensure that patients receive adequate treatment by licensed optometrists.[556] They argue that optometrists cannot meet the needs of consumers at all locations, and are forced to provide lower quality care due to shorter examinations and increased treatment by unlicensed staff.[557] This should not be a concern, provided the optometrist employs other optometrists when needed to meet the staffing requirements of multiple practice locations.[558] There is nothing inherent in

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556 See, e.g., D. Barkiske, Optometrist, H-137 at p. 1; M. Raymon, California Optometrist, H-39 at p. 1; E. McCrary, Vice President, Maryland Optometric Ass'n, J-5 at 2; J. Honaker, President, Kentucky Board of Optometry, Tr. 711; L. Thal, President, California Board of Optometry J-46 at p. 3; C. Beier, President, Kansas Board of Optometry, Tr. 2143; L. Strulowitz, Member, New Jersey Board of Optometry, Tr. 35; G. Easton, President-elect, AOA, Tr. 142.

Others argue that these restrictions do not promote quality. See ,e.g., D. Staten, Nevada Optometrist, J-27 at p. 3; NAOO Comment at pp. 63-65; P. Zeidman, Counsel, International Franchise Association, J-14 at p. 20-22.

557 Some commentors also argue that these restrictions threaten quality by reducing office hours. They fail to state how office hours compromise quality care, and staff is unable to discern from the record how this may occur. If anything, changes in offices hours at multiple location practices could shift optometric practice hours to when they are most needed.

558 During his testimony, Dr. C. Beier, President of the Kansas Board of Optometry, was asked whether hiring additional professional staff would resolve his concern about the availability of professional staff in branch office locations. Dr. Beier said that such hiring would solve the availability problem, but he still objected to branch offices. He was unable to provide any additional reasons for his objection. C. Beier, (footnote continued)

the number of branch offices maintained by optometrists that should lead to inadequate availability of professional staff. The record provides no evidence to indicate that such a problem has, in fact, occurred in any state currently permitting unlimited branch office practice.

A second commonly raised argument in favor of restricting branch offices is that branch offices reduce direct contact between the optometrist who owns the practice and his or her patients.[559] The record does not reveal what presumed danger to quality of care results from reduced contact. Any quality of care concerns should be alleviated if the patient is treated at a branch office by a licensed optometrist. A related concern is that patients will be increasingly treated by non-licensed staff and that the optometrist will be unable to adequately supervise this staff.[560] The record provides no empirical evidence and little anecdotal evidence to support these allegations.[561] Most optometrists employ at least some support staff.[562] Absent

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President, Kansas Board of Optometry, Tr. at 2143.

559 See, e.g., M. Raymon, California Optometrist, H-39 at p. 1; J. Kavanagh, New York Optometrist, H-58; C. Wong, California Optometrist, H-105; G. Easton, President-elect, AOA, Tr. 142.

560 Id.

561 See, e.g., C. Dabb, Former California Optical employee, Tr. 2443 (witness testified that as a technician with a large chain, she performed tasks that constituted unlicensed practice); H. White, President, Kansas Optometric Association, H-84 at p. 2 (cites problems with unlicensed contact lens fitting by commercial optical dispensers). The ancedotal evidence on the record deals with isolated instances of conduct occuring in commercial practices generally, and does not even identify the use of branch offices as the cause of these incidents of optometric misconduct.
(footnote continued)

evidence that these employees engage in the practice of optometry, their performance of technical or dispensing functions should not harm patients.[563] Existing state regulations prohibiting the unlicensed practice of optometry, and requiring that optometrists display their licenses, should prevent such unprofessional conduct.[564] More important, the record does not show that such problems occur in states permitting branch offices.

Thus, the record contains no evidence indicating that branch office restrictions increase the quality of care delivered.

(c) Mercantile Location Restrictions

(1) Interference with Professional Judgment

Several commentors took the position that mercantile location restrictions, like bans on lay association, are needed to prevent corporate lessors and employers, whether involved in the sale of eyewear or not, from interfering with the

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562 See California Department of Consumer Affairs, Commercial Practice Restrictions in Optometry, J-24(b)(Exhibit A) at pp. 4, 5.

563 Indeed, this division of function between optometrists and support staff likely benefits consumers because it is a more efficient means of conducting a practice. See supra section III.B.1.c.ii.(b)., "Management and Payroll."

564 See chart, supra at pp. 33-46.

professional judgment of the optometrist.[565] This concern, which is raised about commercial practice generally, is that optometrists will be pressured to overprescribe and reduce the thoroughness of examinations.[566]

To the extent that the concern for the protection of the optometrist's professional judgment arises from the nature of the business relationship between the optometrist and lessor, that issue is dealt with elsewhere in this report.[567] To the extent, however, that it is based on the location of the practice itself, the record contains no credible evidence to suggest that there is a relationship between location and interference with professional judgment.

One commentor pointed out that restrictions on practice in mercantile locations reduces the number of distractions to the optometrist, thus enabling him or her to give a higher quality

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565 E.g., E. McCrary, Vice-President, Maryland Optometric Ass'n, J-5 at p. 2; C. Beier, President, Kansas Board of Optometry, Tr. 2136; D. Kuwabara, Chairman, Hawaii Board of Optometry, J-34; L. La Pierre, Kansas Optometrist, H-128; M. Pickel, Indiana Optometrist, H-96. Other commentors limited their objections to optometrists located in retail optical establishments. They did not object to practice in other mercantile locations. L. Zuern, Member, North Dakota Board of Optometry, J-40 at p. 6.

566 D. Crum, Kansas Optometrist, H-20 at p. 1; J. Leopold, Kansas Optometrist, H-142; L. Powers, Kansas Optometrist, H-149. All of these commentors are from a state that prohibits practice in mercantile locations.

567 See supra section III.B.1., "Restrictions on Lay Association," As noted in that section, the incentive of commercial optometrists to overprescribe is the same as that for private optometrists who profit directly from the sale of eyewear.

exam.[568] There is no evidence that distraction of optometrists is a problem in states that permit practice in stores.[569]

A related objection to practice in mercantile locations is that the quality of care is lower because those practice locations are less dignified than traditional offices. It was frequently stated that an optometrist cannot offer quality optometric care in the same setting as a shoe, sporting goods, or ladies' undergarments section of a department store.[570] There is no evidence, however, that practice in such locations reduces the quality of care.

(2) Emergency Access to Premises

Another justification advanced for restrictions on mercantile locations is that optometrists practicing in such locations might not have access to their offices on a 24-hour basis.[571] These commentators stated that 24-hour access is

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568 L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 4 and Tr. 33.

569 Implicit in this criticism is the assumption that if practice in department stores is permitted, optometrists will be required to examine patients on the open sales floor. There is no evidence that this happens. At least one state requires that a room be available for the exclusive use of the optometrist. Pennsylvania.

570 P. Slayton, Minnesota Optometrist, H-18; L. La Pierre, Kansas Optometrist, H-128; E. McCrary, Vice-President, Maryland Optometric Ass'n, J-5 at p. 2; L. Strulewitz, Member, New Jersey Board of Optometry, J-1 at p. 3, Tr. 16.

571 J. Robinson, Secretary, North Carolina Board, Tr. 2993; L. La Pierre, Kansas Optometrist, H-128.

needed in case of emergencies. No state, however, requires optometrists to be available to patients on a 24-hour basis, nor is there any evidence that access to the office is necessary in order to deal with after-hour emergencies.[572] Nor was any evidence presented that optometrists or patients in states that do permit practice in mercantile locations have had difficulties because of lack of 24-hour access.[573]

(3) Separation of Examination and Dispensing

A central justification offered for restrictions prohibiting optometrists from practicing inside retail optical establishments is that it prevents the proprietor from placing excessive pressure on the patient to purchase eyewear at the same location.[574] As noted elsewhere, however,[575] commercial

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[572] The president of one state board testified that an optometrist could be away from his office for an extended period of time without leaving patients a contact. F. Honaker, President, Kentucky Board of Optometry, Tr. 742-43. This suggests that emergency access is not viewed as critical by all boards.

[573] One state does require that an optometrist have 24-hour access to the office in order to practice in a mercantile location. S. Clark, Arkansas Attorney General, Tr. 3025. No similar requirement appears to be imposed on optometrists in other states, however.

[574] M. Raymon, California Optometrist, H-39; H. Kroschell, Massachusetts Optometrist, H-11; W. Van Patten, Secretary, Nevada Board of Optometry, Tr. 2261-62.

[575] See supra section III.C.3.c.ii.(b)., Evidence Against the Restrictions."

optometrists have no more incentive to sell eyewear to patients than do private optometrists. If the purpose of this restriction is to prevent this sort of pressure, there is no evidence that it achieves this goal.

(d) Trade Name Restrictions

Proponents of trade name restrictions often argue that optometrists can practice anonymously behind their trade names, reducing or eliminating their accountability to their patients and therefore reducing their incentive to provide quality service.[576] Doctors are thus freed from the responsibility of providing quality care, according to these commenters, because they cannot be identified personally in the trade name setting.[577] In addition, these commenters argue that trade names destroy the traditional doctor-patient relationship, in which the

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[576] See e.g., N. Varnum, Secretary-Treasurer, Maine Board of Optometry, E-8 at p. 2; A. Crump, Nebraska Deputy Attorney General, E-20 at p. 6; P. Brungardt, Kansas Optometrist, H-29 at p. 1. G. Easton, President-elect, AOA, Tr. 144-145; A. Gorz, President, Wisconsin Optometric Association H-40 at p. 2; C. Beier, President, Kansas Board of Optometry, J-52 at pp. 4-5; M. Coble, Kansas Optometrist, H-143. In addition, some optometrists argue that trade names are harmful because they promote the development of commercial practice. See, e.g., C. Beier, Tr. 2132-2134.

[577] See, e.g., N. Varnum, Secretary-Treasurer, Maine Board of Optometry, E-8 at p. 2; A. Crump, Nebraska Deputy Attorney General, E-20 at p. 6. Because of this presumed anonymity, at least one commenter believes trade names may promote optometric practice by unlicensed staff. However, unlicensed practice is prohibited in every state and no evidence establishes that this is any more of a problem in trade name practices than elsewhere. J. O'Connor, Indiana Optometrist, H-108 at p. 2.

patient expects to see the same doctor at every visit.[578] They argue that in such a relationship, the doctor may maintain an active interest with that patient, thus improving the overall quality of care.[579] By contrast, these commenters argue that when patients visit a trade name practice, they may never see the same practitioner twice, and never develop a personal relationship with their doctors.[580]

These arguments are without record support. The commenters fail to establish that optometrists practicing under trade names do so anonymously. Such anonymity is unlikely in light of numerous state regulations requiring that optometrists prominently display their licenses at their practice location.[581] These commenters do no more than speculate on what effect this alleged anonymity has on overall quality results. The arguments concerning the impact of the doctor-patient relationship on quality are similarly unsupported. There is no evidence demonstrating that optometrists treating a patient for the first time are more likely to provide inferior care or less likely to detect disease.[582] Moreover, there is no evidence

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578 Noncommercial optometrists can and do employ other optometrists even in restrictive states. If patients do indeed develop such an expectation, and there is no support in the record that patients do (or care), this expectation can be easily thwarted even in a traditional setting.

579 See supra at note 576.

580 See supra note 576.

581 See chart, supra pp. 33-46.

582 Most states require optometrists to maintain records of (footnote continued)

showing that consumers desiring a continuing doctor-patient relationship cannot develop one in markets offering commercial practice.

To the contrary, trade name firms have strong incentives to maintain at least a level of quality consistent with consumer expectations. To the extent that consumers rely on reputation information in selecting eye care providers, the reputation embodied in the trade name becomes a valuable asset to the firm.[583] Generally, firms are not willing to risk the value of their reputation by providing poor quality care. The record establishes that trade name firms make an affirmative effort to ensure a consistent level of quality. Many chain firms maintain quality control programs designed to protect the quality of services offered at their practice locations.[584] These firms

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their patient's treatment. These records are available for an examining optometrist to review regardless of whether a different optometrist originally treated the patient. See chart, pp. 33-46. These same arguments could be raised concerning practice in HMO's, yet HMO's are increasingly recognized as a legitimate health care choice for consumers.

583 See J. Kwoka, Professor, George Washington Univ., J-12(a) at p. 5.

The value to a firm of its trade name may extend beyond its ability to attract customers through reputation. The value of a trade name is represented by the goodwill built up in a firm. If that firm is sold, the price paid reflects the value of the goodwill established in the trade name. Id.

584 E.g., NAOO Panel 1-A, Tr. 1938-1939. For example, some firms have dismissed employed optometrists for failing to live up to the firms' quality standards. NAOO Panel 1-A, Tr. 1927. Moreover, franchising agreements contractually require that the franchisee maintain high quality standards as "essential to maintain the uniform image and favorable reputation" of the firm's outlets. See Franchising Agreement by Pearle Vision Center, Inc. p. 6, (Appendix K to NAOO Comment). See also, (footnote continued)

recognize that failure to maintain quality could cause an erosion of their reputation, followed by loss of business or even business failure.[585]

(e) Conclusion

In summary, commenters alleged that each of the specific restrictions is needed to maintain quality of care. While some limited anecdotes were presented in support of these arguments, no convincing evidence indicates that the specific restrictions enhance the quality of care. Moreover, none of this evidence refutes the conclusions of the studies, discussed above, demonstrating that commercial practice restrictions do not increase the quality of care delivered.

d. Frequency of Obtaining Care

i. Effects of Restrictions Generally

A second aspect of quality of care relates to the frequency with which consumers obtain eye care. The record evidence, including survey evidence, indicates that, as a result of the

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NuVision Office Franchising Agreement (Appendix J to NAOO Comment). Failure to live up to expected quality levels by the franchisee will result in termination of the franchise. P. Zeidman, Counsel, International Franchise Ass'n, Tr. 600-01.

585 It seems reasonable that most optometrists employed by these firms would recognize a self-interest in maintaining quality, in that their jobs are dependent on the quality of their performance and the continued health of the firm.

higher prices in markets with commercial practice restrictions, consumers obtain eye care less frequently than they otherwise would. While some consumers may be foregoing eye care entirely, others are delaying the purchase of eyeglasses and eye exams. Both effects may result in inadequate vision and untreated eye problems. Very few proponents of the restrictions addressed this issue, and none offered any evidence to the contrary.[586]

Several commenters addressed this issue, stating that, as a result of the restrictions, consumers likely purchase eye care less frequently. Professors James Begun and Lee Benham, two independent economists, stressed the importance of frequency of eye care as an aspect of quality and stated that there can be little doubt that the restrictions result in a reduced frequency of vision care purchases.[587] This could result because consumers cannot afford the higher-priced goods and services in restrictive markets or because consumers cannot conveniently travel to practitioners.[588] Consumers Union stated that removal of the

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586 In proposing the rule, the Commission stated that it had reason to believe that the restrictions reduce the accessibility and limit the availability of vision care. Notice of Proposed Rulemaking, 50 Fed. Reg. 598,599 (1985). The Initial Staff Report, B-2, also contained a discussion of the issue.

587 J. Begun, Professor, Virginia Commonwealth University, K-1, Exhibit 12 (attachment to Rebuttal Statement of NAOO); Rebuttal Statement of Lee Benham, Professor, Washington University, K-17 at p. 2; A. Beckenstein, Professor, University of Virginia, at p. A-7 (Appendix A to Rebuttal Statement of NAOO).

588 Professor Beckenstein, a consulting economist for NAOO, stated that the social welfare gains of providing care to that segment of the market that would otherwise receive no care or less care are clearly substantial. He stated that this is the central quality-of-care issue, "being far more important than the (footnote continued)

restrictions will allow more frequent eye exams and improve patient health because more consumers will be able to afford the vision care and eyeglasses they need.[589] Commenters also noted that this issue of less frequent care was not addressed by proponents of the restrictions.[590]

Evidence on the rulemaking record shows that some consumers are not obtaining adequate vision care because of financial circumstances. AOA, in testifying before Congress in 1976 about the plight of the elderly who cannot afford adequate vision care, noted that Medicare generally does not cover vision care,[591] and stated:

> Yet, we find too many elderly Americans who count up their remaining loose change at the end of a month and say to themselves that they cannot afford to have their eyes examined, they cannot afford to have spectacle frames repaired, they cannot afford new prescription lenses.[592]

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debate over who prescribes slightly more accurately or spends more time with patients." Rebuttal Statement of NAOO, K-1, Appendix A, at p. A-7.

589 H. Snyder, West Coast Director, Consumer's Union, J-24(a) at p. 2, citing, State of Cal., Dept. of Consumer Affairs, Commercial Practice Restrictions in Optometry, J-24(a), Exh. A at p. iii (attachment to Statement of Consumers Union).

590 J. Begun, Professor, Virginia Commonwealth Univ., K-1, Ex. 12 at p. 2 (attachment to Rebuttal Statement of NAOO).

591 Medical Appliances for the Elderly: Needs and Costs, Hearings Before the Subcomm. on Health and Long-term Care of the House Select Comm. on Aging, 94th Cong., 2d Sess. (1976), (Statement of the AOA) B-2-36 at p. 155. (cited in the Eyeglass I Staff Report, p. 89 n. 206). AOA was testifying in favor of Medicare coverage for eye care.

592 Id. at p. 156.

In its testimony, AOA also stated that 85% of all serious injuries sustained by persons 65 and older are caused by falls; 25% of these relate directly to uncorrected vision problems.[593] This testimony indicates that a substantial number of elderly people are foregoing needed vision care.

Survey evidence also demonstrates that higher prices result in reduced purchases of eye care. Based on the results of an extensive nation-wide survey, Professors Alexandra and Lee Benham found that significantly fewer individuals purchased eyeglasses in a given year in states with higher prices.[594] This survey was conducted in 1970 and consisted of interviews with 10,000 individuals. The sample was drawn to overrepresent elderly individuals and individuals living in inner cities and in rural areas.[595]

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593 Id. at p. 156.

594 L. Benham and A. Benham, Regulating Through the Professions: A Perspective on Information Control, 18 J. L. & Econ. 421, 438 (Oct. 1975).

595 Id. at p. 428.

Nathan, in a footnote to their statement, stated that the Benhams' analysis is inadequate for two reasons. First, they stated that it mainly analyzed eyeglasses and not eye exams. Second, they stated that the Benhams classified markets on the basis of advertising in combination with commercial restrictions. Nathan study, Vol. I, Ex. 1, at p. 89 n. 1.

While it is true that the Benhams looked at eyeglass prices and purchases, the study results nevertheless have implications for vision care generally. First, eyeglasses are undeniably an important aspect of vision care. Second, although consumer's demand elasticity -- changes in purchasing behavior as price changes -- may be greater for eyeglasses than for eye exams, the Benhams' data provides some indication that consumers reduce (footnote continued)

In 1979, a second survey of 1,254 families, sponsored by General Mills, found that as a result of inflation, families had cut back on annual medical checkups, getting new glasses, dental work and various preventive health care techniques. Forty-eight percent of families said that they had cut back on such expenditures as a result of inflation; 56% of low-income families, 60% of minorities and 72% of single parents made this statement.[596] In its comment, NAOO also stated that, during the recent recession, the purchase cycle for vision care lengthened: consumers waited longer before obtaining eye exams or purchasing eyewear.[597]

Finally, Public Health Service data indicates that annual purchase and repair of eyeglasses increases with family income.[598] 1977 data indicated that there was a 25% increase in the number of persons who purchased or repaired eyeglasses in that year as family income increased from less than $12,000 to

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their expenditures for vision care as prices rise.

Regarding Nathan's second point, it is true that the Benhams' did not control for advertising in their analysis. Since advertising could have influenced people to purchase more eyeglasses, part of the increase in purchases found in the Study could have been attributable to advertising. Nevertheless, the conclusion we draw from their work remains valid: higher prices result in significantly fewer purchases.

596 M. Kernan, U.S. Health Profile, Washington Post, Apr. 26, 1979, at p. C-1, col. 4, B-2-37 (Cited in the Eyeglasses I Staff Report, p. 89 n. 208).

597 NAOO Comment at p. 2.

598 Eyeglasses and Contact Lenses: Purchases, Expenditures, and Sources of Payment, National Health Care Expenditures Study, Public Health Service, 1979, G-14 at p. 4.

$25,000 or more per year. These surveys indicates that monetary considerations influence health care expenditures, including vision care, and thus, that people are likely to cut-back such expenditures as prices rise.

Very few proponents of the restrictions addressed the question of the frequency of eye care. A few commenters did state that no one is going without eye care since special assistance is available for the indigent.[599] However, no evidence was presented by these commenters to indicate how extensive such programs are or under what circumstances they would apply. Moreover, these commenters did not address the point that consumers may be delaying purchases because of higher prices.

On the other hand, consumer groups testified that vision care is an out-of-pocket expense for all but the poorest consumers under limited circumstances.[600] In addition, a study by the Optical Manufacturers Association found that only 10-20% of all expenditures for eye examinations, eyeglasses and contact lenses are covered by any form of third-party payment. The remaining 80-90% is directly paid by the patient.[601] Further,

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599 See, e.g., Nathan study, Vol. I, Ex. 1 at pp. 109-110; J. Moye, Mississippi Optometrist, Tr. 428-29; J. Robinson, Secretary, North Carolina Board of Optometry, Tr. 3001.

600 See, e.g., H. Snyder, West Coast Director, Consumers Union, J-24(a) at p. 2 and Tr. 1059-60; J. Denning, President-elect, American Ass'n of Retired Persons, Tr. 60; E. Eggan, Director, American Ass'n of Retired Persons, J-37(a) at p. 6. Medicare does not, in general, cover vision care.

(footnote continued)

the survey data analyzed by the Benhams is directly relevant to this point since elderly individuals and individuals living in the inner city were overrepresented. While special programs may well be available for the very indigent under some circumstances, the impact of these programs appears to be limited.

Commercial practice restrictions may also affect consumers' access to vision care by restricting locations and the number of providers. By restricting the development of commercial firms, commercial practice restrictions likely reduce the number of firms in the marketplace. The record also indicates that commercial optometrists may be more conveniently located[602] and may be more frequently available on weekends and evenings.[603] These are additional reasons why restrictions on such firms may reduce accessibility and reduce the frequency of purchase of vision care.

ii. Effects of Specific Restrictions

While all of the restrictions tend to reduce the availability of optometric services, some evidence was also presented indicating how branch office restrictions, in particular, reduce accessibility. Such restrictions may

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601 Optical Manufacturers Association, National Consumer Eyewear Study III, April, 1984, cited in, NAOO Comment at p. 2.

602 See, NAOO Comment at p. 4. See also supra section III.B.3., "Restrictions on Mercantile Locations."

603 See, NAOO Comment at p. 3; NAOO Panel, Tr. 383-84.

particularly harm small communities that are unable to support a full-time practitioner.[604] Where areas remain unserved by optometrists, finding suitable eye care is more difficult, and consumers must incur additional search and travel costs to obtain it. In some instances, the increased costs and reduced availability of eye care are sufficient to cause some consumers to seek eye care less frequently or to forego eye care altogether.[605]

Proponents of these restrictions argue that unlimited branch offices actually may reduce the accessibility of optometric care. They state that many small communities cannot support more than one practitioner.[606] They argue that some optometrists would open part-time branch offices in small communities barely able to support a solo full-time optometrist. The result, they argue, might be that both optometrists might be forced out of practice, or that the part-time branch office practitioner might be the sole survivor, and that either way, the community would receive

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604 Branch offices may be a more effective way to serve small communities. An optometrist opening a branch office need not risk his or her entire practice in an area of relatively low demand for optometric services. Moreover, the multiple practice setting provides the opportunity to increase volume as a means to lower costs, thus making practice in lower demand areas potentially more profitable. And, if need be, the optometrist can further reduce costs by operating the small town branch office on a part-time basis, an option that may not be feasible for an O.D. relying on that office for his entire practice.

605 See e.g., J. Denning, President-elect, American Ass'n of Retired Persons, Tr. 58-60; H. Snyder, West Coast Director, Consumers Union, Tr. 1055-56, 1060.

606 See, e.g., L. Oxford, Executive Secretary, Oklahoma Optometric Ass'n, Tr. 2559.

less service than before.[607] Not only is this argument unsupported by factual evidence in the record, but even proponents of this view recognize that branch offices may be needed to provide optometric services to some communities that would otherwise go unserved.[608]

The AOA also disputes the conclusion that branch office restrictions may hinder entry into areas that would otherwise benefit from increased accessibility to optometric care. They state that, according to figures derived from the Department of Health and Human Services, the number of optometrists per 100,000 population is larger in states that restrict branch offices than in nonrestrictive states.[609] Thus, they argue that these restrictive states actually have greater access to care.[610] These figures do not demonstrate that the restrictive laws result

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607 Id. This argument was used to justify, in part, Oklahoma's current restriction prohibiting optometrists from establishing branches in areas served by at least one optometrist. See NAOO Comment, Appendix U.

608 For example, one stated rationale for lifting Oklahoma's total ban on branch offices was the suggestion by Oklahoma optometrists that some communities were completely lacking in any optometric care, and that branch offices could provide care in these areas. Id; L. Oxford, Executive Secretary, Oklahoma Optometric Ass'n, Tr. 2559. See also, supra section III.B.2., "Branch Office Restrictions."

609 AOA Comment at pp. 23-24.

610 Id. at 23. AOA quotes the BE Study as stating that the number of optometrists per capita is a measurement of the strength of price competition in a relevant market. The number of optometrists per capita was a variable the study's regression analysis which was used to control factors which may affect price other than the variable of interest in that study. That figure was never used in the study as a test for the strength of competition and its use as such in this instance is inaccurate.

in greater accessibility. Because the AOA did not correlate these figures with the restrictions at issue while holding other potential factors constant, it is impossible to draw any meaningful conclusions from this statistic. Many other factors, such as greater demand or higher prices for optometric services, could cause a variation in optometrists per capita.

In conclusion, the record demonstrates that commercial practice restrictions result in reduced accessibility of eye care to consumers. The evidence indicates that, as a result of the higher prices and reduced availability of eye care resulting from the restrictions, consumers are delaying, or even foregoing, the purchase of vision care. The evidence indicates that delayed vision care can result in inadequate eye care, including poor vision, untreated eye problems and undetected eye diseases. This aspect of eye care must also be considered in assessing the quality implications of commercial practice restrictions.

e. Effect on Preventing Deception

In addition to making claims about the quality implications of the restrictions, some commenters also claimed that trade name restrictions and branch office restrictions are needed to prevent deception. The evidence indicates, however, that use of trade name and branch offices are not inherently deceptive. Moreover, there is no evidence of widespread deception or that such restrictions actually decrease the incidence of deception. Further, any specific instances of deception which may be found

to occur can be dealt with through less-restrictive alternatives.

i. Trade Name Restrictions

(a) In General

Proponents of trade name bans point to various ways in which they believe trade names can be used to deceive consumers of optometric goods and services. Some commenters argue that consumer reliance on the quality reputation information conveyed by trade names is misleading because chain firms cannot provide uniform quality at different locations.[611] Some commenters claim that practitioners may deceive consumers by changing trade names when the practice's reputation is ruined by poor quality service or malpractice claims.[612] Other commenters note that because trade names can be bought and sold, an optometrist may use the reputation attached to a purchased trade name to deceptively acquire customers expecting to be treated by the new optometrist's predecessor.[613] In addition, some commenters argue

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611 RRNA Rebuttal, K-4 at p. 18; R. Baver, Indiana Optometrist, H-126 at pp. 1-2.

612 These commenters do not cite first-hand knowledge of any such occurrence, however. See, e.g., J. Crum, Kansas Optometrist, H-20 at p. 5; M. Raymon, California Optometrist, H-39 at p. 2; A. Gorz, President, Wisconsin Optometric Ass'n., H-40 at p. 2; R. Szabo, Indiana Optometrist, H-94 at p. 3; J. Honaker, President, Kentucky Board of Optometry, J-17 at p. 1.

613 See, e.g., J. Crum, Kansas Optometrist, H-20 at p. 5; K. Van Arsdall, Indiana Optometrist, H-97 at p 3. Most states have regulations permitting successors in practice to use the predecessor's name for a limited time, usually two years.

that trade names can be used to disguise unlicensed care[614] and high turnover,[615] and can create a false image of competition by having one owner use different trade names for different offices in the same market.[616]

These comments raise three questions. First, does the record establish whether trade names are inherently deceptive? Second, is deception in fact a widespread, significant concern? Finally, if so, is a ban on trade names necessary to prevent the deception? Based on the record, all three questions are easily answered in the negative.

First, the only comments suggesting that trade names are deceptive in all instances are claims that the alleged inability to provide standardized quality misleads consumers about the service they will receive. These commenters argue that consumer reliance on the quality reputation information conveyed by trade names is misplaced because chain firms cannot provide uniform quality at different locations.[617] Nathan cites data gathered in their New York survey in which individuals visited different branches of the same chain firms on thirteen occasions. According to the Nathan analysis, in 38% of these cases, a vision

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614 J. O'Connor, Indiana Optometrist, H-108 at p. 2.

615 R. Fiegel, Kansas Optometrist, H-65 at p. 2.

616 N. Otte, Indiana Optometrist, H-36 at p. 1; F. Neimann, Attorney, Texas Optometric Ass'n, J-23.

617 RRNA Rebuttal, K-4 at p. 18; R. Baver, Indiana Optometrist, H-126 at pp. 1-2.

problem was detected in one location of a firm and not another, and in 62% of the cases, case histories were deemed taken in one location but not another.[618] Nathan concludes from this data that quality care in chain firms varies widely from location to location.[619]

The significance of this data is undermined, however. First, the 62% figure is unreliable because of the methodology used by Nathan. The techniques used by Nathan to determine whether case histories were taken by the survey optometrists are not useful for comparison purposes because they were too subjective and resulted in considerable variation from optometrist to optometrist.[620]

Second, the significance of the 38% figure is unclear because of the lack of a standard of comparison. Since chain firms would never be able to reduce the variation to zero, the relevant question is whether chain firms have a lower variation in quality than optometrists in general. The Nathan data is incomplete without such a basis for comparison.

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618 RRNA Rebuttal, K-4 at pp. 18-19.

619 Id.

620 No consistent standard was used in determining whether a case history was taken. Some patients reported that a case history was taken if the optometrist asked one question about medical history, while other patients reported that no case history was taken unless the optometrist asked a number of questions. Thus, because there was no standardized procedure for determining case history, this data cannot be used to determine actual variation among providers. See A. Cahill, Economist, Nathan and Assoc., Tr. 2737-38, 2804.

Further, other data indicate that chain firms may have a lower variation in quality than optometrists in general. Calculations performed on data from the BE study show less variance in exam thoroughness for chain firms than for traditional providers.[621] In addition, calculations performed on the Nathan New York City study data show that prescription measurements varied less for chain firms than for traditional practices.[622] This data suggests that optometric chain firms may maintain a more constant level of quality than optometrists in general. Such a finding is also consistent with already discussed efforts of chain firms to maintain quality control at practice locations.

Consumers are not deceived unless their reasonable expectations concerning the level of quality are thwarted. The evidence fails to reveal that such has been the case, and it establishes that trade names are not inherently deceptive.

Second, the record does not establish that trade name use

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621 See J. Kwoka, Professor, George Washington Univ., J-12(a) at p. 10-11.

622 This analysis was performed by Valerie Cheh, a Ph.D. Student in economics. Ms. Cheh drew no conclusions about quality based on the calculations. Rebuttal Statement of V. Cheh, Economics student, K-16 at p. 2.

Ms. Cheh examined the prescriptions returned by subjects in that study and found that in a majority of the cases the range of the spherical and cylinder measurements was greater for the private practitioners than for the commercial practitioners. The presciptions contained the spherical and cylinder measurements, as well as other measurements in some instances. Thus, the data used by Ms. Cheh did not include the entire prescription written in all instances.

results in widespread deception. The record fails to reveal any empirical or even significant anecdotal evidence of actual deception, and certainly shows no widespread abuse.[623] Moreover, the state boards, whose duty it is to police the practice of optometry in their states, have failed to submit into the record evidence of cases involving the deceptive use of trade names.[624]

In the absence of other evidence, supporters of trade name bans often cite to the Supreme Court's opinion in Friedman v. Rogers, as providing evidence of actual instances of trade name deception.[625] The Court in Friedman concluded that a Texas ban

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[623] The record also reveal a few specific complaints concerning the quality of firms that utilize trade names. See, e.g., R. Fiegel, Kansas Optometrist, H-65 at p. 2; T. Ray, Optometrist, J-62 at p. 2; W. Sullins, Tennessee Optometrist, AOA trustee, Tr. 1553, H. Woodring, California Optometrist, Tr. 2355-60; C. Dabb, Former California Optical employee, Tr. 2443. However, much of this testimony, provides no basis for inferring that trade names were responsible for the problems cited or that consumers were deceived by use of the trade name. Moreover, evidence of limited alleged abuses, in the absence of evidence of more widespread abuse, is inadequate to link the alleged problems to the state restrictions at issue in this proceeding.

[624] We have received comments or testimony from officials in virtually all states. Dr. Robinson of the North Carolina Board noted violations of the state's restrictions on trade names (requiring that the word "optometry" be included in the trade name) but no consumer complaints of actual deception. See Statistical Breakdown of North Carolina State Board of Examiners in Optometry Complaint Log, J-80; J. Robinson, Secretary, North Carolina Board of Optometry, Tr. 2993-94. Our knowledge, however, may not be complete in that one state board refused to voluntarily submit information regarding their enforcement activities (New Jersey), and another submitted complaint files without indicating the nature of the charges involved (Maryland). Nonetheless, the best assumption is that the commenters would have submitted the best evidence they had to support their charges, and therefore, the absence of specific evidence suggests that none is available.
(footnote continued)

on trade names was not violative of the First Amendment because the state had experienced a history of deceptive trade name use which the state had a substantial interest in eliminating.[626] The facts of that case are of limited usefulness in the current proceeding,[627] and reflect a situation no longer extant in Texas. In 1984, the trade name ban at issue in Friedman was repealed by the Texas legislature.[628] The decision to permit trade names in Texas was apparently based on the state legislature's conclusion that the ban was no longer needed to protect Texas citizens from deception.[629] There has been no indication that trade names have resulted in deception in Texas since their use has been reauthorized.[630]

Third, while trade names undoubtedly have been and could continue to be used deceptively in at least some specific instances,[631] there is no evidence that deceptive trade name use

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625 440 U.S. 1 (1979). See, e.g., A. Crump, Nebraska Deputy Attorney General, E-20 at p. 6; A. Swarner, President, Alaska Optometric Ass'n, H-104; D. McBride, President, Montana Optometric Ass'n, J-57 at pp. 2-3. Depositions, interrogatories, and briefs in Friedman were submitted into the record to demonstrate instances of trade name deception in Texas. See F. Niemann, Counsel, Texas Optometric Ass'n, J-23(d)-(g).

626 440 U.S. 1.

627 The distinctions between Friedman and the current proceedings are discussed more fully at infra at section V.C., "Friedman v. Rogers."

628 Tex. Health and Safety Code Ann. §5.13.

629 R. Friedman, Former Chairman, Texas Optometry Board, Tr. 2406.

630 Id.
(footnote continued)

is any more common than deceptive advertising generally or that trade name bans actually reduce the incidence of deception. Further, the record indicates that trade name bans are not needed to prevent deception. All states already have complete authority to deal with deceptive practices even without regulations specifically addressed to trade name use.[632] Thus, the states have mechanisms at their disposal to curb any specific instances of deception which may occur.

(b) Trade Name Disclosure Requirements

As noted above, some states require that advertisements for optometric services disclose the names of all optometrists practicing under the advertiser's trade name or the names of all optometrists practicing at particularly advertised locations.[633] Proponents of these disclosure laws argue that

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631 See supra note 625.

632 For example, every state prohibits deception as part of its regulation of optometry, see chart, supra at pp. 33-46, and most states have general consumer protection or "little FTC" acts that prohibit deceptive practices. See e.g., Ala Code §8-19-1 et seq.; Ark. Stat Ann. §70-901 et seq.; Colo. Rev. Stat. §6-1-101 et seq.; Idaho Code §48-601 et seq.; Mass. Gen. Laws Ann. Ch. 93A §1 et seq. Other specific concerns about the potential deceptive use of trade names can be resolved by the states without resort to a trade name ban. For example, the allegations discussed above concerning optometrists escaping accountability by hiding behind trade names do not pose real problems because states currently require optometrists to post their licenses at their practice location. See, e.g., Ala Code § 34-22-20; Alaska Admin. Code tit. 12, §48.050; Ark. Admin. Reg. Art. V. §3; Cal. Bus. & Prof. Code §3075.

(footnote continued)

such disclosure is needed to prevent deception, claiming that consumers need information concerning who is providing optometric services before choosing a provider.[634]

The record indicates that these disclosure requirements are not needed to prevent deception for the same reasons that trade name usage in general is not deceptive. Proponents of these rules appear implicitly to assume that advertisements are nondeceptive only if they provide all of the information a consumer might possibly want in making a choice.[635] Advertisers do not carry this obligation. The use of a trade name without these disclosures does not deceive consumers as to who is providing eye care services. It provides some useful information concerning the firm, leaving to the consumer the choice of whether to pursue additional information as to who the firm employs.[636]

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633 See supra section III.B.4., "Restrictions on Trade Name Usage."

634 See, e.g., L. Harris, Kansas Optometrist, H-71 at p. 8; W. Kirby, Indiana Optometrist, H-107 at p. 2; T. Vail, Illinois Optometrist, H-115 at p. 5; J. Kintner, Indiana Optometrist, H-117 at p. 4; L. Asper, California Optometrist, H-148 at p. 2; R. Ireland, Indiana Optometrist, H-151 at p. 2; C. Beier, President, Kansas Board of Optometry, J-52 at p. 5.

635 See supra note 634. One possible exception could be if a patient makes a return visit to a firm, expecting to see his or her previous provider, but discovers that optometrist has left the firm. Not only could this occur in a traditional office that employs optometrists, but there is no allegation of any resulting harm to the consumer, who is free to call ahead or choose another optometrist. These commenters do not allege that trade names contain an implied representation that a firm will never change its staff.

636 These proponents also fail to state why such disclosures are necessary for meaningful choice.

ii. Branch Office Restrictions

Some commentors also state that the elimination of branch office restrictions will lead to deception.[637] These commentors believe consumers will be deceived because they will visit a practice location expecting to see the optometrist who owns the practice, but will instead be cared for by some other optometrist. The record does not contain evidence, however, that consumers have been deceived in this way or that they have been harmed by not knowing in advance who their optometrist will be.[638]

In conclusion, the record establishes that neither a firm's use of trade names nor a firm's opening of branch office's inherently deceives consumers. Further, there is no evidence that either trade name use or branch office practice has resulted in widespread deception or that bans on such activities actually decrease the incidence of deception. Any limited instances of

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637 See e.g., M. Starr, Nebraska Assistant Attorney General, E-20 at p.3; J. Honaker, President, Kentucky Board of Optometry, E-17 at p. 1; D. Kuwabara, Chairman, Hawaii Board of Optometry, E-34 at p. 4. The potential for deception occurring as a result of trade names used is discussed at infra section III.C.3.e., "Effect on Preventing Deception." The same analysis applies here, because arguments on both issues are predicated on the claim that consumers are not actually treated at the optometrist's office by the same practitioners they expected to see when they selected that office.

638 Should the state reasonably determine that deception is occurring, it could, consistent with the recommended rule, act to eliminate such deception.

deception which may be found to occur can be dealt with through less restrictive means.

f. Conclusion

The evidence indicates that state commercial practice restrictions not only fail to increase the quality of care for those who receive care but, in fact, reduce the frequency of eye care in the market. Thus, overall, the restrictions decrease the level of quality of optometric care in the market. Further, restrictions are not needed to prevent deception.

The BE and Contact Lens Studies, and, to a lesser extent, the Atlanta Survey, provide convincing, systematic evidence that, for consumers who receive care, the quality of care is not higher in markets with restrictions on commercial practice. The BE Study indicates that there is no difference in quality between markets with chain firms and markets without chain firms. The Contact Lens Study lead further supports to this conclusion, indicating that commercial optometrists fit cosmetic contact lenses at least as well as other providers. The Atlanta survey supports the same conclusion. No reliable survey evidence rebuts this conclusion. Other evidence on the record is anecdotal in nature and provides no information on systematic differences between markets with chain firms and markets without chain firms.

The evidence also clearly indicates that the higher prices associated with the restrictions reduce consumers access to

vision care. Some consumers may forego eye care entirely, while others delay their purchases, likely resulting in reduced vision and increased eye problems. When this aspect of eye care quality is considered, the evidence indicates that commercial practice restrictions reduced the level of quality in the market.

IV. PRESCRIPTION RELEASE

A. Introduction

On June 2, 1978, the Commission promulgated the Eyeglasses I Rule.[639] That rule, in pertinent part, requires optometrists and ophthalmologists to release to their patients copies of their eyeglass prescriptions immediately following eye examinations.[640] The rule also prohibits optometrists and ophthalmologists from charging additional fees for the prescriptions or from conditioning the availability of eye examinations on the purchase of ophthalmic goods.[641] The prescription release requirement was upheld by the U.S. Court of Appeals in 1980.[642]

In the Notice of Proposed Rulemaking (NPR) issued in January 1985, the Commission raised three questions regarding possible modifications to this prescription release requirement.[643] One, the Commission asked whether the prescription release requirement should be modified to require that eyeglass prescriptions be

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639 43 Fed. Reg. 23992 (1978) (codified at 16 C.F.R. §456).

640 Id.

641 Id. The rule also prohibits optometrists or ophthalmologists from waiving or disclaiming liability for the accuracy of the eye examination or the accuracy of goods dispensed by another seller. These sections of the prescription release rule are not at issue in this proceeding and no modifications to these sections have been proposed.

642 American Optometric Association v. FTC, 626 F.2d 896 (D.C. Cir. 1980).

643 50 Fed. Reg. 602-03 (Jan. 4, 1985).

given to patients only in those instances where patients request them. Two, the Commission asked whether instead the requirement should be modified to require optometrists and ophthalmologists only to offer, rather than give, eyeglass prescriptions to all of their patients. Three, the Commission asked whether the prescription release requirement should be repealed altogether.

These questions were raised, in part, based on a 1980 staff recommendation that the Commission modify the rule to require release of the prescription only if the consumer asks for it.[644] While the Commission declined to propose the modification to the rule as recommended by staff, it did raise the questions indicated.

Staff now recommends that the Commission modify the rule to require practitioners to release prescriptions only upon request of the patient, based on record evidence that consumers are generally knowledgeable enough to request eyeglass prescriptions if they want them and that practitioners release them upon request. For the same reasons, staff recommends that the Commission not modify the rule to require practitioners to offer a prescription to every patient regardless of whether the patient requests it. Further, staff does not recommend repeal of the rule altogether.

In the NPR, the Commission also raised three additional

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644 Initial Staff Report at p. 248; Memo to the Commission from Carol Crawford, Director, BCP, April 13, 1984, B-1 at pp. 5-6.

questions regarding possible extensions of the prescription release requirement. One, the Commission asked whether optometrists and ophthalmologists should be required to release to patients complete contact lens prescriptions. The record does not support a recommended rule in this area. It does not contain sufficient reliable evidence to permit a conclusion that refusal to release contact lenses is a prevalent practice or that there are no quality justifications for refusal to release.

Two, the Commission asked whether optometrists and ophthalmologists should be required to release duplicate copies of prescriptions to patients who lose or misplace their original copies. The record contains no evidence that practitioners refuse to release duplicate copies of eyeglass prescriptions to consumers who request and therefore provides no basis for a recommendation that practitioners should be required to release duplicate copies of prescriptions.

Three, the Commission asked whether eyeglass dispensers should be required to return the eyeglass prescription to patients after filling the prescription. The record contains no significant evidence that dispensers refuse to return prescriptions to patients. Therefore, such a requirement is not warranted by the record.

Below, we discuss the record evidence on each of these questions.

B. Spectacle Prescription Release

1. Introduction

The Commission promulgated the Eyeglasses I prescription release requirement based on evidence that many consumers were being deterred from comparison shopping for eyeglasses because optometrists and ophthalmologists refused to release eyeglass prescriptions even when requested to do so, refused to conduct an examination unless the patient agreed to purchase eyeglasses from the practitioner, or charged an additional fee, beyond the examination fee, for release of the prescription.[645] Studies showed that as many as 50% of optometrists refused to release the prescription or imposed some restriction on the availability of the prescription such as an extra fee.[646]

In addition to prohibiting these practices, the rule also required release of the prescription after every exam, regardless of whether the patient requests it. The Commission promulgated this requirement based on a finding of "consumers' lack of awareness that the purchase of eyeglasses need not be a unitary process" — i.e., that purchasing eyeglasses can be separated

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[645] In addition, some practitioners included potentially intimidating disclaimers of liability on the prescriptions. Statements of Basis and Purpose, 43 Fed. Reg. 23992, 23998 (1978).

[646] Eyes I Staff Report, B-2-52-1 at p. 252.

from the process of obtaining an eye exam.[647] The automatic release provision was imposed as a remedial measure. The Commission also noted that the mandatory requirement would simplify enforcement of the rule and that there was no evidence of any significant burden attendant upon release in every instance.[648]

The record evidence indicates that market conditions have changed significantly. Refractionists are no longer refusing to release prescriptions upon request and few are charging extra for the prescription. Thus, the major abuses against which the rule was directed are no longer occurring.

Many refractionists, however, apparently are not complying with the automatic release, or remedial provision, of the rule. Thus, current violators of the rule are only violating its technical requirements.

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647 Advertising of Ophthalmic Goods and Services, Statement of Basis and Purpose, 43 Fed. Reg. 23992, 23998 (1978).

Survey evidence revealed that:

> Sizeable numbers [of consumers] do not differentiate between the process of an eye exam and filling the prescription.

Eyeglasses I Staff Report, B-2-52-1 at p. 268, quoting Outline of testimony of Paul A. Fine, California Citizen Action Group.

Survey evidence also showed that 44% of consumers said they had never thought about going elsewhere to purchase their eyeglasses and almost 20% did not know that they could go somewhere else. Eyeglasses I Staff Report, B-2-52-1 at p. 268.

648 43 Fed. Reg. 23992, 23998 (1978).

The evidence also indicates that a large majority of consumers are now generally knowledgeable about the availability of eyeglass prescriptions. Although they may not be aware of their exact legal rights to a prescription, most appear to have sufficient knowledge to request a prescription if they want one. In addition, further increases in consumer knowledge are likely as a result of advertising by opticians and dissemination of information through word-of-mouth. Thus, since refractionists are releasing prescriptions upon request, those consumers who desire to shop around are able to do so.

Based on this evidence, staff recommends that the rule be modified to require optometrists and ophthalmologists to release prescriptions only upon request of the patient.

2. Evidence on the Record -- Prescription Release Practices and Consumer Knowledge

a. Market Facts Study

In December 1981, the Commission released a study entitled "FTC Eyeglasses Study: An Evaluation of the Prescription Release Requirement."[649] The study, developed by the staff in conjunction with the Market Facts Public Sector Research Group, was designed to measure eye doctors' compliance with the prescription release requirement and consumer knowledge about

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649 B-6. Hereinafter referred to as "Market Facts Study."

prescriptions.

i. Methodology

The Market Facts Study was conducted using a study sample composed of consumers who had received eye examinations within the previous twelve months.[650] The sample was derived from the Market Facts Consumer Mail Panel, a pool of over 100,000 households selected to provide a demographic sample representative of the nation's population. Thirty-two hundred households were randomly selected from this pool, with 50% drawn from urban households and 50% from rural households.[651] The members of this sample were sent brief screening questionnaires to determine whether they met the sample profile. Of the 2,634 responses, a total of 1,248 households had at least one member with recent eye exam experience and were sent the survey questionnaire.[652] The final data consisted of 986 completed consumer responses.[653]

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650 Id. at p. 7. The sample also contained persons accompanying a child or elderly family member to an eye exam, but only if these persons were present during the entire exam and had primary responsibility for the purchase of eyeglasses. Id.

651 Id. at pp. 7, 8.

652 Id. The survey questionnaire is duplicated in Appendix C of the study.

653 Id. at p. 8. 1,058, or 84.7%, of the questionnaires were returned. Of these, 72 were disqualified. Nearly half (47.8%) were excluded from the analysis of professional compliance with the rule because these consumers did not require new eyeglasses, did not adequately recall the eye exam, required contact lenses or did not complete the entire questionnaire. Id. at 10.

The study was conducted to reflect the nationwide experiences of consumers as well as the differences between urban and rural consumers.[654] The analysis used unweighted data to compare the urban-rural consumer differences. When examining nationwide consumer experiences, the analysis weighted the sample to reflect the correct urban-rural proportions of the U.S. population.[655]

ii. Study results

The Study found that all consumers who asked for a prescription received one.[656] Thus, of all consumers who reported that their refractionists had not complied with the rule, none had asked for the prescription.[657]

The survey also found that less than one percent of consumers were told that they would have to pay extra for their prescription.[658] Also, only 1.2% of consumers were told that

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654 The study concluded that urban consumers were somewhat more knowledgeable than rural consumer about their right to their prescriptions, more likely to ask for their prescription, and more likely to comparison shop for eyeglasses. Id.

655 Id. at p. 8. The weighting procedures are described in Appendix A of the study.

656 Of consumers who asked before ordering eyeglasses, 100% reported that they received a prescription before ordering or were told before ordering that they could have a copy of their prescription if they desire one. Consumers who asked after ordering also received one or were told that they could have the prescription. Id. at p. 21.

657 Id.

(footnote continued)

they would have to purchase glasses from the examining doctor.[659]

In addition, the study measured both "technical" and "substantial" compliance with the requirements of the prescription release rule. Here the analysis did not distinquish between patients who asked and those who did not ask. 37.3 percent of refractionists were found to be in technical compliance with the rule, meaning that they either gave the patient a prescription immediately following the examination or told patients that they could have a copy if they paid for the exam.[660] An additional 18.9 percent of refractionist were in substantial compliance with the rule, meaning that they gave the patient a prescription after the patient looked at frames, but before ordering glasses, or offered the prescription any time before the consumer ordered eyeglasses.[661] 44.1% of refractionists did not comply with the rule, in that they did not provide or inform consumers that their prescription was available, or first mentioned the prescription after the consumer ordered eyeglasses.[662] Among consumers who did not ask for a

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658 Id at p. 21.

659 Id. at p. 23.

660 Id. at p. 11. 46% of these patients asked for the prescription and 44% did not ask.

661 Id at p. 14. Those in substantial compliance were in technical violation of the rule because they failed to provide the prescription immediately following the eye exam. They were considered to have substantially complied because the consumer had the opportunity to use the prescription to shop around for eyeglasses before ordering.

662 Id. at p. 16.

prescription, 58% reported that their eye doctor did not release a prescription.[663]

The second major purpose of the Market Facts Study was to assess the consumers' level of knowledge about eyeglass prescriptions and their knowledge of their ability to purchase eyeglasses from someone other than the examining doctor. To assess level of knowledge mail panel members were asked to respond to three questions: two true-false about knowledge of prescriptions and one (for those who did not ask or consider asking) regarding why they did not ask for a prescription. Over 94% indicated they knew (correctly) that they did not have to purchase eyeglasses from the examining eye doctor and that they could ask for an eyeglass prescription from the doctor after an examination.[664] In addition, among those who did not ask or consider asking for a prescription, only 3.7% indicated they did not know about eyeglass prescription. 85.9% of consumers were judged "knowledgeable" about prescriptions -- answers to all three questions were combined in defining "knowledgeable." The study data also indicated that consumer knowledge was almost equally extensive among consumers who were buying glasses for the first time as among replacement buyers.[665]

Consumer's knowledge of the exact legal requirements of the

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663 Id. at p. 20.

664 Id. at p. 27.

665 T. Maronick, Ph. D., FTC Staff, J-20 at pp. 7-8.

rule was found to be lower. 38% of consumers knew that they were automatically entitled to their eyeglass prescription.[666] 45.7% mistakenly believed that they were entitled to the prescription only upon request, and 18% wrongly believed that eye doctors were entitled to charge extra if the consumer asked for a prescription.[667]

iii. Comments about the Study

Comments about the Market Facts survey centered on three issues: that the study sample was not representative, that the survey knowledge questions were poorly designed, and that the study draws conclusions which mischaracterize the study results.

Commenters criticized the use of a consumer mail panel as the source of the survey sample.[668] They argued that a voluntary panel of consumers recruited by Market Facts is not representative of persons across the country in the way that a random sample would be.[669] They also stated that the sample participants would likely be more sensitive to consumer issues, more practiced in responding to consumer mail questionnaires, and therefore more likely to demonstrate higher than average consumer awareness.[670]

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666 Market Facts Study, supra note 649 at p. 30.

667 Id.

668 See Rebuttal Statement of AARP, K-24 at p. 1.

669 Id.
(footnote continued)

Although the study was not drawn in a random fashion and does not strictly fulfill the criteria of probability samples, the study was designed to be representative of the U.S. population.[671] The sample was balanced against census figures for certain demographic variables, including U.S. Census Region, population density, household income, and age.[672] Further, the Market Facts mail panel is periodically updated, and families replaced, so that panel members would not be expected to become too familiar with consumer issues simply by virtue of being part of the mail panel.[673] As a result, the survey provides data generalized to the total population because it is reasonably representative of general population.[674]

Another criticism focused on the nature and phrasing of questions regarding consumer knowledge in the survey questionnaire.[675] Critics argued that poorly-phrased questions

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670 Id.

671 Market Facts Study, supra note 649 at p. 9; T. Maronick, Ph.D., FTC staff, J-20(a), pp. 3-4.

672 Market Facts Study, supra note 649 at p. 9, Appendix A-1. See also T. Maronick, Ph.D., FTC staff, J-20(a), pp. 3-4.

673 Market Facts study, supra note 649 at p. 7.

674 T. Maronick, Ph.D., FTC staff, J-20(a) at p. 4.

675 Some commenters argued that because thousands of consumers become first-time wearers each year, a finding that consumers are currently knowledgeable does not mean that they will remain aware in the future. See OAA Comment at p. 25. Although the Market Facts study controlled for first-time wearers, these commenters stated that the study was conducted in an environment in which mandatory release was in effect, and that a subsequent modification of the rule could reduce the awareness of first-time eyeglass wearers.

caused results that overstated the percentage of consumers judged "knowledgeable" about prescriptions.[676] These critics stated that the knowledge questions could be correctly answered by consumers without knowledge about prescriptions. Thus, one commenter stated, a question asking whether a consumer must purchase eyeglasses from the examiner could be misinterpreted and correctly answered false because consumers may know that they cannot be compelled to purchase anything they do not want. The commenter also stated that a second question asking whether a consumer may ask the doctor for his or her prescription could be answered yes because consumers may know that they can always ask for anything.[677] Because consumers correctly responding to these questions were classified as knowledgeable about prescriptions, critics argued that the study confuses generally aware consumers with those knowledgeable on this particular issue.

Critics also questioned the Study results showing that of all consumers who failed to ask for their prescription, only 3.7% did so because they did not know about eyeglass prescriptions. They stated that this figure is open to question, in that it is possible that some consumers who did not know about prescriptions may have responded with other reasons for not requesting a prescription.[678]

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676 AARP Rebuttal, K-24 at p. 2. Staff notes that AARP buttresses this argument in part by comparison with its own telephone survey, and that similar criticism of the wording of the AARP questionnaire has been raised during these proceedings. See infra section IV.B.2.b., "AARP Study."

677 AARP Rebuttal, K-24 at p. 2.
(footnote continued)

While it is true that some consumers may have misinterpreted the questions or guessed the answers, we do not believe that any such problems would so substantially alter the results as to change the basic conclusion that a large majority of consumers are knowledgeable enough to request a prescription. Consumers are likely to interpret questions in a common-sense way. For example, the first knowledge question asks "once a person decides where to have his eyes examined, he must purchase his eyeglasses from his doctor."[679] The average consumer is likely to assume, in answering this question, that the consumer will follow the doctor's advice to obtain eyeglasses. The interpretation suggested by critics, that the mail panel member will realize that a consumer could decline to follow the doctor's advice and not obtain eyeglasses at all, is a possible, but not a likely reading of the question. Further, while some consumers may have

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678 The question presented five alternative responses to why the consumer did not ask for a prescription. Thus, even if a consumer did not know to ask for his prescription, he may have picked another response, such as "I did not want one because I decided not to get new glasses" or "the doctor gave me the prescription before I could ask," if these were also true. Market Facts study, supra note 649 at Appendix A.

The study results are also mischaracterized, according to this commenter, in that it concludes that 63% of consumers said they did not ask for their prescription because they wanted tc "buy from the doctor." It states that using this data to conclude that these consumers do not require their prescriptions immediately following the examination is inaccurate because it creates the inference that consumers made a reasoned choice tc purchase eyeglasses from their doctors rather than responding to pressures from the doctor-patient relationship. It argues that the study should have explored the 63% figure further. OAA Comment at p. 23.

679 Market Facts study, supra note 649 at p. 27.

simply been able to guess the correct answer based on general awareness of consumer rights rather than knowledge of the specific issues, it is also likely that such generally aware consumers will have sufficient knowledge to request a prescription, even if they do not know whether they are legally entitled to one. Since over 94% of consumers correctly responded to each of these questions, even if this overstates consumer knowledge to some degree, the conclusion remains that a large majority of consumers are knowledgeable enough to request an eyeglass prescription if they want one.

Finally, at least one commenter argued that even if statistically valid, the study mischaracterizes its results.[680] According to this argument, compliance with the rule is overestimated by the survey because it mischaracterizes "substantial compliance" as a form of compliance. It argues that this category includes refractionists who may have subverted the supposed underlying purpose of the rule by holding the consumer "captive" for selling purposes before offering to release the prescription.[681] Thus, it contends that "substantial compliance" is not really compliance at all. However, this argument ignores that substantially complying refractionists do make prescriptions available to consumers, and that the rule was not intended to prevent consumers from receiving a sales pitch together with the prescription.

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680 OAA Comment, at p. 22.

681 Id. at 23.

b. AARP Study

In addition to the Market Facts Survey, a second survey regarding eyeglass prescriptions was presented by the American Association of Retired Persons ("AARP"). In the spring of 1985, AARP commissioned the firm of Hamilton and Staff, Inc. to conduct a nationwide telephone survey of older Americans concerning their familiarity with eyeglass prescriptions. AARP stated that the results of this survey contradict the findings of the Market Facts study. The AARP survey found that many refractionists were not complying with the automatic release requirement of the rule and that many consumers are unaware of their rights with respect to prescriptions.[682] The survey did not examine whether consumers who asked for their prescriptions received them and did not examine general consumer knowledge about prescriptions.

The methodology of the AARP survey is subject to serious criticism regarding both sampling technique and the form of the survey questionnaire.[683] The most serious criticism raised about

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682 AARP Survey, J-37(b) at p. 1 (Attachment to Statement of E. Eggan, Director, American Ass'n of Retired Persons), hereinafter referred to as "AARP Survey." The survey found that 47% of the sample said that they did not receive a prescription. The survey also found that 32% of consumers who did not receive a prescription stated that they did not know to ask for one. It also found that 56% of older consumers knew that if a person decided to purchase eyeglasses from someone other than the examining doctor, he would not need to get a new eye examination. AARP Survey at pp. 2-4.

683 According to its critics, the AARP survey sample is not representative of the population being measured (Americans over (footnote continued)

the AARP Study concerns the manner in which the survey questionnaire was constructed and presented to respondents. One concern relates to the dependence of the study on the respondents' recall ability. The respondents were asked to recall events from their last eye examination, regardless of how long ago it occurred.[684]

Criticism about the questionnaire also centers on the

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50). They argue that the survey did not attempt to compare or control for possible differences between respondents and the nonresponse groups (persons who refused to participate and persons not at home when the interviews attempted to call). They further argue that the sample was not demographically or geographically balanced. For example, they cite U.S. Census figures to indicate that the AARP sample substantially underrepresented higher income older Americans. This underrepresentation allegedly resulted in bias in finding that lower income persons were less likely to receive their eyeglass prescription. Rebuttal Submission of RRNA, K-8 at p-10.

Criticism was also directed at the interpretation and presentation of the study results. Respondents answering "don't know" to many questions were categorized with other categories to overstate the lack of consumer awareness. For example, the 32% of respondents who stated that they did not receive a prescription because they did not know to ask were categorized together with an additional 26% who responded that they did not know why they did not receive their prescription. Id. at 13. This interpretation of the results would severely bias the study's conclusions against findings of consumer knowledge. No significance in the survey findings should be ascribed to respondents who cannot answer the questions.

Finally, critics argue that data showing the number of respondents who would have purchased eyeglasses elsewhere if they had received their prescription cannot be relied upon because the data was not derived from or cross-tabulated with respondents who said they didn't need a prescription. Id. at 14.

684 Id. at 2-3. RRNA notes that events possibly five years or more in the past could not be recalled accurately, yet respondents may nonetheless attempt to answer questions based on those events. Id. at 3-4. In contrast, the Market Facts study limited the sample to persons who had eye exams within the past year, thus minimizing the danger of faulty recall.

construction or wording of the questions. For example, the first question in the survey was, "The last time you had your eyes examined, did you get a copy of your prescription or not?"[685] Commenters note that use of "or not" at the end of the question may be viewed as a confusing and inadequate means of expressing a second alternative, and may lead to some inaccurate responses.[686] The "or not" ending was also used in questions relating to consumer knowledge. Similar criticism of ambiguity was raised for other questions.[687]

Unfortunately, AARP decided not to respond to these criticisms in their rebuttal or testimony and decided not to make any of the survey authors available for cross-examination. The criticisms point to major flaws in the survey's methodology which, if left unexplained, undermine our ability to rely on any of the survey results. Due to the apparent inadequacies in the survey, and AARP's failure or inability to respond, staff must conclude that the study figures cannot be relied upon. While the AARP survey may indicate that some older Americans have not received their eyeglass prescriptions and do not know about the current rule, it does not provide any evidence to undercut the findings of the Market Facts survey.

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685 Id. at p. 5, reprinted from J-37(b), p. A-3.

686 Id. at p. 5. Commenters also notes the possibility that some respondents may have answered question 1 in the negative because they were offered a prescription but chose not to take it. Id. at p. 6.

687 Id. at pp. 7-8.

c. Other Evidence Regarding Prescription Release Practices and Consumer Knowledge

Little additional evidence was offered on the issue of optometrists' prescription release practices. No evidence was presented showing any refusals by optometrists to provide prescriptions upon request.

Some additional opinion and anecdotal evidence was presented on the issue of consumer knowledge. AARP pointed to 757 letters received in response to an informative article in its newsletter from elderly consumers who were unaware of their right to an eyeglass prescription.[688] These letters apparently related to consumers' knowledge about their legal rights rather than general knowledge about access to a prescription. Other commenters, on the other hand, argued that consumers are now aware of their rights.[689]

The record does indicate that consumer knowledge likely has increased since 1981 when the survey was conducted, and is likely to continue to increase. Extensive advertising by opticians has undoubtedly contributed to increased consumer awareness. For example, many opticians advertise "prescriptions filled" or "bring your prescription to us."[690] Such notices, while not

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688 Rebuttal Statement of AARP, K-23 p. 6.

689 See, e.g., Comment of AOA, H-81 at pp. 55-56.

(footnote continued)

necessarily sufficient to fully inform consumers about prescriptions, may well be sufficient to trigger a further inquiry by consumers about the availability and use of eyeglass prescriptions. This may be especially true when accompanied by attractive prices for eyeglasses. Thus, consumers may well learn about prescriptions and comparison shopping either from such advertisements themselves, or from a subsequent inquiry that such ads could trigger. Further, since consumers often learn about vision care purchases from friends or relatives, consumer knowledge can be expected to be gradually disseminated to larger numbers of people.

d. Conclusions

i. Prescription Release Practices

The record clearly establishes that optometrists and ophthalmologists are now releasing eyeglass prescriptions upon request and that only a small percentage of refractionists are charging extra for release of the prescription. The Market Facts Survey provides reliable evidence demonstrating that all consumers who requested eyeglass prescriptions received them and less than one percent of consumers were told that they would have to pay extra for the prescription.

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690 See, e.g., New York City Yellow Pages, 1985, K-21 at Appendix E (attachment to Rebuttal Statement of J. Mulholland and R. Kinscheck, FTC staff); Advertisement of Vision World, Little Rock, Arkansas, K-2 at A-7 (Attachment of Rebuttal Statement of RRNA).

While the record does establish that many eye doctors are complying with the automatic release, or remedial, provision of the rule, a sizeable number are not. The Market Facts survey found that 44% of all refractionists -- none of whom had been asked for a prescription -- were reported as not releasing the prescriptions.

ii. Consumer Knowledge

The record indicates that a large majority of consumers are knowledgeable enough to request a prescription if they want one. The Market Facts survey found that more than 94% of consumers correctly answered the knowledge questions. While this may overstate consumer knowledge to some degree, any potential problems with the wording of the knowledge questions are not so substantial as to alter the basic finding that a large majority of consumers are knowledgeable enough to request eyeglass prescriptions if they want them. Moreover, consumer knowledge has likely increased since the survey was conducted, and is likely to continue to increase, as a result of advertising by opticians.

3. Costs Imposed by the Rule

A third issue relates to the costs imposed on refractionists by the current rule. Many optometrists and other commenters stated that mandatory prescription release imposes unnecessary

costs on optometrists and ophthalmologists by forcing them to write out prescriptions even when consumers do not need or want them.[691] They argued that writing the prescription takes time that could otherwise be spent examining other patients.[692] Underlying many of these complaints may well be the belief that the rule, in effect, requires refractionists to alert consumers to the fact that the consumer is free to patronize the refractionist's competitor.[693]

Other commenters disputed that there was any significant burden, stating that medical doctors routinely write out prescriptions for all patients requiring treatment. These commenters stated that prescriptions are part of the eye examination, and that the minimal cost of providing a prescription is already paid for by the patient.[694] They stated that because the examiner must enter the prescription in his own records, or draft a laboratory work order, even if a copy is not released to the patient, the additional burden of providing a

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691 See, e.g., R. Johnston, Virginia Ophthalmologist, H-8 at p. 1; L. Harris, Kansas Optometrist, H-71 at p. 9.

692 Other doctors complained of increased stationary costs for prescription forms. See e.g., R. Johnston, Virginia Ophthalmologist, H-8, p. 1.

693 See, e.g., NAOO Comment at p. 93. The NAOO subsequently rebutted its own comment regarding prescription release. NAOO Rebuttal, K-1 at p. 28.

694 See e.g., J. Denning, President-elect, American Ass'n of Retired Persons, Statement, J-2 at p. 3; D. Klauer, Vice President, OAA, J-15 at pp. 9-10; H. Snyder, West Coast Director, Consumers Union, J-24 at p. 4; J. Tiernan, Director, California Ass'n of Dispensing Opticians, J-30 at p. 4; F. Rozak, NAOO Panel, Tr. 329.

copy to the patient at the time of the exam is not great.[695]

The real issue is whether eye doctors are being forced, by the rule, to write significant numbers of prescriptions for consumers who do not want them or use them. Few, if any, optometrists object to the burden involved in writing prescriptions for consumers who want them. Many optometrists do object, however, to the wasted time and effort in writing prescriptions for consumers who do not want or use them. In the next section, we discuss the extent to which consumers use prescriptions which they did not ask for.

In addition to the potential burdens the rule may place on optometrists, some commenters stated that the rule creates problems for some consumers. They stated that some consumers are confused when they receive prescriptions following an eye examination when they do not need a change in their prescriptions. In such instances, some consumers may erroneously believe that they need to purchase new eyeglasses when none are in fact needed, or that the doctor does not wish to fill the prescription.[696] While this type of problem may well occur, there is no evidence that it is prevalent.

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695 Many optometrists who claim that writing a prescription takes excessive time emphasize the time it takes to look the prescription up from the patients' records. Such problems occur only when patients request the prescriptions after the initial exam. L. Harris, Kansas Optometrist, H-71 at p. 8; E. McCrary, Maryland Optometrist, Tr. 186-91.

696 See e.g., T. Vail Illinois Optometrist, H-115; Jonathan Kintner, Indiana Optometrist, H-117.

4. Consumer Benefit from Automatic Release Provision

The fact that the vast majority of consumers are knowledgeable enough to ask for a prescription if they want one suggests that consumers who do not ask generally want to purchase from the examining practitioner. However, there may well be a small group of consumers who benefit from the automatic release provision, either because they do not have sufficient knowledge to ask, do not consider asking or are too shy or hesitate to ask.

Proponents of automatic prescription release argued that this requirement is needed to preserve the consumers' "unencumbered right" to purchase eyeglasses from providers of their own choice.[697] They argued that unless eyeglass prescriptions are released automatically by the examiners as part of the examination process, many consumers who might otherwise shop elsewhere for eyeglasses will be unable to do so because they will not receive their prescriptions.

According to some commenters, due to sales pressure by the optometrist[698] or undue deference by the consumer to the optometrist,[699] consumers may be too hesitant to ask for their

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697 H. Snyder, West Coast Director, Consumers Union of U.S. Inc., J-24(a) at p. 4.

698 See, e.g., OAA Comment at p. 23; B. Sturm, California Optometrist, J-28 at p. 1; M. Tiernan, Director, California Ass'n of Dispensing Opticians, Tr. 1279.

699 See supra note 698.

prescription. They stated that because patients tend to defer to the doctor's superior expertise, and because patients may be unwilling to risk offending their doctors,[700] they may not feel comfortable requesting their prescription.[701]

One finding of the Market Facts Survey sheds light on the extent to which consumers who receive a prescription without asking use that prescription. The survey examined the number of consumers who purchased eyeglasses elsewhere among consumers who did not ask for their prescriptions (and would not have asked)[702] but who received them.[703] The study found that only 11% of consumers who received their prescription without asking purchased eyeglasses elsewhere. This could be because these

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700 Id.

701 Rebuttal Statement of AARP, K-23 at p. 6. These commenters argued that the Market Facts study should have explored this effect, and that its failure to do so renders its results unreliable. The study found that 63.9 percent of consumers did not ask for their prescription because they wanted to "buy from the doctor." Market Facts survey, supra note 649 at p. 26. Commenters argued that the study ignored the possibility that consumers would have chosen to comparison shop if freed from overreaching by their doctors. The commenters also stated that the potential for overreaching was made even more apparent by the Market Facts finding that many optometrists were in "substantial compliance" with the rule, speculating that these providers tried to influence their consumers with a sales pitch prior to releasing the prescription.

702 Consumers who received their prescriptions were asked whether they would have asked for the prescription if they had not received it. Consumers who stated that they would not have asked even if they had not received the prescription were grouped with consumers who did not ask. Thus, consumers who did not ask but stated that they would have asked if they had not received the prescription were excluded from this analysis.

703 Market Facts survey, supra note 649 at p. 37.

consumers were not knowledgeable about prescriptions. (89% of these consumers purchased from the examining eye doctor.)

The study found that approximately 51% of consumers who should have received a prescription under the rule did not ask (and would not have asked).[704] If all of these 51% had received a prescription, the study data suggest that 11% of them would purchase eyeglasses elsewhere. Thus, it can be roughly estimated that approximately 5-6% of all consumers covered by the rule might have benefited from the mandatory release provision. A small percentage of consumers appear to receive direct benefits from the mandatory release provision.

5. Arguments for and Against Modification

The record contains numerous comments and testimony by optometrists, opticians, professional associations, state boards and consumer groups expressing their views on the issue of prescription release. Generally, the current mandatory release rule is supported by consumer groups, opticians, the NAOO, and some independent optometrists and state boards. Many traditional optometrists, the AOA, and most state boards and associations favor a complete repeal or at least some modification of the rule's release requirement.

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704 Id. at p. 32.

6. Recommendations

a. "Upon-Request" Standard

Staff recommends that the prescription release requirement be amended to require optometrists and ophthalmologists to release the prescription upon request of the patient. This would eliminate the largely unnecessary remedial provision of the rule.

The record indicates that market conditions have changed significantly since the rule was promulgated. Refractionists are now releasing prescriptions to patients who request them and are rarely charging extra for their release. Thus, refractionists are no longer engaging in the abuses against which the rule was directed. Instead, only violations of the remedial provision of the rule are occurring.

The record further indicates that the vast majority of consumers are sufficiently knowledgeable that they can request an eyeglass prescription. Further, advertising by opticians can be expected to continue to alert consumers to the possibility of using prescriptions to comparison shop, as it apparently has done in the past. Thus, increasing numbers of consumers can be expected to become knowledgeable about prescriptions, as they learn from advertisement, experience or inquires to friends and relatives. Thus, consumer knowledge is likely to continue to increase.

The record indicates that only a small group of consumers may be benefiting from the remedial provisions of the rule; at most, roughly 5-6% of consumers covered by the rule may use a prescription which they received without asking and shop elsewhere for eyeglasses. Thus, the total consumer benefit from the remedial provision appears to be small, and, in many instances optometrists and ophthalmologists are being forced to release prescriptions to consumers who don't want or need them.

An additional reason for staff's recommendation relates to the enforcement problems connected with the mandatory release requirement. The Commission promulgated the remedial provision of the Eyeglasses I rule based, in part, on a conclusion that this requirement would simplify enforcement of the rule and avoid "an evidentiary squabble" over whether or not the consumer had requested the prescription.[705] Based on staff's experience in enforcing this rule, however, we have found that the requirement does not ease the Commission's enforcement burden but, in fact, increases it.

One, since refractionists are releasing the prescription upon request, and, in general, not charging extra, the only rule violations brought to our attention have involved optometrists and ophthalmologists who failed to release the prescription in every instance, while releasing it upon request. An "upon request" standard would entail virtually no enforcement effort

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705 43 Fed. Reg. at 23998.

since refractionists are complying with this requirement. Under the current rule however, the Commission is faced with the prospect of bringing enforcement actions against individual optometrists who are violating only the remedial provision of the rule.

Two, the automatic release requirement does not avoid an "evidentiary squabble." Under the current rule, an "evidentiary squabble" could develop over whether the refractionist had released the prescription. Whether or not an optometrist has released a prescription cannot, in most cases, be ascertained by documentary evidence. Thus, under either the automatic release requirement or the "upon-request" standard, the Commission would rely upon evidence presented by consumers to document a rule violation. Thus, enforcing the "upon request" standard presents no significantly greater evidentiary problems than the current mandatory release provision.

For these reasons the major justifications for the remedial requirement are no longer present. Since refractionists are releasing prescriptions upon request and since a large majority of consumers have sufficient knowledge to request a prescription if they want one, consumers who desire to comparison shop can do so.

b. Repeal of the Rule

Staff does not recommend complete repeal of the prescription

release requirement. While arguments can be made in favor of this course, on balance, the evidence does not demonstrate that the rule is no longer needed.

The fact that refractionists are now releasing prescriptions upon request and that consumers are generally knowledgeable suggests that the rule may no longer be necessary. Optometrists and ophthalmologists may voluntarily continue their current practices even in the absence of an FTC rule or may be forced to do so by pressure from increasingly sophisticated and knowledgeable consumers. However, it is impossible to say what would happen in the absence of a rule. It is possible that refractionists would revert to refusing to release prescriptions even upon request. It is also unclear whether consumers would have sufficient knowledge or incentive to inquire about a practitioner's prescription release policies before obtaining an eye exam, and thus be able to select a practitioner who voluntarily releases prescriptions.

c. The "offer" Standard

Little, if any, evidence was presented in response to the Commission's question regarding an "offer" requirement -- e.g., that optometrists be required to offer to provide prescriptions to their patients, either orally or in writing.[706] Comments from

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706 Notice of Proposed Rulemaking, 50 Fed. Reg. at 602. Given the choice between the posting of a written prescription offer and some form of oral offer, most commenters on this issue favor (footnote continued)

parties on both sides of the issues generally oppose the use of an offer in lieu of their favored position.

Staff does not recommend that the Commission adopt such a standard for essentially the same reasons that staff recommends deleting the automatic release provision. Although the offer requirement may arguably be slightly less burdensome to optometrists than the automatic release provision, the difference does not appear to be significant. However, the offer requirement would present essentially the same enforcement burden for the Commission as the current rule. The Commission would be faced with bringing enforcement actions against individual optometrists who released prescriptions upon request but who failed to offer prescriptions in every instance. There is no reason to believe that a requirement to offer a prescription would in any way simplify enforcement of the rule. As with the automatic release provision, there appears to be little consumer benefit attributable to the "offer" requirement, given the large numbers of consumers who are generally knowledgeable about prescriptions and the small number who shop elsewhere when offered or given a prescription they did not ask for. Therefore, staff does not recommend that the Commission adopt this standard.

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a written offer. See, e.g., L. Harris, Kansas Optometrist, H-71 at p. 9; C. Shearer, Indiana Optometrist, H-153 at p. 5; L. Zuern, Member, North Dakota Board of Optometry, J-40 at p. 4. They argue that unlike an oral offer, a written notice would reduce the burden on an optometrist to engage in a time consuming explanation of the patient's prescription rights. Id. One commenter however, believed the written offer would raise more questions among consumers than it would answer, leading to even longer conversations than a clearly explained oral offer. P. Elliot, Member, Florida Board of Opticianry, J-22 at p. 3.

C. Contact Lens Prescription Release

The Notice of Proposed Rulemaking requested comment on whether significant numbers of consumers were refused copies of their contact lens prescriptions, whether consumers could reasonably get around these refusals, and what are the costs and benefits of a rule extending the prescription release rule to contact lenses.[707] While the record suggests that it is not uncommon for practitioners to refuse to give patients their contact lens prescriptions, the record does not reveal how prevalent this practice is. Moreover, the record does not provide a basis from which it can be concluded that the refusal to release contact lens specifications is unrelated to quality of care.

In 1983, approximately 20 million Americans wore contact lenses.[708] The average contact lens wearer replaces one lens each year, either because the lens is damaged or because it is lost.[709] While the average replacement cost is $25 to $35 per

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707 Notice of Proposed Rulemaking, 50 Fed. Reg. at p. 603. The Commission also asked for comments on the costs and benefits of efforts to increase consumer awareness of the need to determine whether a particular doctor will release contact lens specifications. No comments or evidence was received on this issue.

708 Contact Lens Study at p. 5.

709 Initial Staff Report at p. 167 (citing American Optometric Ass'n, Contact Lens News Backgrounder, 14 (April 1978); "Contact Lenses," Consumer Reports, May, 1980, B-5-4, 288 at 292.

lens,[710] the cost varies greatly. Prices for the same lens can range anywhere from $20 to $100 per lens.[711] To the extent that consumers are unable to purchase replacement lenses from lower-cost providers because the original fitter will not release the lens specifications, and must pay the original fitter a higher price, the cost to consumers could be substantial.

A contact lens prescription consists of two components. The first describes the refractive properties of the lens. This component, by itself, forms a complete spectacle prescription, but is only part of a contact lens prescription. The second component is the lens specification, which refers to the dimensions of the lens necessary to fit the cornea. These specifications include the base curvative and diameter of the lens.[712] The component that forms a spectacle prescription must currently be released to the patient under the Commission's Eyeglasses I Rule. The rule does not presently require release of lens specifications however.

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710 "Contact Lenses," Consumer Reports, May 1980, B-5-4, p. 288 at 292, See also Initial Staff Report at pp. 170-73.

711 G. Easton, President-Elect, American Optometric Ass'n, Tr. 156 (cost of particular replacement lens can range from $20 to $100).

712 According to one state's regulations, a hard lens prescription consists of base curve, power, diameter, optical zone, peripheral curve and width, secondary curve and width, blend, color, thickness, manufacturer (when needed), and type of lens and material. A soft lens prescription consists of base curve, power, diameter (when needed), manufacturer, water content (where needed), type (spherical, tonic, or extended wear), color, and manufacturer's suggested sterilization. Tex. Admin. Code tit. 22, § 279.1.

Hard contact lenses are generally ordered from an optical laboratory.[713] They are then frequently modified by the fitter on a custom basis.[714] Soft lenses and extended-wear lenses are manufactured in ready-to-wear condition, and are dispensed directly from the manufacturer's vial.[715] These are not susceptible to modification by the fitter. Since their introduction in 1971, soft lenses have grown in popularity. About 60 percent of all wearers, and seventy percent of new wearers, use soft lenses.[716]

Traditionally, replacement contact lenses had to be obtained from the original fitter. In recent years, a replacement soft contact lens industry has developed. These replacement providers do not perform examinations or initial fittings, but do provide replacement lenses on an over-the-counter or a mail-order basis.[717] These providers can only operate, however, to the extent that practitioners will release contact lens prescriptions to their patients.

For the purpose of this discussion, release of contact lens specifications refers only to release after the fitting process is complete,[718] and does not encompass release for the purpose of

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713 Contact Lens Study at p. 9.

714 NAOO Comment at p. 98.

715 Id.

716 D. Sullins, Tennessee Optometrist, AOA trustee, J-39 at pp. 4, 6.

717 "It's in the Mail," 20/20, May, 1985, J-51(f) at p. 102. (footnote continued)

initial fitting.[719] Professional fitting is essential to safe and successful contact lens wear, and professional judgment must be exercised to determine if the lens specifications are appropriate. During the fitting process, it is not unusual for the lens specifications to be changed in order to achieve a better fit.[720]

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[718] The fitting process begins after the examination has concluded. If the examination reveals nothing that would contraindicate wearing of contact lenses, the patient is given a Keratometric examination to determine what the lens specfications should be. Hard lenses are then made to order by an optical laboratory; soft lenses are selected from stock or ordered from the manufacturer. The fitter then evaluates the fit of the lens on the wearer's eye, usually through use of a biomicroscope, which is also known as a slit lamp. Contact Lens Study at p. 9. The wearer then makes periodic follow-up visits to the fitter for a period of approximately six months. During these follow-up examinations, the fitter re-evaluates the fit of the lens and evaluates the eye for possible development of pathology. If indicated, a different lens may be substituted to achieve a better fit. At the end of this period, when the fitter is satisfied that a successful fit has been achieved, the process is complete. Fitting may be by ophthalmologists, optometrists, or, in some states, opticians. For the purpose of this discussion, fitters will be referred to us "practitioners."

[719] Release for initial fitting involves scope of practice issues such as whether persons other than optometrists and ophthalmologists may initially fit contact lenses. While the Contact Lens Study indicates that opticians may safely fit contact lenses, it is evident that there is a substantial quality of care dimension to the issue. The fit of the lens on the eye must be observed, different lenses may have to be substituted, and the patient must be encouraged to return for follow-up examinations. Because quality of care issues are involved, the record does not currently justify interference with states' judgment as to who may initially fit contact lenses.

[720] E.g., A. Gorz, President, Wisconsin Optometric, Ass'n, Tr. 1106-08; T. Vail, Illinois Optometrist, H-115 at p. 9; B. Davis, Texas Optometrist Tr. 1939-41, 1970-71; D. Sullins, Tennessee Optometrist, J-39 at p. 12; N. Otte, Indiana Optometrist, H-36; F. Weinstock, Ohio Ophthalmologist, H-9.

1. Economic Effects

Denying consumers' access to their contact lens specifications could lead to a finding of unfairness if it causes substantial injury, if the injury is not outweighed by benefits to consumers resulting from denial of access, and if consumers cannot reasonably avoid the injury. This section will examine the extent of injury that results from refusal to release contact lens prescriptions. The following sections will examine the ability of consumers to avoid harm and the countervailing benefits of refusal to release.

Substantial injury would result if consumers are denied access to their contact lens specifications by a substantial number of practitioners, are consequently forced to buy replacement lenses from the examining practitioner, and if a substantial number of practitioners charge non-competitive prices.

a. Frequency of Refusal to Release Lens Specifications

Consumer injury can result only if a substantial number of practitioners refuse to release lens specifications. Otherwise, consumers could avoid injury by refusing to patronize those that refuse. The record does not permit a conclusion as to whether a substantial number of practitioners refuse, however.

Most ophthalmologists routinely release contact lens specifications to patients at the conclusion of the fitting process.[721] The American Academy of Ophthalmology takes the position that patients should be given a copy of their contact lens specifications at that time.[722] The record contains no evidence of failure to release contact lens specifications by ophthalmologists upon the completion of fitting.

Anecdotal evidence suggests that optometrists' policies on lens specification release vary. Several optometrists testified that they do release lens specifications after fitting is complete,[723] while others testified that they do not.[724]

Several opticians organizations stated that in their experience, a substantial number of optometrists do not release contact lens specifications after fitting.[725] The record

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721 E.g., D. Klauer, Vice President, Opticians Ass'n of America, Tr. 642.

722 R. Reinecke, Secretary for Governmental Relations, American Academy of Ophthalmology, H-79. However, the AAO has also taken the position that release of contact lens specifications should be left to the ophthalmologist's discretion. Comment of American Academy of Ophthalmology, American Ass'n of Ophthalmology, and Contact Lens Ass'n of Ophthalmologists, B-5-3.

723 A. Gorz, President, Wisconsin Optometric Ass'n, Tr. 1106-08; R. Moroff, New York Optometrist, Tr. 2063-65.

724 T. Vail, Illinois Optometrist, H-115 at p. 9; M. Allmaras, Illinois Optometrist, Tr. 2062; H. Hanlen, Pennsylvania Optometrist, Tr. 2316-18. Most optometrists will apparently release them to other qualified practitioners, even if they will not release them to patients. NAOO Comment, p. 99; H. Hanlen, Pennsylvania Optometrist, Tr. 2316-18; C. Shearer, Indiana Optometrist, H-153; J. Kintner, Indiana Optometrist, H-117 at p. 6.

(footnote continued)

contains several dozen consumer complaints about refusal to release.[726]

One study addressing contact lens specification release was presented for the record. This study was conducted by employees of USA Lens, a mail-order retailer of replacement contact lenses.[727] According to this study, 34 percent of optometrists refuse to release contact lens specifications, 7 percent release them only to other practitioners but not to the patient, 47 percent release them to the patient, and 12 percent didn't know.[728] Although the study attempts to answer an important question, its methodology is seriously flawed. Among its deficiencies are a haphazardly selected sample frame, interviewer bias, a poorly designed questionnaire, and a failure to take

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725 D. Klauer, Vice-President, Opticians Association of America, Tr. 640; P. Elliott, Member, Florida Board of Opticianry, J-22(a) at p.4.

726 B-9-1 to B-9-41.

727 J-70(b). The USA Lens Study was a telephone survey of optometrists conducted by the staff of USA Lens, Inc. According to the survey's authors, the sample population was drawn from all states in proportion to population, with 50 percent of the sample drawn from rural areas, and 50 percent from urban areas. USA Lens Survey, J-70(b) at p. 4. 206 optometrists were interviewed out of a sample frame of 215. Id. at p. 7. Interviewers posed as prospective customers, and administered a questionnaire of eight items. After obtaining price data, the pertinent questions were: "if I'm out of town, and need a replacement pair, you can just send them to me, can't you? You do mail replacement lenses?;" "If not: why not, I tried this before with no problem;" "If I should want to buy them from Dr. Seriani, at 800 USA Lens mail order, would it be okay for you to give me my prescription to give to them." Questionnaires, J-70(c). Interviewers were permitted to vary the form of the questions if they thought it appropriate. S. Wu, USA Lens Employee, Tr. 3061.

728 USA Lens Study, J-70(b) at p. 9.

steps to ensure that the data collected was accurate.[729] Staff

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[729] The sample frame was drawn in a haphazard, uncontrolled manner. It was drawn from "directories, phone books, and the Blue Book of Optometry." S. Wu, USA Lens employee, Tr. 3055. No particular technique was used to ensure randomness; apparently names were picked at the whim of the interviewer. Id. at Tr. 3056. Failure to use a technique to ensure randomness raises a significant risk that the survey sample will not be representative of the population it purports to survey.

The telephone questionnaire was administered to the individual answering the phone at the optometrist's office. The survey's author claimed that there was no reason to believe that receptionists would systematically err to one side or another on prescription release policy. USA Lens Study, J-70(b) at p. 5. No effort was made to test this assumption.

Other problems arise from the questionnaire design. Several questions assume knowledge on the part of the respondent. One critical question is highly leading. The question that measured release policy was "If I'm out of town, and need a replacement pair, you can just send them to me, can't you? You do mail replacement lenses?" Id. at App. A. This leading question almost begs the respondent to answer "yes." As the study's authors admit, a leading question could bias the findings. Tr 3059. Another question, "If I should want to buy them from Dr. Seriani, at 800 USA Lens mail order, would it be okay for you to give me my prescription to give to them," is similarly flawed. This question could leave the respondent unclear as to whether it relates to initial fitting or to a replacement lens. Moreover, since Dr. Seriani (the President of USA Lens) is apparently a high profile and controversial figure within the optometric profession, "The Rise and Fall of Dr. Joe Serian," Capitol, Nov. 13, 1983, J-51(e) and "The Postman Always Rings Twice," 20/20, May, 1985, J-51(f), his own reputation could have influenced the respondent's answer.

Interviewer bias is also a major problem with the survey. An interviewer who consciously or subconsciously desires to elicit a particular response can bias the outcome of a survey. In this case, the interviewers were employees of USA Lens who were interested in seeing the company do well. S. Wu, Tr. 3060-61. They may have had some indication as to what responses would favor the company's position, and could thus could have consciously or subconsciously attempted to elicit these responses. The potential for bias is increased where, as here, the interviewer has broad discretion as to the phrasing of the question. Tr. 3061. The survey's author made no effort to validate the work of the interviewers, Tr. 3075-76, did not pre-test it, Tr. 3057, and indeed was not present to supervise the data collection. Tr. 3076.

The accuracy of the data tabulation is called into question by several disparities between the data claimed by the author and the data shown on the survey forms. The author claimed that the (footnote continued)

concludes that as a result, the USA Lens Study's findings are not reliable. It can be cited only for the limited proposition that some optometrists do refuse to release contact lens specifications to patients and some do not.

In sum, the evidence indicates that some optometrists refuse to release contact lens specifications to their patients. Although there is a strong suggestion that this practice may be prevalent, the record does not contain sufficient reliable evidence to permit a conclusion to that effect.

b. Price differences

The evidence indicates that the price of replacement contact lenses varies widely. Data collected in the Contact Lens Study indicates that in 1980, the out-of-pocket cost of individual hard replacement lenses ranged from under ten dollars to over seventy dollars.[730] The cost of individual soft replacement lenses

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study subjects were evenly distributed throughout the United States by population, and evenly divided between rural and urban practitioners. USA Lens Study, J-70(b) at p. 4. This was not, in fact, the case. There was wide variation in the proportion of optometrists sampled in each state. See tabulation in Rebuttal Submission of Robert R. Nathan & Associates, Inc., K-10 at pp. 7-9. Moreover, 81% of the sample frame is urban, rather than the 50% claimed. Id. at p. 9. While it is not clear how this would bias the study, it does illustrate the quality problems endemic in this study.

730 Initial Staff Report at p. 170. The median cost was between $20 and $30. The total cost, which adds any insurance premium to the out-of-pocket cost, had the same price range, but the median cost was between $30 and $40. Id. at p. 172. These results were reported in the Initial Staff Report, but were not reported in the final Contact Lens Study.

varied from under ten dollars to over eighty dollars.[731]

In addition to the Contact Lens Study, anecdotal evidence suggests that in some cases, replacement contact lenses may be obtained from alternative dispensers at a lower cost than that charged by the original prescriber.[732] The comments of many dispensing optometrists, who sought to explain the difference in price, implicitly provides further evidence that a price differential exists.[733] No evidence was offered to suggest that such a price difference does not exist.

Several explanations for the price difference were suggested, although no systematic evidence was offered in support of any of them. A number of private dispensing optometrists and ophthalmologists pointed out that prescribing doctors charge more because they render professional services in verifying the lens and its fit on the eye.[734] These commentors also maintained that

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731 Initial Staff Report at p. 171. The median was between $20 and $30. The total cost ranged from less than $10 to over $100, with a median cost between $40 and $50. Id. at p. 173.

732 L. Fenner, Pennsylvania Consumer, B-9-37; J. Rittenshaus, New York Consumer, B-9-39; J. Brown, North Carolina Consumer; B-9-38; G. Matteson, Indiana Consumer, B-9-37; E. Verrette, Georgia Consumer, B-9-36; M. Droves, Maryland Consumer, B-9-29; c. Kincard, Virginia Consumer, B-9-12; "The Rise and Fall of Dr. Joe Serian," Capitol, Nov. 13, 1983, J-51(e) at p. 14.

733 See infra footnote 734.

734 C. Beier, President, Kansas Board, J-52; T. Vail, Illinois Optometrist, H-115 at p. 10; L. Harris, Kansas Optometrist, H-71 at p. 11; R. Peach, Indiana Optometrist, H-73 at p. 2; R. Reinecke, Secretary for Governmental Relations, American Academy of Ophthalmologists, H-79 at p. 3; R. Saul, Florida Optometrist, H-93; L. Van Arsdall, Indiana Optometrist, H-97 at p. 4; J. Kintnen, Indiana Optometrist, H-117 at p. 7.

prescribing doctors provide higher quality lenses than replacement lens vendors[735] and have higher overhead costs.[736] Alternative dispensers of replacement contact lenses, on the other hand, maintain that prescribing doctors refuse to release contact lens specifications to protect their own economic self-interest.[737] If the doctor is the only possible source of replacement lenses, according to this argument, the opportunity to maintain higher prices is enhanced.[738]

Staff concludes that there is a wide difference in the price of replacement contact lenses. This may be explained in part by the cost of the practitioner's services in verifying the fit of the lens.[739] However, given the near absolute power of practitioners who do not release specifications to maintain above-market prices for replacement lenses, at least some of this difference may be explained by a lack of competition.

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735 C. Beier, President, Kansas Board of Optometry, J-52; R. Reinecke, Secretary for Governmental Relations, American Academy of Ophthalmologists, H-79 at p. 3.

736 R. Ireland, Indiana Optometrist, H-151.

737 J. Seriani & S. Wu, "The USA Lens Survey," J-70(b) at p. 12 (attachment to statement of J. Seriani & S. Wu).

738 Id. See also Initial Staff Report at p. 167 n. 45. The only other option open to the consumer is to obtain a new examination from a practitioner who will release the specifications.

739 But see infra section IV.C.3.a., "Need for Verification of Lens," indicating that many practitioners do not verify the fit of replacement lenses when dispensing them.

2. Ability of Consumers to Avoid Harm

Consumers may avoid artifically high replacement lens prices in two ways. First, before submitting to an examination and fitting, they may inquire as to the practitioner's policies concerning lens specification release and, if not satisfied with the policy, take their business elsewhere. The extent to which prospective contact lens wearers are aware that replacement lenses will be needed, what the cost will be, or that they are available from other dispensers is unknown.

Second, if the consumer has already been fit with contact lenses and the fitter will not release lens specifications, the only way to avoid the harm of an unreasonably high cost for replacement lenses is to obtain an entire new examination and fitting. The cost of this may average between $119 and $183 in the case of hard lenses, and between $150 and $234 in the case of soft lenses, depending on the type of fitter.[740] Thus, the ability to avoid harm through this alternative is limited.

3. Quality Effects of Refusal to Release

Opponents of mandatory release of contact lens specifications allege that any benefits from mandatory release

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[740] Contact Lens Study at p. C-7. These are 1980 figures for complete contact lens packages. Individual practitioners may charge more or less than these figures.

would be outweighed by an adverse impact on eye health. This allegation has two dimensions: that refusal to release is necessary to permit the fitter to verify the fit of the lens, and that mandatory release might reduce the frequency of patients seeking follow-up care.

a. Need for verification of lens

The need for verification of the lens on the eye is somewhat different with respect to hard and soft contact lenses.

Hard lenses are ordered from the laboratory to the fitter's specifications. In many cases, they are then modified or finished by the fitter on a custom basis.[741] Given the need for verification and custom-finishing, it cannot be concluded that substantial benefits to consumers do not attend the withholding of hard lens prescriptions.

Soft lenses, on the other hand, are produced and packaged by manufacturers in standard sizes in ready-to-wear form. It is impossible to verify the parameters of a soft lens without observing it on the eye, according to the witnesses.[742]

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741 NAOO Comment at p. 98.

742 E. McCrary, Vice-President, Maryland Optometric Ass'n, Tr. 182; J. Moye, Mississippi Optometrist, Tr 432; USA Lens Study, J-70(b) at p. 18. Some optometrists state that the thickness of a lens can be verified with a radioscope. J. Kennedy, Minnesota Optometrist, Tr. 1134-35. This technique is apparently not in widely used, however. D. Staten, Nevada Optometrist, Tr. 1183.

The parameters of a soft lens as described on the vial in which it is packaged are often quite different than the actual parameters of the lens, according to several commentors.[743] Therefore, practitioners must either rely on the description on the vial or verify the power and fit of the lens by observing it on the patient's eye.[744] Between five and ten percent of soft contact lenses do not match the description on the vial, according to estimates given by witnesses.[745] There is claimed to be considerable variation among manufacturers in the degree of quality control over soft lenses labelling.[746] There is no systematic record evidence on this issue, however.

Because of the dangers that lenses may not conform to the eye as expected, many practitioners claim that replacement soft contact lenses cannot safely be dispensed without observing the

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743 H. Hanlen, Pennsylvania Optometrist, Tr. 2316-18; T. Vail, Illinois Optometrist, H-115 at p. 9; E. O'Connor, Indiana Optometrist, H-108 at p. 2; R. Saul, Florida Optometrist, Tr. 433; G. Easton, President-Elect, American Optometric Ass'n Tr. 154, 158; D. O'Connor, Indiana Optometrist, Tr. 680; J. Honaker, President, Kentucky Board of Optometry, Tr. 731.

744 E. McCrary, Vice President, Maryland Optometric Ass'n, Tr 182; G. Easton, President-Elect, American Optometric Ass'n Tr. 154; H. Hanlen, Pennsylvania Optometrist, Tr. 2316-18; T. Vail; Illinois Optometrist, H-115 at p. 9.

745 E. McCrary, Vice-President, Maryland Optometric Ass'n, Tr. 185 (10% of patients claim problems with replacement lenses); G. Easton, President-Elect American Optometric Ass'n; Tr. 158; T. Vail, Illinois Optometrist, H-115 at p. 9; D. Klauer, Vice President, Opticians Ass'n of America, Tr. 640. The record refers to a study showing that measured lens parameters are frequently at variance with the parameters on the vial. "The Postman Always Rings Twice," 20/20, May, 1985, J-51(f) at p. 98. The study itself is not on the record.

746 J. Moye, Mississippi Optometrist, Tr. 433.

lens on the eye.[747] Therefore, they claim, it would be inappropriate to require them to release contact lens specifications to their patients, since patients could then obtain replacement lenses from dispensers that do not do this.[748]

If this were true, one would expect that the routine practice of optometrists and ophthalmologists would be to verify lenses on the patient's eye before dispensing. Several optometrists testified that they routinely do so.[749] The Contact Lens Study, however, found that this was not the case. The study found that only 48 percent of optometrists and 39 percent of ophthalmologists verified replacement lenses on the eye before dispensing them.[750] Thirty-six percent of all hard lens fitters examined the replacement lens on the eye; 49 percent of all soft lens fitters did so.[751] While this evidence may reflect a difference in professional practice techniques or competence, it

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747 E. McCrary, Vice President, Maryland Optometric Ass'n, Tr. 182; G. Easton, President-elect, American Optometric Ass'n, Tr. 154; H. Haneln, Pennsylvania Optometrist, Tr. 2316-18; T. Vail; Illinois Optometrist, H-115 at p. 9.

748 Some optometrists expressed fear that they could be held responsible for damage caused by lenses dispensed by others pursuant to their prescriptions and specifications. R. Saul, Florida Optometrist, H-93 at pp. 3-4; A. Gossan, Michigan Optometrist, H-1.

749 G. Easton, President-elect, AOA, Tr. 154; A. Gorz, President, Wisconsin Optometric Ass'n, Tr. 1108; D. Connor, Director, Department of Legal Affairs, Indiana Optometric Ass'n, Tr. 683.

750 Initial Staff Report at pp. 175-76. The difference between the two groups was not statistically significant. Id. at p. 175.

751 Id. at p. 176.

may also indicate that the need for an evaluation of a lens on the patient's eye is not as great was suggested.[752]

b. Need to encourage frequent examination

Because contact lenses are in direct contact with the eye, they may potentially damage the eye.[753] Some of the eye conditions that may result develop gradually over a substantial period of time. These include superior limbic keratitus, giant papillary conjunctivitis, sensitization to preservatives and chemicals, corneal erosions, and vascularization.[754] Changes in the eye itself can also affect the fit of a lens. Over time, the curvature of the cornea may change, thus rendering a once-successful fit into a potentially dangerous one.[755] Several commentors stated that periodic follow-up care is necessary to detect these problems before serious pathological conditions develop.[756] This is especially true of extended-wear soft

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752 The "USA Lens Study" reported that a large percentage of optometrists would mail replacement lenses to patients. Thus, according to its authors, it also indicates that optometrists do not view an examination of a replacement lens on the eye to be critical. J-70(b) at pp. 22-24. As noted previously, however, this survey suffers from methodological flaws, and must be viewed with great skepticism.

753 J. Kennedy, Minnesota Optometrist, Tr. 1119.

754 R. B. Grene, Kansas Ophthalmologist, J-64(a) at pp. 2-3. See also, T. Vail, Illinois Optometrist, H-115 at p. 9; J. Kennedy, Minnesota Optometrist, Tr. 1120.

755 R.B. Grene, Kansas Ophthalmologist, J-64(a) at p. 2; L. Harris, Kansas Optometrist, H-71 at p. 9; T. Vail, Illinois optometrist, H-115 at p. 10; J. Kintner, Indiana Optometrist, H-117 at p. 6.
(footnote continued)

lenses.[757] If patients must return to the original fitter, or another doctor, for replacement lenses, this follow-up care is said to be more likely to occur.[758] On the other hand, if patients can obtain replacement lenses without visiting a doctor, the follow-up is claimed to be less likely to occur.[759] Some commentors suggested that an expiration date on prescription is necessary in order to encourage follow-up care.[760]

The record does not disclose whether pathologies that may result from improperly fitting hard or soft lenses all manifest themselves to patients in the form of discomfort or irritation. If this were the case, any danger would be mitigated by the probability that the patient would remove the lens or return to the doctor. In the case of extended-wear contact lenses, however, the record does indicate that patients may not always able to detect symptoms of incipient pathology.[761]

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[756] J. Kennedy, Minnesota Optometrist, Tr. 1121-22.

[757] K. Kenyon, "Complications of Soft Contact Lenses." J-64(a) at p. 9 (attachment to Statement of R.B. Grene, M.D.); J. Kennedy, Minnesota Optometrist, Tr. 1123-24.

[758] R. B. Grene, Kansas Ophthalmologist, J-64(a); T. Vail, Illinois Optometrist, H-115 at p. 9; L. Harris, Kansas Optometrist, H-71 at p. 9; A. Gossan, Michigan Optometrist, H-1; W. Van Patten, Secretary, Nevada Board of Optometry, J-56; C. Shearer, Indiana Optometrist, H-153.

[759] See supra note 758.

[760] L. Harris, Kansas Optometrist, H-71 at p. 9; T. Vail, Illinois Optometrist, H-115 at p. 10 (contact lens prescription valid only for six months). Cf. R. Moroff, New York Optometrist, Tr. 2063-65 (will not sell replacements after a certain time).

[761] K. Kenyon, "Complications of Soft Contact Lenses," J-64(a) (footnote continued)

4. Conclusion

Staff cannot conclude from the rulemaking record that a practitioner's refusal to release contact lens prescriptions is or is not an unfair act or practice.

While the record suggests that optometrists may frequently refuse to release contact lens prescriptions to patients and that the resulting costs to consumers could be significant, it does not contain sufficient reliable evidence to permit a conclusion to that effect. Nor does it permit a conclusion that there are no quality benefits associated with the refusal to release contact lens prescriptions. Hard lenses are often made to order for the patient and the accuracy of a replacement lens must be verified. Soft lenses are manufactured in ready-to-wear form and are not susceptible to objective verification. However, there is contradictory evidence on mislabelling of soft lenses. Thus, it cannot be concluded from the record that there are no quality justifications for refusing to release contact lens prescriptions.

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at p. 13 (attachment to statement of R.B. Grene, M.D.); J. Kennedy, Minnesota Optometrist, J-26 at p. 6 (corneal molding not readily apparent to patient).

D. Re-Release of Spectacle Prescriptions

1. Re-release of duplicate prescription by doctor

The Notice of Proposed Rulemaking requested comment as to whether optometrists and ophthalmologists should be required to release duplicate copies of prescriptions to consumers who lose or misplace their original prescriptions and if so, whether they should be allowed to charge for them. It also asks for comment as to whether significant numbers of eyeglass dispensers refuse to return fillable copies of spectacle prescriptions to consumers after the prescription is filled, whether consumers can reasonably avoid any resulting injury, and what are the costs and benefits of a rule requiring that eyeglass dispensers return fillable prescriptions to consumers.[762]

The record contains no evidence that optometrists or ophthalmologists refuse to release duplicate copies of eyeglass prescriptions to consumers who ask for them.

Apart from the question of prevalence, comment was mixed as to the desirability of requiring the release of duplicate prescriptions. Several opticians groups[763] and one consumer

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[762] Notice of Proposed Rulemaking, 50 Fed. Reg. at 602-03. The Notice also asked what are the costs and benefits of efforts to increase consumer awareness of the need to determine whether a particular dispenser will provide a copy of the prescription before deciding where to purchase eyeglasses. No significant evidence was received on this point.
(footnote continued)

group[764] favored such a requirement. Several optometrists and one state board appeared to agree that mandatory release would be reasonable.[765] Opponents of mandatory release maintained that to require the release of duplicate prescriptions in all cases would interfere with the optometrist's judgment by requiring the release of dated prescriptions that might no longer be valid.[766] The American Academy of Ophthalmology stated that the obligation to release duplicate prescriptions should rest with dispensers.[767]

Several commentors stated that doctors should be permitted to charge for duplicate prescriptions, since to issue a duplicate the doctor must locate the patient's file, read it, decide if the prescription is still valid, and possibly discuss the need for a new examination with the patient.[768] Other commentors stated

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763 G. Black, President, Arkansas Retail Merchants Ass'n, D-1 (rule would be particularly desirable in states where, as in Arkansas, duplication of existing lenses is prohibited); D. Maffly, Attorney, California Ass'n of Dispensing Opticians, H-112 at p. 4; M. Tiernan, Director, California Ass'n of Dispensing Opticians; J-30; P. Elliot, Member, Florida Board of Opticianry, J-22 at pp. 3-4.

764 H. Snyder, West Coast Director, Consumers Union of the U.S., J-24 at pp. 3-4.

765 R. Szabo, Indiana Optometrist, H-94 at p. 4; K. Van Arsdell, Indiana Optometrist, H-97 at p. 3 (within one year of prescription date); C. Kowrach, Idaho Optometrist, H-132; L. Zuern, Member, North Dakota Board of Optometry.

766 D. Robbins, Indiana Optometrist, H-59 at p. 7.

767 R. Reinecke, Secretary for Governmental Relations, American Academy of Ophthalmology, H-59 at p.7.

768 T. Vail, Illinois Optometrist, H-115 at pp. 8-9; R. Szabo, Indiana Optometrist, H-94 at p. 4. See also K. Van Arsdall, (footnote continued)

that since release of duplicate prescriptions is a routine service, the charge is built into the initial fee and no additional charge should be permitted.[769]

Since refusal to release duplicate prescriptions does not appear to be prevalent, no consumer injury can be demonstrated. Rulemaking in this area would thus be inappropriate.

Indiana Optometrist, H-97 at p. 3; G. Black, President, Arkansas Retail Merchants Ass'n, D-1.

[769] D. Maffly, Attorney, California Ass'n of Dispensing Opticians, H-112 at p. 4; H. Snyder, West Coast Director, Consumers Union of the U.S., J-24(a) at pp. 3-4; C. Kowrach, Idaho Optometrist, H-132.

2. Re-release of prescription by dispenser

There is no significant evidence that dispensers, including opticians and dispensing ophthalmologists and optometrists, refuse to return fillable[770] copies of prescriptions to consumers after the prescription is filled. The Notice of Proposed Rulemaking noted that the Commission has received few complaints about failure to return prescriptions after dispensing.[771] No substantial evidence on this point was introduced at the hearings. Several commentors expressed the opinion that patients requesting copies of their prescription from dispensers generally receive them.[772] On the other hand, one member of a state optician's board stated that there had been some complaints about

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770 A fillable prescription is one containing all of the parameters necessary to fashion the lens nad that complies with state requirements for a legal prescription. By contrast, a prescription that lacks a necessary component, or that is not signed by the doctor may not be fillable under state law.

771 Notice of Proposed Rulemaking, 50 Fed. Reg. at p. 602.

772 OAA Comment at pp. 28-29; NAOO Comment at pp. 95-96; AOA Comment at pp. 57-58; R. Reinecke, Secretary for Government Relations, American Academy of Ophthalmology, H-79; R. Szabo, Indiana Optometrist, H-94 at p. 4; D. Maffly, Attorney, California Ass'n of Dispensing Opticians, H-112 at pp. 4-5; T. Vail, Illinois Optometrist, H-115 at p. 9; D. Klauer, Vice-President, Opticians Ass'n of America, J-15 at pp. 18-19.

In the BE study, blurred vision subjects were told to obtain a copy of their prescription after purchasing eyeglasses from the examining doctor. Of 280 examination/eyeglass packages purchased, these subjects were able to obtain copies of their prescription from all but seven dispensers, or in 2.5% of the cases. BE Study at p. 75, n. 2. However, the BE study examined dispensing optometrists only and did not examine the practices of opticians or other non-prescribing dispensers.

refusal to return prescriptions, but provided no data on the frequency of complaints.[773]

Several commentors, while denying the existence of a problem, stated that consumer injury results from a dispenser's refusal to return prescriptions to consumers after the prescription has been filled. If a consumer desires an extra or replacement pair of glasses or a pair of prescription sunglasses, the consumer could not freely choose dispensers, but would be required to purchase it from the original dispenser.[774] One commentor noted that the prescription is the patient's property once it is paid for.[775]

Refusal to return a copy of the prescription has some countervailing consumer benefits, according to other commentors. A dispenser should be able to retain the original prescription on file in order to prove, if necessary, that the prescription was filled accurately.[776] To prepare copies for

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773 P. Elliot, Member, Florida Board of Dispensing Opticians, Tr. 944-45, 960. Florida has a statute requiring the return of prescriptions by the dispenser. Fla. Stat. § 484.012(2). Only one consumer complaint appears on the record. Letter from C. Koseki, B-10-1.

774 OAA Comment at pp. 28-29; NAOO Comment at pp. 95-96; D. Maffly, Attorney, California Ass'n of Dispensing Opticians, H-112 at pp. 4-5; D. Klauer, Vice President, Opticians Ass'n of America, J-15 at pp. 18-19.

775 R. Szabo, Indiana Optometrist, H-94 at p. 4.

776 NAOO Comment at pp. 95-96; R. Saul, Florida Optometrist, H-93 at p. 3; J. Kintner, Indiana Optometrist, H-117 at p. 6 (identical comment by C. Shearer, Indiana Optometrist, H-153 at p. 6).

customers, the dispenser may have to purchase copying equipment that would otherwise be unnecessary.[777] The extent to which this would impose costs on dispensers[778] and whether other means could be used to comply is unclear from the record.

The record contains no significant evidence that dispensers refuse to return fillable copies of eyeglass prescriptions to patients after the prescription is filled. Therefore, no consumer injury can be demonstrated,[779] and rulemaking in this area would be inappropriate.

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[777] J. Kintner, Indiana Optometrist, H-117 at p. 6 (identical comment by C. Shearer, Indiana Optometrist, H-153 at p. 6).

[778] For example, if most opticians maintained copying equipment for other purposes, the incremental cost of making copies would be minor. If not, it could be quite substantial.

[779] Accordingly, it is unnecessary to examine countervailing consumer benefits and consumer ability to avoid injury.

V. LEGAL ANALYSIS

A. Unfair Acts & Practices

1. The Standard

Section 5 of the Federal Trade Commission Act proscribes "unfair . . . acts or practices in or affecting commerce," and directs the Commission to prevent persons, partnerships, and corporations from using them.[780]

Over the years, the general concept of "unfairness" has evolved into an objective and narrowly circumscribed standard. The statute was deliberately framed in general terms since Congress recognized that it was not possible to enumerate specifically all possible unfair trade practices because such a list would quickly become outdated and thus incomplete.[781]

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[780] 15 U.S.C. § 45(a). This rulemaking is premised solely on the Commission's unfairness jurisdiction, Notice of Proposed Rulemaking, 50 Fed. Reg. 598, 605, and not on its "deceptive acts and practices" jurisdiction or its "unfair methods of competition" antitrust jurisdiction.

[781] H.R. Conf. Rep. No. 1142, 63rd Cong., 2d Sess., at 19 (1914). The 1914 statute addressed only "unfair methods of competition." The "unfair acts and practices" language was added by the Wheeler-Lea Act in 1938. Initially, the "unfair methods of competition" language was understood as reaching most of the conduct now viewed as consumer unfairness. See Averitt, The Meaning of Unfair Acts and Practices in Section 5 of the Federal Trade Commission Act, 70 Geo. L.J. 225, 231 (1981). The 1938 language was added in response to FTC v. Raladam, 283 U.S. 643 (1931), which read the initial language as limiting the Commission's jurisdiction to cases where injury to competitors (footnote continued)

Congress left the task of identifying unfair trade practices to the Commission, subject to judicial review, in the expectation that criteria for "unfairness" would evolve and develop over time.[782]

The "most precise definition of unfairness articulated to date"[783] is the Commission's 1980 policy statement on unfairness.[784] In the statement, the Commission identified the basic factors that it would consider in determining if unfairness was present. The primary factor to be considered is whether the practice injures consumers. A secondary factor, which is most often used to confirm a finding of consumer injury, is whether the practice violates established public policy.[785]

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could be shown. The Wheeler-Lea Act eliminated the need for that showing, but did not otherwise change the reach of the Commission's authority. The original legislative history thus remains relevant to construction of that part of the statute.

782 See generally Letter from five Commissioners to Senators Ford and Danforth, Dec. 17, 1980, G-5 (hereinafter "Unfairness Statement"); Averitt, The Meaning of Unfair Acts and Practices of the Federal Trade Commission Act, 70 Geo. L. J. 225 (1981); Craswell, The Identification of Unfair Acts and Practices by the Federal Trade Commission, 1981 Wis. L. Rev. 107; American Financial Services Ass'n v. FTC, 767 F.2d 957, 965-67 (D.C. Cir. 1985).

783 American Financial Services Ass'n v. FTC, 767 F.2d 957, 982 (D.C. Cir. 1985).

784 Letter from five Commissioners to Senators Ford and Danforth, Dec. 17, 1980, G-5 (hereinafter "Unfairness Statement"); American Financial Services Ass'n v. FTC, 767 F.2d 957, 982 (D.C. Civ. 1985).

785 Unfairness Statement, supra note 782 at p. 4. The Unfairness Statement is the culmination of several formulations used over the last two decades. In promulgating the Cigarette Rule, 16 C.F.R. § 408 (1965), the Commission devised a three-part test: did the conduct at issue violate established public policy, was it immoral or unethical, and did it result in substantial (footnote continued)

Three tests must be met in order to satisfy the first factor. First, substantial injury must be present. The "injury" is usually financial, but may also consist of unwarranted health and safety risks.[786] Second, the injury must not be outweighed by offsetting consumer or competitive benefits. If the practice in question results in benefits to consumers that outweigh the injury, or if the proposed remedy itself would result in net injury through reduced incentives to innovation and capital formation, a finding of unfairness would be inappropriate.[787] Third, the injury must be one which consumers could not reasonably have avoided. The market is expected to be self-correcting in most cases, and in those cases where consumers are able to avoid injury by making their own choices in the market, regulatory action is inappropriate.[788] On the other hand, certain market imperfections "may unjustifiably hinder consumers' free market decisions and prevent the forces of supply and demand from maximizing benefits and minimizing costs."[789] In such

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consumer injury. Unfair or Deceptive Advertising of Cigarettes in Regulation to Health Hazards of Smoking, Statement of Basis and Purpose, 20 Fed. Reg. 8324, 8350-54 (1964). The Supreme Court embraced these criteria in FTC v. Sperry & Hutchinson Co., 405 U.S. 233, 244-45, n.5 (1972). The Unfairness Statement goes beyond the old Cigarette Rule criteria by making consumer injury the primary factor, relegating public policy to a secondary role, and eliminating the immoral and unscrupulous criteria altogether.

786 Unfairness Statement, supra note 782 at pp. 5-6. See, e.g., International Harvester Co., 104 F.T.C. 949 (1984).

787 Unfairness Statement, supra note 782 at pp. 6-7.

788 Id. at p. 7.

789 American Financial Services Ass'n v. FTC, 767 F.2d 957, 976 (D.C. Cir. 1985).

cases, regulatory intervention may be appropriate.

The second factor is whether the practice in question is contrary to established public policy. This factor is primarily used to "test the validity and strength"[790] of, or to "cross-check and confirm," a finding of consumer injury.[791] Any policy relied upon must be declared in formal sources such as the Constitution, statutes, or judicial decisions; it must be widely shared; and it must be relatively specific.[792]

2. Consumer Injury Caused by Commercial Practice Restrictions

a. Substantial Injury to Consumers

Substantial consumer injury ordinarily takes the form of economic and monetary harm to the consumer.[793] It may also take the form of unwarranted risks to health and safety.[794] The harm or risk need not be "substantial" to any one consumer, but may instead be substantial in the aggregate, resulting from a small amount of harm or risk occurring to a large number of

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790 Unfairness Statement, supra note 782 at p. 9.

791 International Harvester Co., 104 F.T.C. 949, 1061 n. 43 (1984).

792 Unfairness Statement, supra note 782 at pp. 9-12. Averitt, supra note 781 at p. 276.

793 Unfairness Statement, supra note 782 at pp. 5-6.

794 Id. at p.6.

people.[795] The rulemaking record amply demonstrates that commercial optometric practice restrictions cause substantial consumer economic injury and can have a detrimental effect on consumer health.

As discussed in more detail in the section on "Price Effects of Commercial Practice Restrictions," consumer prices for eye examinations and eyewear average 18 percent higher in markets where restrictions are present. Restrictions prevent alternative forms of practice such as commercial practice from entering the market and competing with traditional providers. The presence of such practitioners in the market results in lower prices throughout the market by optometrists in all types of practice. The finding that the absence of restrictions is associated with lower prices was made by the BE Study and was corroborated by the Contact Lens Study, the Atlanta Study, and the Benham Study. There is no reliable evidence to the contrary; many opponents of the rule effectively concede as much.[796] The record evidence conclusively establishes that consumer prices for eye exams and eyewear are lower in the absence of commercial practice restrictions.

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795 Id. at p. 5; American Financial Services Ass'n, 767 F.2d at 792.

796 Many traditional optometrists opposing the rule expressed a concern that they would not be able to compete with commercial practitioners if restrictions were removed. E.g., B. Corwin, President, South Dakota Board of Optometry, J-44 at p. 5; R. Edgar, Mississippi Optometrist, H-15; G. Schmidt, Florida Optometrist, H-31.

Over half of all Americans use corrective eyewear. Over eight billion dollars was spent on eye examinations and eyewear in 1983.[797] Given the size of this market and the magnitude of the price difference caused by commercial practice restrictions, the degree of monetary consumer injury is "substantial" within the meaning of the Unfairness Statement.

While the studies on the record do not separately describe the effects of particular commercial practice restrictions, the record contains an abundance of other evidence that describes the manner in which each of the four types of commercial practice restrictions inhibit or restrict the formation and expansion of volume optometric practices. In addition, it establishes how they decrease efficiency and increase prices for volume practitioners that manage to enter the market in spite of restrictions. A brief review of each follows.

Restrictions on lay association prohibit optometrists from associating with lay sources of capital, which inhibits capital development. This in turn impedes the development of large-scale practices that can take advantage of economies of scale in the areas of payroll, management efficiency, rent, equipment, supplies, and other areas. These restrictions contribute to higher prices by excluding or deterring volume practitioners from entering the market and by preventing practitioners in the market from operating at the most efficient level.[798]

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797 See supra section II.A., "Description of the Industry."

(footnote continued)

Restrictions on the use of trade names make it difficult for high volume operators to advertise multiple outlets and to allocate advertising expenses over multiple outlets. This may raise the cost and reduce the amount of advertising, thereby depriving consumers of valuable information. These restrictions contribute to higher prices by deterring volume practitioners from entering the market and by preventing practitioners in the market from advertising as efficiently as possible.[799]

Restrictions on mercantile locations, such as stores (including optical outlets) and malls, reduce the ability of practitioners to increase patronage and build volume practices. They also impose unnecessary construction and rental costs on practitioners desiring to practice in such locations. States that enforce mercantile location restrictions typically permit so-called "side-by-side" or "two-door" operations, which are more costly to build and operate. These restrictions contribute to higher prices by deterring volume practitioners from entering the market and by preventing practitioners in the market from operating at the most efficient level.[800]

Restrictions on branch offices reduce the volume that a practitioner might otherwise achieve and thus reduce the

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798 See supra section III.B.1., "Restrictions on Lay Association and other Business Relationships."

799 See supra section III.B.4., "Restrictions on Trade Name Usage."

800 See supra section III.B.3., "Restrictions on Mercantile Locations."

potential realization of economies of scale. They may also reduce the availability of optometric care in small communities. These restrictions contribute to higher prices by deterring volume practitioners from entering the market and by preventing practitioners in the market from operating at the most efficient level.[801]

The evidence is sufficient to support a conclusion that the economic injury caused by restrictions on lay association, trade names, mercantile locations, and branch offices is substantial.

In addition to causing economic injury, commercial practice restrictions impair consumer eye health. As restrictions increase the cost of eye examinations and eyewear, consumers purchase them less frequently.[802] Moreover, as restrictions make it difficult for practitioners to locate in readily accessible, convenient areas such as stores and malls, it is more difficult for consumers to travel to them.[803] As increased price and decreased accessibility reduce the frequency of examinations, more consumers suffer inadequately corrected vision. Further, incipient ocular pathology will not be detected as frequently.

Commercial practice restrictions affect a large number of consumers. Significant restrictions are found in 44 states.[804]

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801 See supra section III.B.2., "Restrictions on Branch Offices."

802 See supra section III.C.3.d., "Frequency of Obtaining Care."

803 Id. These factors particularly affect elderly consumers.

(footnote continued)

Thirty-nine states restrict corporate employment and other business relationships,[805] 32 restrict trade names,[806] 19 impose branch office restrictions,[807] and 30 restrict mercantile locations.[808] The population affected by restrictions is significant. Included in the states imposing restrictions are

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[804] It is not necessary that consumer injury exist in all states, or even in a majority of them, for an unfair act or practice to occur. A rule may properly address a practice that only exists in a few states. The Credit Practices rule declared the use of wage assignments an unfair act or practice, even though they were primarily used in only four states. American Financial Servs. Ass'n v. FTC, 767 F.2d at 974.

[805] See supra section II.B., "Regulatory Environment," For this purpose, a state is considered to restrict lay association if it prohibits lay employment, partnership, or franchising. Fee splitting prohibitions are not counted unless the record indicates that in that state, fee splitting is interpreted to include entering a lay association.

[806] Id. For this purpose, a state is considered to restrict trade name usage if it explicitly prohibits them, prohibits practicing under a name other than one's own, prohibits the display of signs with trade names, or requires that particular words appear in the name. A prohibition against practicing under a false or assumed name is not counted.

[807] Id. For this purpose, a state is considered to restrict branch offices if it prohibits them, limits the number permitted, requires that the optometrist be present a set number of hours per week, requires that the branch office be within a certain distance of the principal office, or requires that the optometrist obtain a permit that may be withheld at the board's discretion.

[808] Id. For this purpose, a state is considered to restrict mercantile locations if it bans an optometrist from practicing in a retail establishment, shopping center, or in proximity to an optician; or imposes one of the following requirements: that the optometrist's premises be separate and distinct, that there be a separate entrance for the optometrist's office, that percentage leases not be used (unless the record indicates that this is not interpreted to ban mercantile location practice), that an optometrist's office be like that of a majority of professional men in the community, or that an optometrist not convey the impression that he or she is connected with a retail establishment.

some of the most populous in the nation.[809]

The Unfairness Statement requires that as part of the countervailing benefit analysis, burdens that the proposed remedy might impose be considered. These might include changed incentives to innovation and increased barriers to capital formation.[810] In the context of this rulemaking, which has proposed removing regulatory barriers rather than imposing them, these burdens result from the commercial practice restrictions themselves rather than the rulemaking, and thus are more properly viewed as part of the basic consumer injury. As noted above, commercial practice restrictions make it difficult to form capital for optometric practices, since lay association restrictions close the door to corporate, partnership, or franchise structures.[811] Other restrictions inhibit expansion of volume optometric practices by making it difficult to take advantage of economies of scale.[812] The record indicates that restrictions have successfully kept volume practices out of many markets and reduced their efficiency in others.[813] The absence

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[809] E.g., California, Texas, Pennsylvania, Massachusetts, Florida, Ohio.

[810] Unfairness Statement, supra note 782 at pp. 6-7. States may also incur transition and compliance costs. These are referred to in the following subsection.

[811] See supra section III.B.1.c.i., "Impact on Capital Formation."

[812] See supra section III.B.1.c.ii., "Availability of Economies of Scale."

[813] E.g., J. Ingalls, President, Western States Optical, Tr. 2185; E.D. Butler, President, Precision Lens Crafters, Tr. 380.

of volume practices, or their reduced efficiency, contributes to increased consumer prices.

The injury to consumers is not speculative. The studies discussed herein concretely demonstrate that commercial practice restrictions are associated with higher prices on a nationwide basis. Defenders of restrictions argue that since the studies do not demonstrate that any particular state's restrictions lead to higher prices, it would be speculative to conclude that consumer injury exists.[814] Valid conclusions can be drawn about the effects of commercial practice restrictions by generally comparing restrictive and non-restrictive markets. The fact that the precise amount of injury caused by commercial practice restrictions in any particular state cannot be quantified does not, as critics suggest, somehow render it speculative.[815]

b. Offsetting Consumer Benefits

Once having determined that substantial consumer injury

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814 AOA Comment at p. 21.

815 Critics of the proposed rule cite Humana of America, Inc. v. Heckler, 753 F.2d 1579 (10th Cir. 1985), and Walter O. Boswell Mem. Hosp. v. Heckler, 749 F.2d 788 (D.C. Cir. 1984) for the proposition that failure to apportion a specific amount of consumer harm to any particular state renders the rule arbitrary and capricious. AOA Comment at p. 22. These cases invalidated a Medicare cost apportionment regulation on the grounds that the studies relied upon in support of the rule were, by their authors' own admission, of doubtful validity, and because of failure to comply with a "cost-shifting" statute not relevant here. These cases are inapposite to the proposition for which cited.

exists, the next relevant issue is whether the practice is injurious in its net effects or whether the injury is outweighed by countervailing consumer benefits.[816]

Proponents of restrictions maintain that restrictions are needed to protect consumers against commercial practitioners who are alleged to deliver inadequate care. In particular, it is claimed that commercial practitioners, in an effort to maximize volume and minimize costs, give "quickie" examinations, fail to detect eye pathology, and fail to make appropriate referrals of those in which pathologies are detected. It is also claimed, among other things, that they overprescribe, dispense poor quality eyewear, and fail to provide adequate follow-up care.[817]

The record indicates, however, that commercial practice restrictions have no effect on the overall quality of care for those who receive care. As discussed earlier in connection with the studies, there is no difference in accuracy of prescription, quality of eyewear, fitting of cosmetic contact lenses, or extent of overprescription between commercial and non-commercial optometrists.[818] Moreover, there is no difference in adequacy of examination between restrictive and non-restrictive markets. Although proportionally more less-thorough exams are performed by

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816 Unfairness Statement, supra note 782 at p. 6; American Financial Servs. Ass'n v. FTC, 767 F.2d at 975.

817 See supra section III.C.3.c., "Quality of Care for Those Receiving Care."

818 See supra section III.C.3.c.i., "The Study Evidence."

commercial optometrists than non-commecial optometrists in non-restrictive markets, the overall proportion of optometrists giving less-thorough exams is about the same in both types of market.

The existence of the rule will not interfere with the ability of states to police the quality of care delivered. To the extent that low-quality care exists, it is present to a similar degree in both restrictive and non-restrictive states. States may combat the incidence of low-quality care with a variety of tools. These include regulations relating to licensure, minimum examination and equipment, continuing education, deceptive advertising, mandatory referral of pathology, and fraud and misrepresentation.[819] No case was cited in the rulemaking proceeding in which an allegedly abusive practice by an optometrist did not also violate one of these types of regulations.[820]

Proponents of restrictions also maintain that commercial practice restrictions reduce the enforcement burdens on the

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819 Virtually every state regulates these matters directly. See supra section II.B., "Regulatory Environment," The record demonstrates that commercial practice restrictions are not related to quality of care. Even if a minor relationship were shown to exist, a finding of unfairness would still be appropriate. The restrictions subject to the rule are to be evaluated in light of their incremental contribution to quality of care over and above the contribution of regulations that would remain unaffected by the rule. American Financial Servs. Ass'n v. F.T.C., 767 F.2d at 975-76. In this case, commercial practice restrictions provide no incremental protections to the public beyond that provided by unaffected regulations.

820 See, e.g., R. Corns, Indiana Optometrist, Tr. 280-99.

states. According to this argument, the cost of bringing individual enforcement actions against errant commercial optometrists would be prohibitive, and that states can avoid those costs to its taxpayers by prohibiting commercial practice instead. This argument assumes that a correlation exists between commercial practice restrictions and quality of care. As has been noted, however, commercial practice restrictions have no effect on quality of care, and thus cannot have the salutary effect that their proponents ascribe to them.

The proposed rule may result in costs to states making the transition from a restrictive to non-restrictive environment.[821] It is not clear from the record what these costs will be. The fact that no state produced any evidence on the subject suggests that they would be minimal, however.

For these reasons, no "countervailing or offsetting benefits" exist that would mitigate a finding of unfairness under the above discussion of consumer injury.

c. Ability of consumers to avoid harm

In order for the Commission to make a finding of unfairness, the harm must not be reasonably avoidable by consumers. Markets are expected to be self-correcting. To the extent that consumers are able to "survey the available alternatives, choose those that

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821 For example, some costs are associated with repealing or amending statutes and regulations.

are most desirable, and avoid those that are inadequate or unsatisfactory,"[822] regulatory intervention will be unnecessary and inappropriate. In the case of commercial practice restrictions, however, there are no realistic choices open to consumers.[823] Since these state restrictions operate across an entire state, there is no way for consumers to take their business elsewhere.[824]

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822 Unfairness Statement, supra note 782 at p.7.

823 Theoretically, consumers could indirectly avoid harm through the political process. According to this argument, consumers who believe themselves harmed by commercial practice restrictions may exert political pressure on state legislators to eliminate the restrictions.

However, the relative interest of individual consumers compared to optometrists on the issue make it difficult for consumers to have a significant effect in this area. The injury to any one consumer is relatively small, and has not resulted in a major lobbying effort by organized consumer groups. On the other hand, organized optometry expends considerable resources on lobbying activities in support of favored legislation. D. Staten, Nevada Optometrist, Tr. 1178-79 (Nevada optometrists maintain PAC fund for legislative campaigns, and have successfully lobbied legislature against repeal of restrictions); W. Van Patten, Secretary, Nevada Board of Optometry, Tr. 2242-43; R. Alderete, Legislative Committee Chmn., Colorado Optom. Ass'n, Tr. 1742-43 (State Optometric Association participated in optometry sunset review but no consumer groups participated); H. Stratton, New Mexico State Representative, Tr. 1745-46, 1765-66 (State Optometric Association politically active).

Not surprisingly, efforts to remove commercial practice restrictions in the legislatures have fared poorly. In several states, they have been defeated after concerted lobbying by organized optometry. R. Alderete, Legislative Comm. Chairman, Colorado Optometric Ass'n, Tr. 1714. Although the issue has been considered by a number of states, only a few states have partially removed their commercial practice restrictions since 1980. E.g., Texas. Only one state, Vermont, has totally removed its restrictions.

824 Some consumers in restrictive states who live near the border with a non-restrictive state, such as Kansas City, Kansas (near Missouri) or Newark, New Jersey (near New York), could (footnote continued)

For persons with defective vision, corrective eyewear is a necessity. It cannot be obtained without obtaining an eye examination. While consumers could forego utilizing optometrists in favor of ophthalmologists, the only other group from which eye examinations are available, this would result in an increase in consumer costs since ophthalmologists are generally more expensive than optometrists[825] and are less accessible because they are more limited in numbers.[826]

For these reasons, consumers cannot reasonably avoid the injury caused by commercial practice restrictions.

3. Public Policy

The second factor, that the conduct in question violate public policy, is rarely used as an independent basis for a finding of unfairness. Rather, public policy is used "for assistance in helping the agency ascertain whether a particular form of conduct does in fact tend to harm consumers."[827] The proposed rule is strongly supported by several well-established federal policies, and is not inconsistent with any established policy at the state level.

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theoretically cross the state line to avoid restrictions. However, even in those cases, additional travel costs would offset at least some of the potential savings.

825 E.g., Contact Lens Study at p. C-7.

826 Supply of Optometrists in the United States, Current and Future, B-2-2 at pp. 3-4.

827 Unfairness Statement, supra note 782 at p. 9.

a. Competition in Health Care

Congress has unambiguously emphasized a policy of encouraging competition among providers in the delivery of health care. This policy was best expressed in the Health Planning and Resources Development Amendments of 1979,[828] which called for "the strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve . . . to advance the purposes of . . . cost effectiveness and access."[829] This act recognized that while the supply of some health services, such as inpatient and institutional care, may not be adequately allocated by competition, many others are. The Act directs states to "give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness and access) to actions which would strengthen the effect of competition on the supply of such services" in such cases.[830] The instant rulemaking is premised on the concept that competition among providers will reduce costs to consumers without adversely impacting quality of care. This is fully consistent with the policy expressed in the Health Planning Amendments.

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828 Pub. L. No. 96-79, § 1502, 93 Stat. 592; 42 U.S.C. § 300k-1 (a)(17) (1982).

829 Id.

830 Id., 42 U.S.C. § 300k-2 (b)(3) (1982).

Congress has explicitly recognized that state regulation can hinder competition among health care providers. In the Health Maintenance Organization Act of 1973,[831] Congress took note of the fact that restrictive laws in 22 states prohibited the operation of HMOs.[832] Finding such restrictions inimical to its purpose of encouraging the growth and development of HMOs, Congress preempted all state laws and regulations that imposed one of four restrictions: (1) required that a medical society approve the furnishing of services by an HMO, (2) required that physicians constitute all or a pecentage of an HMO's governing body, (3) required that all, or a percentage of, local physicians be allowed to participate, or (4) required the HMO to meet the financial standards of an insurer.[833] Congressional approval of the preemption of state medical regulations that hindered the development of HMOs provides strong policy support for a Commission declaration that state laws and regulations that hinder the development of commercial practice are unfair.

b. Health Care Cost Containment

In the National Health Planning and Resources Development

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831 Pub. L 93-222, 87 Stat. 914, 42 U.S.C. § 300e et seq. (1982).

832 S. Rep. 93-129, 93rd Cong. 1st Sess., reprinted at 1973 U.S. Code Cong. & Ad. News 3033, 3057.

833 42 U.S.C. § 300e-10 (1982). The laws and regulations were preempted to the extent that they caused an HMO to be unable to do business.

Act of 1974, Congress found that "[t]he achievement of equal access to quality health care at a reasonable cost is a priority of the federal government."[834] A panoply of federal statutes provides for improved financial and geographic access to health care.[835] Part of the harm caused by commercial practice restrictions is that it reduces the availability of optometric care.[836] These policy declarations also support a finding that commercial practice optometric restrictions are unfair.

c. Deregulatory Policy

A third major policy that supports a finding of unfairness is the deregulatory policy of permitting the market to operate as freely as possible, free from regulatory constraints that serve no public purpose. This policy has been expressed in other industries in recent years, such as in the Airline Deregulation

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834 42 U.S.C. § 300k(a)(1) (1982).

835 See Initial Staff Report at pp. 205-11, discussing other Federal statutes evidencing a policy of controlling health care and enhancing access to health care. These include the Health Professions Educational Assistance Act of 1976, 42 U.S.C. §295g-3, which provides funds for training alternative health care providers, such as physicians' assistants, who can provide routine care at lower costs; the Health Maintenance Organization Act of 1973, 42 U.S.C. §300 et seq., which supports the growth of HMOs; Medicare and Medicaid, 42 U.S.C. §1395 et seq.; the Hill-Burton Act, 42 U.S.C. §291(e), which requires hospitals receiving Federal construction aid to provide care for needy; the National Health Service Corps., 42 U.S.C. §254L, which provides medical scholarships to students in return for their committment to practice in an area with a doctor shortage; Area Health Education Centers of 1976, 42 U.S.C. §295g-1; and the Rural Health Clinic Services Amendments to the Social Security Act, 42 U.S.C. §1395K.

836 See supra section III.C.3.d., "Frequency of Obtaining Care."

Act of 1978,[837] the Motor Carrier Act of 1980,[838] and the Depository Institutions Deregulation and Monetary Control Act of 1980.[839] The thrust of this movement has been to remove restrictions that impose costs and decrease efficiency without contributing to public safety or welfare. The elimination of harmful commercial practice restrictions advances this policy.

d. Effect of state policies

The policy basis underlying state regulation of the practice of optometry is to assure the quality of optometric care.[840]

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[837] Pub. L. 95-504, §3(a)(4), 92 Stat. 1705, codified at 49 U.S.C. §1302(a)(4) ("DECLARATION OF POLICY . . . . [T]he [Civil Aeronautics] Board should consider the following, . . . as being in the public interest, and in accordance with the public convenience and necessity: . . . The placement of maximum reliance on competitive market forces and on actual and potential competition (A) to provide the needed air transportation system, and (B) to encourage efficient and well-managed carriers to earn adequate profits and to attract capital.")

[838] Pub. L. 96-296, §3, 94 Stat. 793. ("The Congress hereby finds that a safe, sound, competitive, and fuel efficient motor carrier system is vital to the maintenance of a strong national economy; . . . . that historically the existing regulatory structure has tended in certain circumstances to inhibit market entry, carrier growth, maximum utilization of equipment and energy resources, . . . [and] that protective regulation has resulted in some operating inefficiencies and some anticompetitive pricing . . . .")

[839] Pub. L. 96-221, §3, 94 Stat. 142 (Congress finds that limitations on interest rates have not achieved purpose of providing even flow of funds for home mortgages, phases out restrictions prohibiting institutions from offering market interest rates).

[840] E.g., Colo. Rev. Stat. §12-40-101 ("The practice of optometry in the state of Colorado is declared to affect the public health and safety and is subject to regulation and control in the public interest. . . . This article shall be liberally (footnote continued)

Commercial practice restrictions are one means that some states have chosen in an effort to implement that policy.[841] No state

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construed to carry out these objects and purposes in accordance with this declaration of policy."); Fla. Stat. §463.001(2) ("The sole legislative purpose in enacting this chapter is to ensure the protection of the public health and safety."); Idaho Code §54-1501 (". . . .The practice of optometry affects the public health, welfare and safety and the public interest requires regulation and control of the practice of optometry and the limitation of the practice to qualified persons."); Ky. Rev. Stat. §320.200 ("The practice of optometry in the Commonwealth of Kentucky is declared to affect the public health and safety and is subject to regulation and control in the public interest. . . . This chapter shall be liberally construed to carry out these objects and purposes in accordance with this declaration of policy."); Nev. Rev. Stat. §636.010 ("The practice of optometry is hereby declared to be a learned profession, affecting public safety and welfare and charged with the public interest, and therefore subject to protection and regulation by the state."); Tex. Health & Safety Code Ann. tit. 71, §4552-5.13(a) ("The provisions of this section are adopted in order to protect the public in the practice of optometry, better enable members of the public to fix professional responsibility, and further safeguard the doctor-patient relationship."); Wash. Rev. Code §18.53.005 ("The legislature finds and declares that the practice of optometry is a learned profession and affects the health, welfare and safety of the people of this state, and should be regulated in the public interest . . ."); P. Moughan, Attorney, N. Mex. Optometric Ass'n, H-121 at p. 1; L. Strulowitz, Member, New Jersey Board of Optometrists, J-1 at p. 1; D. McBride, President, Montana Optometric Ass'n, J-57 at p. 3; K. Eldred, Secretary, Wyoming Board, Tr. 2005-06; D. Conner, Director, Dep't of Legal Affairs, Indiana Optometric Ass'n, Tr. 667; C. Beier, President, Kansas Board of Optometry, J-52(a).

[841] While many states have adopted commercial practice restrictions in an attempt to maintain quality of care, see supra section II.B., "Regulatory Environment," a significant number have determined that they are not needed to uphold this policy. E.g., Ariz. Rev. Stat. Ann. §32-1704(B)(2) ("The board [of optometry] may not adopt a rule which . . . regulates the place in which a doctor of optometry may practice."); Colo. Rev. Stat. §12-40-114(2) ("Any licensee may maintain offices which he periodically visits, other than than in which he maintains and carries on his principal practice. . ."); Fla. Stat. §463.014(1)(d) ("No rule of the board [of optometry] shall forbid the practice of optometry in or on the premises of a commercial or mercantile establishment."); Ga. Code §84-1110.1 ("[T]he board [of examiners in optometry] shall not provide by rule to restrict the location of the practice of a licensed doctor of optometry, and any such rule now in effect shall be null and void."); Ill. (footnote continued)

has advanced any other policy justification for commercial practice restrictions.[842] In the case of commercial practice restrictions, however, the means are unrelated to the policy goal. As discussed elsewhere, commercial practice restrictions do not affect the quality of care delivered in a market.[843] The policy expressed by commercial practice restrictions is thus not

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Rev. Stat. ch. 111, §3804 ("Nothing contained herein shall prevent any such person, firm, or corporation [who manufactures or deals in eyeglasses] from engaging the services of one or more registered optometrists nor prohibit any such registered optometrist when so engaged, to practice optometry . . . when the person, or firm or corporation so conducts his or its business in a permanently established place . . ."); N.Y. Admin. Code tit. 8, §29.8(b) ("Nothing in these Rules shall be construed to . . . prevent any contractual arrangement between any such person, firm, or corporation [that fills eyeglasses or lens prescriptions], its professional employees, or a person leasing space or equipment to such firm or corporation under which the amount due any of such parties is computed on the basis of a percentage of the receipts from the performance of professional services."); S.C. Code Ann. §40-37-290 ("Nothing in this chapter shall be construed to limit the number of offices each individual optometrist or group of optometrists may operate."); Tex. Health & Safety Code Ann. tit. 71, §4552-5.13(d) ("An optometrist may practice optometry under a trade name or an assumed name or under the name of a professional corporation or a professional association."); Vt. Stat. Ann., tit. 26 §1708(c) ("The [optometry] board shall not: (1) limit the ownership of optometric practices to licensed optometrists; (2) limit the number of offices or sites at which an optometrist may practice; or (3) limit the right of optometrists to practice in an association, partnership, corporation, or other lawful entity with anyone."); Wis. Stat. §449.03(1) (. . .[N]or shall the [optometry] examining board enact rules which forbid the employment of an optometrist or declare such employment unprofessional conduct, or prohibit the operation of an optometric department by optometrists in a mercantile establishment.").

[842] There may be a single exception to this. Oklahoma may use branch office restrictions to implement a policy of making choice practice sites available to new optometry graduates. L. Oxford, Executive Director, Oklahoma Optometric Ass'n, Tr. 2559.

[843] See supra section III.C.3.c., "Quality of Care for those Receiving Care."

inconsistent with the proposed rule.

State approval of a practice does not preclude the Commission from finding it unfair if there is strong evidence of net consumer injury.[844] It does, however, underscore the need for a close examination of whether the proposed Commission action is inconsistent with state policy,[845] and if so, the competing policies involved.[846] Commercial practice restrictions, however, are not policies themselves, but tools intended to implement a policy. Where, as here, the tools cause net consumer injury and are unrelated to the policy goal they purport to implement, public policy is no barrier to a finding of unfairness.

4. Conclusion

The four types of commercial practice restrictions that form the basis for the proposed rule cause substantial consumer injury in several ways. They impose unnecessary costs on consumers and reduce the availability of optometric care, they do not serve to increase the quality of optometric care in a market, and their impact cannot reasonably be avoided by consumers. Further, commercial practice restrictions are contrary to well-established policies that favor containment of health-care costs and the

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844 Unfairness Statement, supra note 782 at p. 10.

845 Averitt, supra note 781 at p. 277, citing Statement of Basis and Purpose, Preservation of Consumers' Claims and Defenses, 40 Fed. Reg. 53,506, 53,507-08 (1975).

846 Unfairness Statement, supra note 782 at p. 10.

unfettered operation of the market for health care delivery, confirming this finding of consumer injury. They do not advance state policies favoring maintenance of quality of care. Restriction of these commercial practices therefore constitutes an unfair act or practice within the meaning of Section 5 of the Federal Trade Commission Act.

B. Preemption of State Law

1. Introduction

Although the language of the FTCA does not expressly address the preemptive effect of Commission rules, it is clear that FTC Rules preempt inconsistent state law.[847] The preemptive effect of Commission rules has been recognized by courts which have addressed the issue.[848] The conclusion that FTC rules preempt

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[847] This section focuses on the preemptive effect of FTC Rules promulgated pursuant to Section 18 of the Federal Trade Commission Act, 15 U.S.C. §57a. It does not address the preemptive effect of Commission orders under Section 5 of the FTCA, or of rules under Section 6(g).

The Commission has stated on several occasions that FTC trade regulation rules preempt inconsistent state laws. Statement by the Commission in Hearings on S. 986, 92nd Cong. 1st Sess. 65 (1971) at 15; Statement of Basis and Purpose, Trade Regulation Rule on Advertising of Ophthalmic Goods and Services, 43 Fed. Reg. 23992, 24003; Statement of Basis and Purpose, Trade Regulation Rule on Credit Practices, 49 Fed. Reg. 7740, 7782 n. 1.

[848] American Financial Services v. FTC, 767 F.2d 957 (D.C. Cir. 1985); See also, Katharine Gibbs Schools v. FTC, 612 F.2d 658 (2d Cir. 1979).

Several commenters who have addressed the issue have also (footnote continued)

inconsistent state law is based on two closely related points: (1) under the Supremacy Clause, state law which conflicts with valid federal regulations is preempted; and (2) the legislative history of Magnuson-Moss indicates that Congress understood and intended that Commission rules preempt inconsistent state law. Subpart (1) of this section discusses both of these points more fully.

The legislative history and court opinions indicate, however, that there are limitations on the Commission's use of its preemptive power, and provide guidelines for the use of that power. For example, the courts have suggested that the Commission should not intrude "gratuitously" on the state's police powers. These limitations and guidelines are discussed more fully in subsection (2) of this section. There, we also discuss how the recommended Eyeglasses II rule is consistent with these limitations and guidelines.

2. General Preemptive Power

a. Supremacy Clause

Under the Supremacy Clause of the U.S. Constitution[849]

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reached this conclusion. See, e.g., P. Verkuill, Preemption of State Law, 1976 Duke Law Rev. 225; Note, The State Action Exemption, 89 Harv. L. Rev. 715 (1976).

[849] U.S. Constitution, Art. VI Cl. 2: "This Constitution, and the laws of the United States which shall be made in pursuance thereof; . . ., shall be the supreme law of the land . . ., anything in the Constitution or laws of any state to the contrary (footnote continued)

federal law supercedes inconsistent state law.[850] This so-called "conflict" preemption flows naturally from the Supremacy Clause and does not depend upon an express Congressional statement, either in the statutory language or legislative history.[851] Validly enacted regulations of federal agencies have the same preemptive effect as federal statutes.[852] Thus, agency rules preempt inconsistent state laws even in the absence of any Congressional statement of intent to preempt.[853] In fact, there appears to be no case where a Congressional delegation of substantive rulemaking power to an administrative agency has ever been construed as requiring a federal agency's rules to yield to state laws in the event of a direct conflict.

"Conflict" preemption contrasts with so-called "occupation of the field" preemption. The latter occurs only where Congress intends for the federal government to occupy an entire field of regulation and thus precludes any state regulation in the

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notwithstanding."

850 See, e.g., Gibbons v. Ogden, 9 Wheat. 1 (1824).

851 See, e.g., Paul v. United States, 371 U.S. 245 (1963); Free v. Bland, 369 U.S. 663 (1962).

852 Fidelity Federal Savings and Loan Ass'n v. De La Questa, 458 U.S. 141, 153-54 (1982); Free v. Bland, 369 U.S. 663, 666-668 (1962).

853 Fidelity Federal Savings and Loan Ass'n v. De La Questa, 458 U.S. 141, 153-54 (1982); Free v. Bland, 369 U.S. 663, 666-668 (1962). See also Michigan Canners and Freezers Ass'n v. Agriculture Marketing and Bargaining Board, 467 U.S. 461, 469-70 (1984). Conflict preemption has been upheld even where the Federal enabling statute stated that it "shall not be construed to change or modify existing state law." Id. at 469-70 (quoting Agricultural Fair Practices Act, 7 U.S.C. §2305(d).

field.[854] It is clear that Congress did not intend for the Federal Trade Commission Act to occupy the field of consumer protection or antitrust regulation.[855]

Courts which have considered and ruled on the issue have held that Commission rules preempt inconsistent state laws, relying both on general supremacy clause principles and on Congressional intent in enacting Magnuson-Moss. In 1985, the Court in American Financial Services v. FTC, in upholding the Commission's Credit Practice Rule, held that Commission rules preempt inconsistent state laws.[856] The court held that "[i]t has long since been firmly established that state statutes and regulations may be superseded by validly enacted regulations of federal agencies such as the FTC."[857] In addition, the court in Katharine Gibbs Schools v. FTC,[858] while remanding the entire Vocational School Rule, relied on similar reasoning in stating

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854 See, e.g., Rice v. Santa Fe Elevator Corp. 331 U.S. 218 (1947); Hines v. Davidowitz, 312 U.S. 52 (1941).

855 See discussion at infra note 871.

856 767 F.2d 957 (D.C. Cir. 1985). While the opinion speaks broadly about the preemptive effect of Commission rules, it is possible to argue that the decision should be construed more narrowly and limited to the factual situation of that rule. The Credit Practices Rule prohibited conduct which was authorized by state statute or common law. Thus, creditors could comply with both state law and the Commission rule. Statement of Basis and Purpose, Credit Practices Rule, 49 Fed. Reg. 7740, 7782. The court, however, did not indicate that its holding was limited to this type of preemption but stated broadly that Commission rules preempt inconsistent state laws.

857 Id. at 989, citing Katharine Gibbs Schools v. FTC, 612 F.2d 658, 667 (2d Cir. 1979).

858 612 F.2d 658 (2d Cir. 1979).

that Commission rules preempt inconsistent state laws.[859]

b. Legislative History of the Magnuson-Moss Act

The legislative history of the Magnuson-Moss Act establishes that Congress recognized that Commission rules would preempt conflicting state laws.[860] Throughout the period when rulemaking legislation was being considered, Congress was aware that Commission rules, like other federal agency rules, would preempt state law, even in the absence of express statutory language. In

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[859] Id. at 667. The Katharine Gibbs court held, however, that the particular preemption provision in that rule was overbroad and beyond the Commission's power because the Commission had not defined with specificity the unfair acts and practices subject to the rule. The entire Vocational School rule was remanded. 612 F.2d at 662. The court stated that if the Commission had defined with specificity the unfair acts or practices, "questions of preemption could be answered with relatively little difficulty." 612 F.2d at 667.

In American Optometric Association v. FTC, 626 F.2d 897 (D.C. Cir. 1980), the court remanded the Eyeglasses I Rule to the agency for further consideration, without deciding the preemption issue. The court held that, as a result of the Bates case, changes in the "core circumstances" underlying the rule had occurred since the rule was promulgated. In Bates v. State Bar of Arizona, 433 U.S. 350 (1977), the Supreme Court held that the First Amendment protects the right of lawyers to advertise prices of routine services. Under this ruling, total bans on ophthalmic advertising, prime targets of the Eyeglasses I rule, were clearly unconstitutional. Much of the evidence in the Eyeglasses I proceeding had concerned total bans and predated the Bates decision.

[860] The Magnuson-Moss Act expressly conferred substantive rulemaking power upon the FTC (§ 202), expanded the Commission's jurisdiction to matters "in or affecting" interstate commerce (§ 201), and granted the Commission certain additional remedies. Magnuson-Moss Warranty - Federal Trade Commission Improvement Act, 88 Stat. 2183 (1975) codified at 15 U.S.C.A. §§ 45 et. seq.

fact, Congress sought to clarify or limit the preemptive effect of the Magnuson-Moss Amendment and Commission rules by stating that the Federal Trade Commission Act would not occupy the field and that only inconsistent state laws would be preempted.[861]

To understand the Congressional intent in enacting Magnuson-Moss it is necessary to consider the entire period in which Congress was considering bills to clarify the Commission's rulemaking authority. The Magnuson-Moss Amendments were not finally passed until the 93d Congress. However, similar measures had been introduced in the two previous Congresses and the history of those measures helps in understanding the Congressional intent concerning the final version.[862] The clearest statements of Congressional understanding occurred in the 91st and 92d Congresses.

The earliest rulemaking bill to be considered, in the 91st Congress, contained a provision that the Act would not displace state laws except laws which "conflict with the provisions of the Federal Trade Commission Act, regulations thereunder, or the exercise of any authority by the Commission under such Act."[863]

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[861] S. 3201, 91st Cong., 2d Sess. §106 (1970). See S. Rep. No. 91-1124, 91st Cong., 2d Sess. 23 (1970).

[862] It is well established that the history of earlier bills may be used in interpreting the final version. See e.g., United States v. Enmons, 410 U.S. 396, 404-06 (1973); Sperry v. Florida ex rel. Florida State Bar 373 U.S. 379, 393-94 (1963); Schwegmann Bros. v. Calvert Distillers Corp., 341 U.S. 384, 390-95 (1951).

[863] S. 3201, 91st Cong., 2d Sess. § 106 (1970). See S. Rep. No. 91-1124, 91st Cong., 2d Sess. 23 (1970).

The purpose of this language was to ensure that the expansion of the FTC's jurisdiction to "affecting commerce" not be interpreted to preempt state law not in conflict with the act,[864] or to occupy the field and preclude all state consumer protection regulation.

A similar bill was introduced in the 92d Congress but without language addressing preemption. The report of the Senate Commerce Committee stated that "[a]t the present time a Trade Regulation Rule would preempt state legislation or regulation that conflicted."[865] The subcommittee chairman and bill's sponsor explained that no specific language was needed in the bill because preemption of conflicting state laws was the customary result under the Supremacy Clause, and thus that the omission of the language on preemption was of "no legal consequence."[866]

In the 93d Congress, the Senate bill initially contained a provision explicitly recognizing the preemptive effect of Commission rules.[867] However, the entire rulemaking provision was removed from the bill, at the FTC's request, pending adjudication of the Commission's power to issue rules under section 6(g) of the FTCA.[868] The Senate Commerce Committee

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864 S. Rep. No. 1124, 91st Cong., 2d Sess. 11 (1970).

865 S. Rep. No. 92-269, 92d Cong., 1st Sess. 28 (1971).

866 117 Cong. Rec. 39826 (1971) (Remarks of Senator Moss).

867 S. 356, 93d Cong., 1st Sess. §206 (1973); 119 Cong. Rec. 972 (1973).
(footnote continued)

report stated that "the deletion of rulemaking power by the committee is not to be read in any way as a reversal of the Senate's position in the 92nd Congress. . . ."[869] Subsequently, a rulemaking provision was added in conference and ultimately became law.

Throughout the debates in both the House and the Senate, both supporters and opponents of the legislation recognized that Commission rules would preempt conflicting state laws. Opponents objected to granting the Commission the authority to promulgate rules because of their opposition to preemption, but none suggested that Commission rules would not preempt.[870]

The last explicit reference to preemption is contained in the House Committee Report, 93d Congress, which stated, in connection with the expansion of jurisdiction to "in or affecting commerce:"

> The expansion of the FTC's jurisdiction made by this section 201 is not intended to occupy the

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[868] The district court had ruled that the FTC had no substantive rulemaking power under section 6(g). National Petroleum Refiners Ass'n v. FTC, 340 F. Supp. 1343 (D.D.C. 1972). At the opening of the 93d Congress, the FTC was appealing this decision to the Court of Appeals.

[869] S. Rep. No. 93-151, 93d Cong., 1st Sess. at 2, 32. The House bill initially contained no rulemaking provision. The rulemaking provision was added in Committee. H.R. 7917, §202, 93d Cong., 2d Sess. (1974).

[870] See, e.g., Hearings on S. 3201, 91st Cong., 2d Sess. 40, 92-93, 130-31, 238-39, 320 (1971); Hearings on S. 986, 92d Cong., 1st Sess. 76-78, 85 (1971); 117 Cong. Rec. 39835-36, 39840 (1971); Hearings on H.R. 4809, 92d Cong., 1st Sess. 456 (1971); Hearings on H.R. 20, 93d Cong., 1st Sess. 202, 217 (Statement of Sen. Moss) 235, 250-51, 317, 345 (1973).

> field or in any way to preempt State or local agencies from carrying out consumer protection or other activities within their jurisdiction which are also within the expanded jurisdiction of the Commission.
>
> Where cases of consumer fraud of a local nature which affect commerce are being effectively dealt with by State or local government agencies, it is the Committee's intent that the Federal Trade Commission should not intrude.[871]

Thus the expansion of the Commission's jurisdiction to "affecting commerce" was not of itself intended to preempt state or local regulation; that is, the expansion of jurisdiction was not intended to occupy the field of consumer protection legislation thus precluding all state consumer protection regulation. However, the report implies that the FTC may "intrude" upon state and local enforcement activities if it is not interfering with state laws which effectively deal with consumer fraud.[872] This statement is consistent with a Congressional understanding that Commission rules preempt, and a Congressional concern to limit that preemption power.

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871 H.R. Rep. No. 93-1107, 93d Cong., 2d Sess. 45 (1974).

Section 201 of the Federal Trade Commission Improvement Act expanded the Commission's jurisdiction to "in or affecting" commerce. The House Report makes clear that the FTC Act itself was not intended to occupy the field and, consequently, preempt all state laws in that field. See discussion at infra note 901, for a discussion of "occupation of the field" preemption. The fact that Congress did not intend for the FTCA to occupy the field is not inconsistent with an intent that Commission rules would preempt inconsistent state laws.

872 See, P. Verkuill, Preemption of State Law By the Federal Trade Commission, 1976 Duke L.J. 225, 240-241; P. Verkuill, Dean, Tulane Law School, J-9(a) at pp. 9-10; Comment, 51 Temp. L. Q. 281-312 (1978).

Thus, the legislative history of the Magnuson-Moss Amendments indicates that Congress understood that Commission rules would preempt inconsistent state laws regardless of any express language granting preemptive power. By incorporating language in earlier bills and in various committee reports regarding preemption, Congress did not view itself as granting preemptive power which the Commission would not otherwise have, but was concerned with limiting or clarifying the preemptive effect of the Magnuson-Moss Amendments or Commission rules.[873] The Senate Commerce Committee Report in the 92d Congress stated that Commission rules preempt inconsistent state laws despite the fact that the bill voted out by the Committee contained no language on preemption. It seems unlikely that Congress would have included such language in the Committee Report and not in the statute itself if Congress had viewed itself as affirmatively granting preemptive authority which the Commission would not otherwise have. This Congressional view of preemption is consistent with the general principles regarding conflict preemption which flow from the Supremacy Clause.

It could be argued that the intent of only the 93d Congress is relevant, not earlier Congresses, and that the 93d Congress

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873 Arguably, a contrary implication may result from the preemption language that was originally included in § 356, the rulemaking provision introduced in the 93d Congress, and subsequently deleted. 119 Cong. Rec. 972 (1973). This provision appears to be an express grant of preemption authority. It also appears to include the authority to occupy the field. While no explanation was given for including this provision, the desire to ensure a broad preemptive authority could be a reason.

expressed no clear intent that Commission Rules have preemptive effect.[874] According to this argument, absent a clear statement,there should be no finding of an intent to grant preemptive authority. A related argument is that since earlier bills and reports contained language regarding preemption, and the final bill and conference report contained no such language, it should be concluded that Congress decided not to grant the Commission preemptive authority. This argument might be more persuasive if earlier language is viewed as granting the FTC preemptive power which it would not otherwise have. However, the legislative history indicates that Congress understood that FTC rules would have preemptive effect in any event.[875]

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[874] See, Brief of the American Optometric Ass'n, AOA v. FTC, H-81, App. A at pp. 25-26 (Attachment to AOA Comment).

[875] Some parties have argued that since Title I of Magnuson-Moss -- dealing with warranties -- expressly deals with preemption, it can be inferred that Congress did not intend for FTC rules promulgated pursuant to Title II -- granting the FTC rulemaking authority with respect to unfair acts or practices -- to preempt state laws. Brief of American Optometric Assoc., AOA v. FTC H-81, App. A at pp. 23-24 (Attachment to AOA Comment). However, Title I does not merely state that FTC Rules under that provision will preempt state laws. Rather, that statute itself preempts certain state laws, including laws which regulate in the same area as the statute. See, 15 U.S.C. §2311(c)(1). Thus, the Congressional intent regarding preemption in this area was very different from what it was regarding Commission Rules under Title II.

It can also be argued that there is little, if any, indication of Congressional intent regarding preemption on the House side, and that most of the legislative history on preemption comes from the Senate side. Brief of American Optometric Ass'n, at pp. 24-25. Evidence on the House side consists of the final House Committee Report in the 93d Congress, H.R. Rep No. 93-1107, 93d Cong., 2d Sess. 45 (1974), and statements in the floor debates, cited at supra note 870.

The courts in both American Financial and Katharine Gibbs in reviewing the legislative history of the Magnuson-Moss Act and the predecessor bills concluded that Congress intended FTC rules to have "that preemptive effect which flows naturally from a repugnancy between the Commission's valid enactments and state laws."[876]

3. State Action Doctrine

It has been argued that the "state action" doctrine of Parker v. Brown[877] should be applied to the Commission's unfairness rulemaking authority.[878] This argument is not valid. The state action doctrine has never been held applicable to the Commission's unfairness jurisdiction nor to agency rulemaking. Moreover, in enacting the Magnuson-Moss Amendments, Congress considered and resolved the preemption issue and the Congressional intent that FTC rules preempt inconsistent state law would be frustrated by application of the state action doctrine. For these and other reasons the doctrine is not applicable to the Commission's unfairness rulemaking authority.

In Parker and its progeny, the Court held that the Sherman

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876 American Financial Services v. FTC, 767 F.2d at 989-990; Katharine Gibbs School v. FTC, 612 F.2d 658 (2d Cir. 1979).

877 317 U.S. 341 (1942).

878 See, Brief of the American Optometric Ass'n, American Optometric Ass'n, v. FTC, H-81, App. A at p. 22-23 (attachment to AOA Comment).

Act does not prohibit restraints which are imposed by a state acting as sovereign.[879] The court stated that "an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress."[880] The court found nothing in the Sherman Act's language or legislative history to suggest that it was meant to prohibit state restraints.[881]

In contrast to the legislative history of the Sherman Act, the legislative history of the Magnuson-Moss Act indicates that Congress did understand that FTC Rules would preempt state laws.[882] Thus, with regard to Commission rulemaking there would

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879 317 U.S. 341, 350-51 (1942). In Parker the question was whether a California state regulatory program which restricted the output of raisins violated the Sherman Act. The Court held that the challenged restraint was exempt from the Sherman Act.

In order to qualify for the exemption, specific criteria must be met, as set forth in the case law. See, e.g., California Retail Liquor Dealers Assoc. v. Midcal Aluminum, 445 U.S. 97, (1980) (challenged restraint must be clearly articulated and affirmatively expressed as state policy and state must actively supervise any private anticompetitive conduct).

880 317 U.S. 341, 350-51.

881 Id. at 351. In a subsequent case, the Court stated that although the Parker Court relied upon Congressional silence on the subject of state action, the legislative history contains some statements expressing a Congressional desire not to invade the legislative authority of the states. Southern Motor Carriers Rate Conference v. United States, 105 S. Ct. 1721, 1726 n. 19 (1985).

882 Congress imposed some limits on the FTC's authority to invalidate state laws by stating that the FTC should not intrude where state laws are "effectively" dealing with consumer fraud, and by precluding occupation of the field by the FTCA. See, P. Verkuil, Preemption of State Law by the Federal Trade Commission, 1976 Duke L.J. 225, 243. It can also be argued that the more stringent procedural safeguards in the rulemaking provision provide a further check on the Commission's preemption power. The Magnuson-Moss Amendments mandate a rulemaking process which (footnote continued)

be no need to infer an intent to invalidate state laws in the face of Congressional silence.[883]

Further, there is direct evidence in the legislative history of a Congressional intent that FTC rules could preempt state laws by declaring such laws "unfair." In an exchange on the floor in the 92d Congress, Senator Hruska cited an example of a state law limiting production of agricultural products, and stated that the FTC could declare such a state program unfair under the proposed rulemaking authority -- which had no preemption provisions:

> Yet that program could well become grist in the mill for the Federal Trade Commission if it were armed with the authority which section [18] seeks to give it. Certainly it could be said it is unfair and it is bad for the consumers to be deprived of those products which could be grown on those unused acres "and we therefore make a rule that there shall be no laws that will forbid the use of acres."
>
> So you see, Mr. President, it is not only in new fields that this power would enable the Federal Trade Commission to function; it could take existing laws and existing statutes and say, "These laws and these statutes are

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has more procedural safeguards, and more stringent judicial review than exists under the Administrative Procedure Act. See 15 U.S.C. §57a. See, Verkuil, 1976 Duke L. J. at 243, 246. In the context of FTC rulemaking, therefore, further limits should not and need not be added by the courts.

883 Another consideration is that application of the state action doctrine could seriously interfere with uniform nationwide rules where conflicting state laws existed. Each conflicting state law would have to be scrutinized to determine whether it met the criteria of "state action," and the preemptive effect of the rule would vary from state to state depending upon whether a particular state's enactments met the criteria for state action. If a significant number of conflicting laws qualified as "state action" such an interpretation would render largely meaningless the preemptive effect of a Commission rule. It seems unlikely that Congress intended such a result.

unfair."

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> Senator MAGNUSON: I listened to the statement by the Senator from Nebraska and I have no objection to the way he analyzes the rulemaking section. Legally I think what he said is correct. I disagree with his statement that some of these things should not happen. I want them to happen.[884]

Thus, the statement of the bill's sponsor, which is considered strong evidence of Congressional intent,[885] clearly indicates that the Commission could preempt a state law, which apparently would meet the criteria for state action, by declaring such a law to be unfair.[886]

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884 117 Cong. Rec. 39835-36, 39840 (1971). Senator Hruska's motion to eliminate the grant of rulemaking authority was subsequently defeated.

885 Statements of a bill's sponsor are strong authority. Schwegmann Brothers v. Calvert Distillers Corp., 341 U.S. 384, 394-95, (1951) ("It is the sponsors that we look to when the meaning of the statutory words is in doubt."); First National Bank of Logan, Utah v. Walker Bank and Trust Co., 385 U.S. 252, 261, (1966); New York v. Train, 494 F.2d 1033, 1039 (1974).

886 It has been argued that since Parker v. Brown was familiar doctrine when Congress passed Magnuson-Moss, Congress would have stated clearly any intention that the doctrine not apply to FTC rulemaking. Brief of American Optometric Ass'n, American Optometric Ass'n v. FTC, H-81, App. A at at p. 23 (Attachment to AOA Comment). However, Congressional failure to mention the doctrine would be consistent with a Congressional understanding that the doctrine would not apply. There is no reason to assume that, in deliberations concerning unfairness authority and rulemaking, Congress believed that the doctrine would apply. Opponents' fears about the preemptive effect of Commission rules could have been easily met by reference to the state action doctrine. This did not occur. See, e.g., Hearings on H.R. 20, 93d Cong., 1st Sess. 202, 217 (comment of Subcommittee Chairman Moss) (1973); Hearings on S. 3201, 91st Cong., 2d Sess. at 92-93, 130-31 (Senators Ervin and Cook).

A number of factors suggest that federalism concerns are less serious in the context of FTC unfairness rulemaking than under the Sherman Act, thus suggesting additional reasons why Parker is not applicable to FTC's unfairness rulemaking.[887] One, the FTC's unfairness jurisdiction has less potential to completely disrupt state regulation. If applied to state action, the Sherman Act could effectively restructure the entire economic regulatory organization of the states.[888] While FTC unfairness authority is also broad, it will not indiscriminately invalidate state regulatory schemes, since it is constrained by the "unfairness" criteria,[889] and the FTC would consider state goals other than competition in deciding whether a practice is unfair.[890]

Two, the FTCA, unlike the Sherman Act, cannot be invoked by private parties. Rather, violations are targeted by a federal agency charged with protecting the public interest, whose actions

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887 A number of commenters who have addressed this issue have agreed. See, e.g., P. Verkuill, Preemption of State Law by the Federal Trade Commission, 1976 Duke L. J. 225; Note, The State Action Exemption and Antitrust Enforcement Under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 732-742 (1976); Comment, The Parker Perplex, 51 Temp. L. Q. 281 (1978).

888 State goals other than competition, such as health and safety could not be considered under current antitrust principles in determining the validity of the state restraints. Even if courts allowed consideration of other goals, this would involve the court in determinations which they traditionally avoid.

889 Unfairness Statement, supra note 782.

890 Id. See also, Note, The State Action Exemption and Antitrust Enforcement Under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 733-34 (1976).

are subject to Congressional and judicial review.[891] The Commission has stated that it considers preemption a remedy of last resort, appropriate only where the evidence of consumer injury from the state law is clear; the alleged benefits of the state regulation are minimal or absent; and states are not acting on their own to remove the restriction. Congressional oversight of FTC action also acts as a restraint on indiscriminate FTC preemption.[892]

Three, the Sherman Act provides for treble damages for private plaintiffs, and for criminal penalties, all of which apply retrospectively.[893] By contrast, FTC rules apply prospectively; criminal sanctions are not available, and civil penalties are available only against persons who violate FTC rules with actual knowledge.[894] Further, the recommended rule declares that state entities will not be subject to any civil penalties or monetary liability for violation of the rule.

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[891] Commentators have noted that FTC rulemaking is curtailed by agency discretions. See, e.g., Note, The State Action Exemption and Antitrust Enforcement Under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 733 (1976).

[892] In the past, Congress has acted to curtail FTC activity of which it disapproved. See, Federal Trade Commission Improvements Act of 1980, 15 U.S.C §57a note. See also, Note, The State Action Exemption and Antitrust Enforcement Under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 733 (1976), which agrees with this point.

[893] 15 U.S.C. §§1-2 (1970); 15 U.S.C. §§15-16 (1970).

[894] 15 U.S.C. §45(m)(1)(A). See, Note, The State Action Exemption and Antitrust Enforcement under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 734-35 (1976).

Four, rulemaking entails procedural safeguards which mitigate concerns about federalism. Rulemaking allows for participation by all interested parties, including affected states. Rulemaking also permits the agency to develop a complete record regarding the need for and effects of preemption.[895] Further, in promulgating the Magnuson-Moss Amendments, Congress imposed additional procedural safeguards on FTC rulemaking above those imposed by the Administrative Procedure Act,[896] thus increasing the procedural protections afforded to state who may be affected by a Commission rulemaking.

In stating that Commission rules preempt inconsistent state laws, the court in American Financial did not mention the state action doctrine.[897] This may be significant since it is logical that, had the court believed that the state action doctrine might apply, it would have mentioned it and inquired whether any of the laws preempted by the rule met the criteria for state action.[898] Similarly, the court in Katharine Gibbs, while

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895 See, Note, The State Action Exemption and Antitrust Enforcement under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 737 (1976).

896 The Magnuson-Moss Amendments mandate additional hearing procedures and expand the scope of court review over Commission rules. 15 U.S.C. §57a. See, also, Verkuil, Preemption of State Law by the Federal Trade Commission, 1976 Duke L. J. at 242-243; Note, The State Action Exemption and Antitrust Enforcement under the Federal Trade Commission Act, 89 Harv. L. Rev. 715, 745-750 (1976).

897 767 F.2d 957, 989-991 (D.C. Cir. 1985). Parker v. Brown was not mentioned in the briefs filed in that case, either.

898 It is at least possible that some of the state laws preempted by the Credit Practices rule could have met the (footnote continued)

stating broadly that Commission rules preempt inconsistent state laws, did not mention the state action doctrine.[899]

In conclusion, the state action doctrine clearly does not apply to Commission rulemaking authority under Section 18. Such an application would be contrary to the Congressional intent that FTC Rules preempt inconsistent state laws and to the principles under the Supremacy Clause.

4. Guidelines and Limitations Concerning Preemption

Several limitations and guidelines emerge from the legislative history and from the cases concerning the Commission's use of its preemption authority. One is that the courts may well strike down a rule which attempts to "occupy the field." In American Financial Services and Katharine Gibbs the courts stated that Congress did not intend for the Commission's regulations to occupy the field.[900]

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criteria for state action. Under the Sherman Act, the doctrine may apply to state laws which permit private anticompetitive conduct as long as certain criteria are met. See Southern Motor Carriers Rate Conference v. U.S., 105 S. Ct. 1721, 1727, 1729 & n. 23 (1985).

899 Katharine Gibbs School v. FTC, 612 F.2d 658, 666-67.

The court in American Optometric Association mentioned the state action doctrine in one sentence. The court listed, but did not answer, a number of questions raised by the rule including whether the state action doctrine applied. 626 F.2d at 910. However, in American Financial Services, the court appeared to distinguish the AOA case on the basis that in Eyeglasses I the Commission proposed to occupy the field. 767 F.2d at 990.

900 767 F.2d at 989-990. In upholding the Credit Practice Rule, the court noted that the Commission explicitly stated its (footnote continued)

Occupation of the field preemption occurs when any state regulation on the same subject as the federal regulation is preempted even though the state regulation does not conflict with the federal requirements.[901] Under this form of preemption, state law which does not conflict with the federal requirement is preempted if the state law regulates the same subject matter as the federal law.

The recommended rule does not occupy the field. Rather the rule prohibits specific unfair practices and state regulation is preempted only if it is in conflict with the prohibitions of the rule. An FTC rule does not occupy the field as long as it prohibits specific unfair practices and does not preclude non-conflicting state regulation in the same area. The recommended rule meets these criteria.

In stating that the FTCA would not occupy the field, Congress intended that both federal and state law would protect consumers. Under the recommended rule both federal and state law would protect eye care consumers; the rule would not prevent states from enacting and enforcing any legitimate consumer protection measures.[902]

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intention not to occupy the field. Id. at 990-91.

901 See, e.g., Rice v. Santa Fe Elevator Corp., 331 U.S. 218 (1947).

902 In the Credit Practices Rule, which was held not to occupy the field, the Commission made it clear that more stringent state regulation of credit practices would not be affected by the rule. 49 Fed. Reg. at 7782.

In discusssing the preemption issue, the court in American Financial Services distinguished American Optometric Association v. FTC[903] by stating that in promulgating the Eyeglasses I rule, the Commission had preempted the whole field of ophthalmic advertising. It stated that both AOA and Katharine Gibbs "recognize only that Congress did not intend for the Commission's regulations to 'occupy the field'."[904] Even assuming the correctness of the court's statement regarding the Eyeglasses I rule, the recommended Eyeglasses II rule can be easily distinguished and clearly does not occupy the field.

The Eyeglasses I rule did not merely prohibit specific unfair practices. Rather, as a remedial measure,[905] the rule prohibited all state restrictions or burdens on ophthalmic advertising with specifically enumerated exceptions. Under the rule states could impose limitations which applied to all retail advertisements of consumer goods and services; states could impose any disclosure requirements on advertisements of eye

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903 626 F.2d 897 (D.C. Cir. 1980).

904 767 F.2d at 990.

In Katharine Gibbs, the court struck down the preemption provision, along with the entire rule, because the provisions would have preempted an indefinite variety of state laws. The rule preempted any state law which was inconsistent or which "otherwise frustrates the purposes" of the rule. 16 C.F.R. §438.9. Further the rule did not define with specificity the unfair acts and practices. The court found the provisions to be overbroad. 612 F.2d at 667.

905 The Commission may include in a rule "requirements prescribed for the purpose of preventing such [unfair] acts or practices. FTCA §18(a)(1)(B); 15 U.S.C. §57a(a)(1)(B).

exams; and states could impose five specifically enumerated disclosures on advertising of ophthalmic goods and services -- i.e., advertising of lenses, eyeglasses and dispensing services.[906] Thus, all time, place and manner restrictions were preempted unless they applied across-the-board to all consumer advertising, and all disclosure requirements on advertising of ophthalmic goods and services were preempted except five specific disclosures. The Commission did not find that these time, place and manner restrictions or disclosure requirements were unfair but justified the rule's prohibitions on these requirements as remedial provisions.[907]

In contrast, the recommended Eyeglasses II Rule would prohibit only four specifically enumerated types of restrictions which are unfair. As such the rule would not invoke the Commission's "remedial" powers. Since each of the state restrictions that would be covered by the rule is a specific "unfair" act or practice, and only conflicting state law would be preempted, the rule clearly does not occupy the field.

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906 See, 16 C.F.R. §§456.3, 456.4 & 456.5.

907 Statement of Basis and Purpose, 43 Fed. Reg. at 24002. The Staff Report stated that the evidence did not show that disclosure requirements had resulted in substantial consumer injury, but that permitting states totally unfettered discretion to adopt disclosure requirements had the potential for their being used to prevent truthful advertising. Eyeglasses I Staff Report, B-2-52-1, at p. 228. The Commission justified these requirements under its remedial power, arguing that they were necessary in order to prevent parties which had committed unfair acts from doing so in the future. Brief of Federal Trade Commission, American Optometric Ass'n v. FTC, G-7.

The recommended Eyeglasses II Rule would not interfere with the states' broad powers to deal with consumer abuses and ensure quality, including the state's ability to regulate abuses and ensure quality in the area of commercial practice. States could regulate commercial optometrists, as they do all optometrists, to protect the health and safety of their citizens. In contrast to the Eyeglasses I rule, states would not be confined to legislate only by laws that apply uniformly to all businesses nor would they be confined to a specifically enumerated list of requirements which they may impose. On the contrary, the states' regulatory schemes would be left intact, with the exception of the four restrictions which are unfair acts or practices. Thus, the rule clearly would not occupy the field.

A second, and related, limitation on preemption is made clear by the legislative history. The House Committee Report, 93d Congress, states that the FTC should not interfere when "cases of consumer fraud . . . are being effectively dealt with by state or local governmental agencies."[908] The court in

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[908] H.R. Rep. No. 93-1107, 93d Cong., 2d Sess. 45 (1974). See also, P. Verkuil, Preemption of State Law by the Federal Trade Commission, 1976 Duke L. J. 225 at 243.

In fact, the Congressional concern that the Commission not occupy the field appears to be very closely related to its concern that the Commission not preclude state regulation which effectively deals with consumer fraud. Arguably, the Eyeglasses I rule occupied the field because it supplanted such state consumer protection activities.

The limitation on preempting or intruding on effective state laws also appears to be related to the American Financial Services court's emphasis on the exemption provision which was included in the Credit Practices Rule. The inclusion of this (footnote continued)

American Financial Services cited this language and concluded that Congress did not intend for the FTC to gratuitously intrude on state or local enforcement activities. "Thus states' regulations are only supplanted when inadequate or counterproductive to the Commission's regulations."[909]

The recommended Eyeglasses II rule would not interfere with state laws which are effectively dealing with consumer fraud or which are effectively protecting the health and safety of the public. The rule has been carefully tailored to intrude on state law as narrowly as possible, to prohibit only harmful state restrictions which are unfair, and not to interfere with the state's legitimate role in protecting health and safety or dealing with consumer abuses.

A closely related, if not identical, limitation is that the Commission should show "deference" to the states and should not intrude "gratuitously" on the states' police powers. In AOA, the court stated that, with the Eyeglasses I rule,

> the Commission has at least approached the outer boundaries of its authority and may have infringed on that deference to the states' exercise of their police powers dictated by the principles of federalism.[910]

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provision appeared to contribute to the court's finding that the rule was a valid exercise of the Commission's power. 767 F.2d at 990-91. The exemption would be available to states providing equal or greater protection than the FTC rule and thus would help ensure that the Commission was not intruding where state laws are effectively dealing with consumer fraud. Since the Eyeglasses II rule would be directed only at harmful state restrictions, the inclusion of an exemption provision would be meaningless.

909 767 F.2d at 989 n. 41.

(footnote continued)

The court also stated that the validity of the rule may depend to some extent on the extent to which the rule "gratuitously intrudes on the exercise of the police powers of the states."[911] In upholding the Credit Practices Rule, the court noted that the Commission had modified the rule to be as consistent with state laws as possible.[912] The recommended Eyeglasses II rule would only remove specific state restrictions which are harmful and unfair, would be as consistent with state law as possible, and has been carefully drafted to avoid any such gratuitous intrusion on state law.

A fourth guideline concerns the Commission's use of its remedial power when preempting state laws. The AOA opinion was critical of the Commission's broad use of its remedial power in the Eyeglasses I Rule.[913] The court questioned the adequacy of the evidence upon which the Commission relied for the remedial provisions,[914] and stated that the Commission was assuming bad faith on the part of the states, based on little evidence. As

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910 626 F.2d at 910.

911 Id.

912 767 F.2d at 990-91.

913 Statement of Basis and Purpose, 43 Fed. Reg at 24002. The Commission found that the disclosure limitations were desirable because there was a "strong possibility" that states would impose unnecessary and burdensome disclosure requirements which could indirectly bar advertising of ophthalmic goods and services.

914 626 F.2d at 910-911. According to the court, there was little evidence regarding the affect of affirmative disclosure requirements and regulations other than total bans, nor was there adequate evidence that states would abuse the power to require affirmative disclosures.

indicated, in Eyeglasses II the Commission would not be imposing remedial requirements.[915]

5. Conclusion

In conclusion, it is clear that Commission rules preempt inconsistent state laws. This has been recognized by courts and is based on the Supremacy Clause and on Congressional intent in enacting the Magnuson-Moss amendments. It is also clear that the state action doctrine of Parker v. Brown does not apply to the Commission's unfairness rulemaking authority.

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[915] In challenging the Eyeglasses I rule, opponents of the rule attempted to rely on the Tenth Amendment to the U.S. Constitution, which states that powere not specifically granted to the federal government by the Constitution are reserved to the states. See, e.g., Brief of the American Optometric Ass'n, Petitioner, American Optometric Ass'n v. FTC, H-81, App. A at p. 38 (Attachment to AOA Comment). Opponents' argument was based primarily upon the Supreme Court's decision in National League of Cities v. Usery, 426 U.S. 833 (1976), which held that Congress could not constitutionally apply the minimum wage provisions of the Fair Labor Standards Act to state and local employees, because these provisions so interfered with traditional state functions that they went beyond Congress' power under the Commerce Clause. In Garcia v. San Antonio Metropolitan Transit Authority, 469 U. S. 528 (1985), the Court explicitly overruled National League of Cities. Garcia clearly indicated that, in general, provided the federal action is a proper exercise of authority under the Commerce Clause (or other constitutional authority), states cannot claim immunity against such action under the Tenth Amendment. Since Garcia, the lower courts have uniformly dismissed arguments that federal action has unconstitutionally interfered with state sovereignty under the Tenth Amendment. See, e.g., Metropolitan Transportation Authority v. ICC, 792 F.2d 287 (2d Cir. 1986); Holland v. Burlington Industries, Inc., 772 F.2d 1140 (4th Cir. 1985); Dressman v. Costle, 759 F.2d 557 (6th Cir. 1985). Thus, Garcia makes clear that opponents of the rule have no legitimate Tenth Amendment challenge.

Other limits do apply, however, to the Commission's preemptive authority. One, court's are likely to strike down a Commission rule which occupies the field. The recommended rule does not occupy the field, however, but would preempt only state law which conflicts with the rule's prohibitions on specific unfair acts or practices. States are not precluded from regulating abuses or promulgating any legitimate consumer protection measures in the area. Two, the FTC should not intrude where states are effectively dealing with consumer problems and should not intrude gratuitously on the states' police power. The recommended rule has been drafted as narrowly as possible to avoid any gratuitous intrusion and would not interfere with the state's legitimate role in protecting health and safety or regulating consumer abuses.

C. Friedman v. Rogers

In 1979, the Supreme Court held in Friedman v. Rogers that a Texas statute prohibiting the use of trade names by optometrists did not violate the First Amendment, but was in furtherance of a substantial state interest in preventing deception.[916] Some commenters argue that the Court's approval of the Texas ban on trade names should preclude the Commission from declaring trade names bans to be unfair.[917] We disagree. The court did not

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916 Friedman v. Rogers, 440 U.S. 1 (1979).

917 See e.g., J. Coady, Executive Director, American Dental Ass'n, D-9 at pp. 3-4; W. Erxleben, Counsel, Washington
(footnote continued)

"validate" trade name bans but only determined that the Texas ban at issue would withstand attack under the First Amendment. Such a determination does not preclude a Commission finding of unfairness. Further, applying the Court's commercial speech analysis to the more extensive rulemaking record regarding the effects of trade name bans should yield different results than the Court reached on the Friedman record.

1. Friedman and the Commission's Unfairness Jurisdiction

In concluding that the Texas ban on trade names did not violate the First Amendment, the Court applied standards different than the Commission would apply in deciding that a trade name ban is an unfair act or practice. This reason alone provides a basis for concluding that the Court's decision does not preclude a Commission finding of unfairness.

In making its determination, the Court in Friedman balanced the First Amendment interest in trade names against the state's interest in preventing trade name use. The Court first reviewed previous cases holding that truthful commercial speech is entitled to some First Amendment protection, although to a lesser extent than other noncommercial speech.[918] The Court found,

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Optometric Ass'n, H-14 at p. 2; A. Gorz, President, Wisconsin Optometric Ass'n, J-25 at p. 5; H. Stratton, Representative, New Mexico State Legislature, J-43 at p. 3.

[918] 440 U.S. at 8-10. The Court reviewed Bates v. State Bar of Arizona, 433 U.S. 350 (1977), and Virginia Pharmacy Board v. Virginia Citizens Consumer Council, 425 U.S. 748 (1978), both of which held that truthful statements about price and products or (footnote continued)

however, that there was very little First Amendment interest in trade name use.[919] The court distinguished trade names from other forms of commercial speech, stating that "the restriction on the use of trade names has only the most incidental effect on the content of the commercial speech of Texas optometrists,"[920] and that factual information can be conveyed without the use of trade names.

Finding minimal First Amendment interest in the use of trade

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services offered were entitled to First Amendment protection. The Friedman Court noted that the extent of commercial speech protection remained "uncharted," 440 U.S. at 11, fn. 9. They stated that commercial speech is entitled to less protection than other forms of speech because its importance to business renders it less likely to be chilled, and because its concern with particular products or services renders it more easily verifiable. 440 U.S. at 10. For example, commercial speech regulation was not (then) subject to overbreadth analysis, 440 U.S. at 11, fn.9. The Court did note that the "property interest" in trade names required that the FTC not prohibit deceptive trade names unless it found that the deception could not be cured by less restrictive means. 440 U.S. at 12 n. 11 (citing FTC v. Royal Milling Co., 298 U.S. 212, 217-218 (1933); Jacob Siegel Co. v. FTC, 327 U.S. 608, 611-613 (1944)). The Court's comment regarding Commission authority appears to have presaged its subsequent analysis of commercial speech protection, which charts a course requiring greater scrutiny than a mere balancing test. See infra at 926.

919 440 U.S. at 12. The Court concluded that trade names did little to further speech interests, in that "the information associated with trade names may be communicated freely and explicitly to the public" despite the Texas ban, id. at 16, and that trade names have "no intrinsic meaning", but only convey information concerning price and quality that becomes associated with a trade name over time. Id. at 12.

The rulemaking record likewise indicates that trade names embody the reputation of a firm for price and quality. However, the record demonstrates that the use of trade names facilitates the dissemination of this information, and at the same time provides incentives for firms to live up to their reputations. See Trade Name Ban Section.

920 440 U.S. at 15-16.

names, the Court did not closely scrutinize the state's rationale for its ban, the evidence it presented regarding deception, or the alternatives available to the state to prevent deception, as it might have had it found a greater First Amendment interest.[921] Rather, the court relied upon evidence regarding several possibilities for deceptive use of trade names and some individual cases in which deception had allegedly occurred.[922] This was sufficient, in the Court's view, to override what the Court perceived as an insubstantial First Amendment claim. Apparently for this reason, the Court did not examine whether less restrictive alternatives could be used to eliminate deception.

Given this apparently minimal scrutiny, the Court's determination should not preclude the Commission, on the basis of more extensive evidence and careful study, from determining that

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921 The Court concluded that deceptive trade name use in Texas is "substantial and well demonstrated." 440 U.S. at 13-15. After citing instances of allegedly deceptive trade name use, the Court noted "even if Rogers' use and advertising of the trade name were not in fact misleading, they were an example of the use of a trade name to facilitate the large-scale commercialization which enhances the opportunity for misleading practices." 440 U.S. at 15.

922 In concluding that Texas had experienced significant deception from trade names, the Court cited trade name usage by two Texas optometric chains that allegedly deceived consumers as to the ownership of the chain's offices. The evidence concerning these two chains were derived from depositions in Texas State Board of Examiners in Optometry v. Carp., 412 S.W.2d 307, appeal dismissed and cert. denied, 389 U.S. 52 (1967) (Carp operated 71 optometric offices under different trade names) and depositions concerning Rogers' own Texas State Optical chain used in the Friedman trial. See also 1980 Staff Report at p. 230. The Court did not find that trade names were inherently deceptive.

trade names are not inherently deceptive, that deception has not been widespread, and that less restrictive alternatives can be used to eliminate any deception which might occur. For the same reason, the Friedman decision should not provide a public policy basis against a finding that trade names bans are unfair.

Further, in considering whether a restriction on trade names is legally unfair, the Commission would consider additional factors beyond the First Amendment interest in trade names and the possibility of deception. Thus, the Commission can properly consider the extensive record evidence of the many consumer benefits of nondeceptive use of trade names. For example, the record contains evidence indicating that trade names reduce consumer search costs and facilitate the advertising of truthful price and quality information that consumers may not otherwise obtain, that trade names provide incentives for firms to maintain or improve quality as a means of protecting or enhancing their reputations, and that trade names may play an important role in reducing costs.[923] Trade names also play an important role in promoting competition from commercial firms and other large-volume providers, which lowers prices throughout the market, and increases the frequency of eye care purchases. These issues were not before the Friedman Court.

Finally, it is well established that even if activities are constitutionally permissible, they are nonetheless subject to

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[923] See supra section III.B.4., "Restrictions on Trade Name Usage."

Commission action if they are unfair. In Spiegel, Inc. v. FTC, the seventh circuit held that the FTC could prohibit Spiegel from using the Illinois long-arm statute to sue delinquent out-of-state customers, even though Spiegel's actions did not violate due process standards.[924] The court stated that "the Commission may find a practice to be unfair. . . even though the same practice has repeatedly withstood attack in the courts."[925] The Speigel decision establishes that practices are not immune from Commission action under Section 5 solely because they are constitutional or otherwise permissible under state law.

2. Trade Names and the First Amendment

The Friedman Court's conclusion that the Texas trade name ban did not violate the First Amendment should also be viewed in the context of subsequent developments in the Court's own analysis of commercial speech protection.

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924 Spiegel, Inc. v. FTC, 540 F.2d 287 (7th Cir. 1976). The court assumed, without explicitly finding, that the Illinois long-arm statue as used by Spiegel was constitutionally permissible. Thus, although Spiegel does not explicitly state that practices held constitutional by the courts can be condemned as unfair under Section 5 of the FTCA, it provides strong support for that conclusion.

925 540 F.2d at 294-295. It is well-established that the Commission may restrain unfair practices even if they are permitted or authorized under state or local law. See FTC v. Sperry & Hutchinson Co., 405 U.S. 233, 239 (1972)) (FTC order declaring trading stamp company practices unfair unsupported by specified grounds for violation); Peerless Products, Inc. v. FTC, 284 F.2d 825, 827 (7th Cir. 1960), cert. denied, 365 U.S. 884 (1960) (Use of merchandise punchboards unfair despite authorization under local law).

Subsequent Court opinions concerning commercial speech rely on Friedman for the proposition that deceptive or misleading speech may be restricted, but establish that deception is only the first test in determining whether commercial speech may be prohibited.[926] In Central Hudson Gas & Electric Corp. v. Public Service Commission of New York, the Court set forth its criteria for when commercial speech may be restricted.[927] If the commercial speech is deceptive, misleading, or related to unlawful activity, it may be prohibited.[928] If it is not, the state must demonstrate a substantial interest in restricting the commercial speech.[929] The state must also show that the restriction at issue directly advances the state interest and is the least restrictive means for advancing that interest.[930]

Applying the Central Hudson test to the extensive rulemaking

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926 See e.g., Central Hudson Gas and Electric Corp. v. Public Service Commission of New York, 447 U.S. 557, 563 (1980); In re R.M.J., 455 U.S. 191, 202 (1982); Zauderer v. Office Disciplinary Counsel of the Supreme Court of Ohio, 105 S.Ct. 2265, 2275 (1985).

927 447 U.S. 557, 564 (1980). Subsequent cases have established that this analysis applies to commercial speech by professionals. See In re R.M.J, 455 U.S. at 204; Zauderer, 105 S.Ct. at 2275.

928 447 U.S. at 564.

929 Id.

930 Id. The Friedman Court noted that the First Amendment did not require Texas to find a less restrictive means of curtailing deception. 440 U.S. at 12, n. 11. It does not appear that the Central Hudson test requires the less restrictive means analysis unless the commercial speech at issue is not deceptive. But cf. Zauderer, 105 S.Ct. at 2278 (prophylactic restrictions not appropriate when information can be presented in nondeceptive form).

record on trade names[931] points clearly to a result different from the one in Friedman. The rulemaking record establishes that trade names generally are not deceptive. Therefore, the analysis should proceed beyond that of Friedman to the other criteria of the Central Hudson test. The states clearly have a substantial interest in regulating deceptive trade names based on their duty to protect their citizens. It is not as clear, however, how bans on nondeceptive trade names would directly advance that interest.[932] Yet even assuming that such bans do so, the record establishes the existence of less restrictive means for preventing deceptive trade name use.[933] Therefore, under criteria established by the Central Hudson Court, a consideration of the rulemaking record could readily lead to the conclusion that nondeceptive trade names deserve First Amendment protection.

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[931] The rulemaking record contains comments and testimony from representatives of every state, as well as from members of industry groups, professional associations, consumer organizations and individual practitioners. The record also contains the depositions and briefs relied on in Friedman. See Exhibits to the Statement of F. Neimann, Counsel, Texas Optometric Ass'n, J-23(c)-(g).

[932] Because trade names are not generally deceptive, bans on their use do not significantly help in curtailing deception. Because trade names do not result in decreased quality care, bans do not advance quality interests. On the contrary, these bans may inhibit advertising by chain firms and increase costs, possibly contrary to the states' interest in protecting consumers. See supra section III.B.4., "Restrictions on Trade Name Usage."

[933] Every state currently has regulatory mechanisms short of trade name bans for dealing with the harm trade names are alleged to cause. See chart at pp. 33-46. In fact, Texas repealed its trade name ban in 1984, and has not experienced a resulting increase in deception since that time. See supra section III.C.3.e.i., "Effects on Preventing Deception."

3. Conclusion

Staff concludes that the Court's decision in Friedman does not preclude a Commission finding that trade name bans are unfair under the FTC Act because the Court in Friedman applied different standards to its determination than would be applied by the Commission in an unfairness determination. Moreover, applying the Court's own treatment of commercial speech in Friedman, Central Hudson, and their progeny to the evidentiary record in these proceedings reveals serious First Amendment problems with trade name bans that would not have been apparent at the time of the Friedman decision.

D. A State as a "Person" within the Meaning of the FTC Act

Section 5(a)(2) of the Federal Trade Commission Act empowers and directs the Commission to prevent, "persons, partnerships, and corporations" from using, among other things, unfair acts and practices in or affecting commerce.[934] This section will examine whether a state is a "person" within the meaning of the Federal Trade Commission Act. While no federal court has determined whether the state is a "person" within the meaning of Section 5 of the Federal Trade Commission Act,[935] the Commission's own

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[934] 15 U.S.C. §45(a)(2). Certain entities, such as railroads, airlines, banks, and savings and loan institutions, are exempted from the Commission's Section 5(a)(2) jurisdiction.

(footnote continued)

decisions and the legislative history of the FTC Act indicate that the state is a person for the purpose of the Commission's unfairness jurisdiction.

In its Statement of Basis and Purpose for the trade regulation rule on Advertising of Ophthalmic Goods and Services,[936] the Commission ruled that a state entity is a "person" within the meaning of Section 5 of the FTC Act.[937] The Commission justified its assertion of authority over states on the grounds that

> [p]ermitting the states to commit unfair acts or practices, i.e. prohibiting the providing of material information to consumers by private parties, would frustrate the purpose of the Federal Trade Commission Act.[938]

American Optometric Ass'n v. FTC[939] does not compel a

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935 But see California ex rel. Christensen v. FTC, 1974-2 Trade Cas. ¶ 75,328 (N.D. Cal. 1974), vacated and remanded, 549 F.2d 1321 (9th Cir.), cert. denied sub nom. California Milk Producers Advisory Board v. FTC, 434 U.S. 876 (1977). The District Court held that a state was not a person, but did not discuss the issue. The Court of Appeals, in vacating and remanding, did not discuss the issue either. It thus cannot be afforded any precedential value.

936 43 Fed. Reg. 23,992, 24,004 (1978).

937 Section 456.3 of the proposed rule would have made state enforcement of an advertising ban on ophthalmic goods and services an "unfair act or practice." 43 Fed. Reg. at 24,007. The Commission ruled that in enforcing Section 456.3 against state entities the Commission retained its "authority to seek cease and desist relief under Section 5(b) of the FTC Act. . ." Id. at 24,002. The Commission went on to rule that the conduct prohibited by Section 456.3 was "substantially unfair within the meaning of Section 5(a)(1) of the FTC Act." Id.

938 Id. at 24,004. The Commission cited Lafayette v. Louisiana Power & Light Co., 435 U.S. 389 (1978) and the cases cited thereing to support its position. Id.
(footnote continued)

different conclusion. The court in American Optometric Ass'n suspended operation of the advertising portions of the rule because of the impact of a supervening Supreme Court decision. While the court did express concern that the Commission may have overreached its authority, that concern was primarily directed at the broad scope of the rule,[940] not at the jurisdiction of the Commission over state entities.[941]

In Indiana Federation of Dentists,[942] the Commission held that a state is a "person" within the meaning of Section 5(b) of the FTC Act. Although in that decision the Commission held only that a state entity is a "person" for purposes of intervenor status, it would be anomalous to assign the term "person" two different meanings within the same section of the same statute.[943]

Commission Administrative Law Judges have held the same way. In Massachusetts Board of Registration in Optometry,[944] it

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939 626 F.2d 896 (D.C. Cir. 1980).

940 See supra section V.B., "Preemption of State Law," for a discussion of how the American Optmetric Ass'n case relates to this issue.

941 While the court noted that the Commission's jurisdiction over states might present an issue, particularly if there was excessive gratuitous intrusion on state police powers, 626 F.2d at 910, it reserved judgment on that issue. Id. at 917.

942 93 F.T.C. 231 n. 1 (1979) (interlocutory order).

943 Cf. United States v. Cooper, 312 U.S. 600, 606 (1941) ("It is hardly credible that Congress used the term 'persons' in different senses in the same sentence").

944 Docket No. 9195, Initial Decision of June 20, 1986 (J. (footnote continued)

was found that a state board was a person in a case alleging both unfair acts and practices and unfair methods of competition. A similar result was reached in Rhode Island Board of Accountancy,"[945] in which the same allegations were made.

As a general proposition, it cannot be abstractly declared whether the term "person," as used in a federal statute, includes a state. Rather, it depends upon its "legislative environment,"[946] which includes such factors as the subject matter, content, legislative history, and executive interpretation.[947]

The legislative history of the FTC Act indicates that Congress intended an expansive meaning for the word "person." Section 5 of the FTC Act gives the Commission jurisdiction over "every kind of person, natural or artificial, who may be engaged in interstate commerce."[948]

Timony, A.L.J.), at pp. 47-48.

945 Docket No. 9181, Order of February 12, 1985 (M. Brown, A.L.J.).

946 Sims v. United States, 359 U.S. 108, 112 (1958) (holding that a state is a "person" within the meaning of a portion of the Internal Revenue Code).

947 Id.

948 51 Cong. Rec. 14,928 (1914). The legislative history of the FTC Act is illustrative with regard to the meaning of the term "person." On the day that the Act was passed by Congress, 51 Cong. Rec. 14,943, a significant statement was made by Rep. Covington, the House sponsor of the FTC Act and a manager of the Act in Conference Committee. See H.R. Rep. No. 553, 63d Cong. 2d Sess. (1914); 51 Cong. Rec. 8840-44; H.R. Rep. No. 1142, 63d Cong. 2d Sess. (1914). In response to a question on the jurisdictional scope of Section 5, Rep. Covington made the following statement on the House floor:
(footnote continued)

The debate over recent amendments to the FTC Act clearly establishes that Congress intended that the Commission's unfairness jurisdiction extend to states. During the debate over the Federal Trade Commission Improvements Act of 1980,[949] Sens. McClure and Melcher introduced an amendment in the Senate "to clarify that the Commission does not have the authority to override state laws and preempt state regulation with respect to certain professions."[950] The co-sponsors of the amendment described the Commission's Eyeglasses I Rule, which prohibited state restrictions on advertising ophthalmic goods and services,[951] as an example of the type of Commission activity

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> The section which deals with unfair methods of competition confers upon the commission certain administrative powers somewhat analogous to the Interstate Commerce Commission, extending to persons, partnerships, and corporations, and with respect to the great industrial activities in interstate commerce. It embraces within the scope of that section every kind of person, natural or artificial, who may be engaged in interstate commerce.

Id. at 14,928 (emphasis supplied). Statements of a bill's sponsor are considered strong evidence of Congressional intent. Schwegmann Bros. v. Calvert Distillers Corp., 341 U.S. 384, 394-95 (1951); First Nat'l Bank of Logan v. Walker Bank and Trust Co., 385 U.S. 252, 261 (1966); New York v. Train, 494 F.2d 1033, 1039 (1974).

Rep. Covington's analogy to the Interstate Commerce Commission was apt: The Elkins Act, 49 U.S.C. § 41(1), which was the ICC's version of the Robinson-Patman Act prior to its repeal in 1978, applied to "person, persons, or corporations." In Union Pacific R. Co. v. United States, 313 U.S. 450 (1941), a state entity was held to be a "person" within the meaning of the Elkins Act.

949 Pub. L. No. 96-252, 94 Stat. 396.

950 126 Cong. Rec. 2066 (1980).

(footnote continued)

their amendment was intended to restrict,[952] and refers to the investigation that preceded the Eyeglasses II rulemaking as well.[953] Sen. McClure stated that the amendment's purpose was to demonstrate "that Congress in enacting the Magnuson-Moss Act did not intend to give the Commission in its rulemaking authority the unbridled power to override State laws, nor to preempt State regulatory agencies from carrying out their legitimate and traditional functions."[954] Opponents of the amendment argued that state regulation of professionals was an entirely appropriate subject of FTC trade regulation rulemaking.[955]

The Senate defeated the McClure-Melcher amendment. In the House, it was recognized that the final bill would not prevent the Commission from prohibiting the unfair acts of states.[956]

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951 15 C.F.R. §456.1. By coincidence, the U.S. Court of Appeals remanded the rule for other reasons on the same day the Senate debate occurred. American Optometric Ass'n v. FTC, 626 F.2d 896 (D.C. Cir. 1980).

952 126 Cong. Rec. 2067 (1980) (statement of Sen. Melcher); 126 Cong. Rec. 2075 (1980) (statement of Sen. McClure).

953 126 Cong. Rec. 2078 (1980) (Letter from M. Pertschuk to Sen. Inouye, Dec. 21, 1979).

954 126 Cong. Rec. 2075 (1980).

955 126 Cong. Rec. 2069 (1980) (Statement of Sen. Metzenbaum); 126 Cong. Rec. 2076-77 (1980) (Statement of Sen. Javits); 126 Cong. Rec. 2077 (1980) (Statement of Sen. Inouye).

956 Rep. Ashbrook urged the House to defeat the conference report. Making apparent reference to the defeated Senate amendment he said, "[A]lthough [the Eyeglass] rule deals only with laws regulating ophthalmic goods and services, it clearly reflects the Commission's view that it has the power to strike down any State law which it regards as 'unfair.'" Rep. Ashbrook went on to object to the conference report because it would not prohibit the Commission from doing so in the future. 126 Cong. Rec. 11,833 (1980) (Statement of Rep. Ashbrook). The House (footnote continued)

It is well established that the positive action of Congress rejecting an amendment that would limit the scope of a federal statute is persuasive evidence that Congress did not intend that the statute be so limited.[957] The Supreme Court has frequently resorted to this sort of construction where the reach of a statute was unclear.[958]

Therefore, Congress' rejection of the McClure-Melcher amendment is strong evidence that Congress intended that states be subject to the Commission's jurisdiction with respect to unfair acts and practices.[959]

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rejected his entreaty and passed the 1980 Act. Id.

[957] Fox v. Standard Oil Co., 294 U.S. 87, 96 (1935) (Cardozo, J.); National Automatic Laundry & Cleaning Council v. Schultz, 443 F.2d 689, 706 (D.C. Cir. 1971); Donovan v. Hotel, Motel and Restaurant Employees and Bartenders Union, 700 F.2d 539, 545 (9th Cir. 1983); 2A Sutherland Statutory Construction §48.18 (4th Ed. 1984) ("Generally the rejection of an amendment indicates that the legislature does not intend the bill to include the provisions embodied in the rejected amendment.")

[958] Gulf Oil Corp. v. Copp Paving Co., 419 U.S 186, 199-200 (1974); Fox v. Standard Oil Company, 294 U.S. 87, 96 (1935); United States v. Great N. Ry. Co., 287 U.S. 144, 155 (1932); United States v. Pfitsch, 256 U.S. 547, 552 (1921); Lapina v. Williams, 232 U.S. 78, 90 (1914). An exception to this doctrine is not applicable here. In FTC v. Dean Foods Co., 384 U.S. 597 (1967), and American Trucking Ass'n v. Atchison, T. & S.F. Ry. Co., 387 U.S. 397, 417-18 (1967), the court ruled that mere Congressional inaction in the face of agency request for amendatory language is entitled to no weight. That exception is inapplicable when "there is not merely silence, proposals languishing without any Congressional action, but positive action by Congress rejecting the limiting amendments." National Automatic Laundry & Cleaning Council v. Schultz, 443 F.2d 689, 706 (D.C. Cir. 1971).

[959] The House of Representatives had tentatively re-confirmed this view in its consideration of the Federal Trade Commission Authorization Act of 1985, H.R. 2385 (99th Cong., 1st Sess.), which passed the House on September 17, 1985. The House Committee report accompanying the bill explicitly recognizes the (footnote continued)

State entities have been held to be "persons" for the purpose of the Robinson-Patman Act,[960] and the Sherman and Clayton Acts.[961] The Commission's unfair methods of competition jurisdiction closely parallels those antitrust laws.[962] The Federal Trade Commission Act was enacted during the same session of Congress as the Clayton Act and shares the same goals and purposes and the same body of precedent as the Clayton Act. The two acts are in pari materia, and should thus be construed together.[963] For this reason, a state is also a person for the purpose of the FTC Act.[964]

Commission's authority to exercise jurisdiction over states:

> "When the Commission's actions approach the area of state regulation, the Commission should move only with caution and deference to those who have discharged their responsibility to regulate in the public interest, but the Commission should retain its present ability to act. The Commission's ability to further the policies underlying federal law should not be further restricted.

H.R. Rep. No. 99-162, 99th Cong., 1st Sess. at 11 (1985) (emphasis supplied). The report also explicitly recognizes the instant rulemaking. The bill also passed the Senate, but was not reported back to the floor by the conference committee before the 99th Congress adjourned.

960 Jefferson Co. Pharm. Ass'n v. Abbott Labs, 460 U.S. 150, 155-56 (1983).

961 Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 394-97 (1978).

962 A violation of the Sherman or Clayton Act is also a violation of the FTC Act. FTC v. Brown Shoe Co., 384 U.S. 316, 322 (1966); Times-Picayune Pub. Co. v. United States, 345 U.S. 594, 609 (1953).

963 United States v. American Building Maintenance Indus., 422 U.S. 271, 277-78 (1975).

964 E.g., Indiana Federation of Dentists, 93 F.T.C. 231 n. 1 (footnote continued)

E. Commerce

Sections 5 and 18 of the FTC Act grant the Commission jurisdiction over acts and practices "in or affecting commerce."[965] The "affecting commerce" language was added to Section 5 by the Magnuson Moss FTC-Improvement Act in 1975. Congress broadened the Commission's jurisdiction in the 1975 Act to give it authority over acts or practices which, although local in character, affect interstate commerce.[966]

The acts and practices at issue in the current proceedings clearly are "in or affecting commerce." The state regulatory activity challenged here has effects on the market for optometric goods and services extends well beyond the states imposing such regulations. For example, restrictions on commercial optometric practice may prohibit or deter the growth of nationwide chain firms into restrictive states. This may prevent these chains from reducing costs even in nonrestrictive states by denying them

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(1979) (interlocutory order); Massachusetts Board of Registration in Optometry, Docket No. 9195, Initial Decision of June 20, 1986 (J. Timony, A.L.J.), at pp. 47-48; Rhode Island Board of Accountancy, Docket No. 9181, Order of Feb. 12, 1985 (M. Brown, A.L.J.). Although the Commission's unfairness jurisdiction is not based on the antitrust laws, FTC v. Sperry & Hutchinson Co., 405 U.S. 233, 244 (1972), its purpose is similar.

965 15 U.S.C. §§ 45, 57a.

966 Pub. L 93-637, § 202a(1)(B), 88 Stat. 2193. American Medical Association, 94 F.T.C. 701, 994 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 445 U.S. 676 (1982) (quoting H.R. Rep. No. 93-1107, 93d Cong., 2d Sess. at 45 (1974)).

the ability to fully take advantage of economies of scale.[967] These restrictions may increase prices or reduce sales for various brands of eyewear, many of which are shipped in from out-of-state. The restrictions may also result in consumers crossing state lines to obtain optometric goods or services.[968] Trade name restrictions may preclude nationwide advertising campaigns by chain firms.[969] Numerous other examples exist to demonstrate the direct and indirect affects of these restrictions on interstate commerce.

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967 See supra section III.B.1., "Restrictions on Lay Associations and Other Business Relationships."

968 This would likely occur where consumers reside in a restrictive state near the border of a nonrestrictive state.

969 See supra section III.B.4., "Restrictions on Trade Name Usage."

VI. RECOMMENDATIONS

A. Introduction

Staff recommends that the Commission promulgate a trade regulation rule which would prohibit certain state restrictions on commercial optometric practice. The recommended rule would bar state or local governmental entities from (1) prohibiting employer-employee or other affiliations between optometrists and persons who are not optometrists; (2) limiting the number of branch offices which optometrists may own or operate; (3) prohibiting optometrists from practicing in commercial locations; and (4) prohibiting optometrists from using trade names. The recommended rule would not interfere with a broad range of state regulations designed to protect consumers, safeguard health and safety and prevent deception.

Staff also recommends modifying the prescription release requirement of the Eyeglasses I Rule. The current rule requires optometrists and ophthalmologists to release an eyeglass prescription to patients after every exam. Staff recommends that the rule be amended to require release of the prescription only upon request of the patient.

B. Bases for Recommendation

The Commission has enumerated a number of standards that it

will consider in deciding whether to issue a trade regulation rule.[970] There can be no doubt that these standards are met here.

One, the Commission will require substantial evidence for the factual propositions underlying a determination that an existing practice is legally unfair. Here, the record contains substantial evidence that these restraints on commercial practice cause significant consumer injury with no countervailing benefits, and that consumers cannot reasonably avoid this injury.

The FTC Studies provide reliable, convincing evidence that restrictions which prevent or limit competition from optometric chain firms, large-volume firms and other commercial providers raise prices to consumers and do not increase the quality of care in the market. The record contains no persuasive survey evidence pointing to a contrary conclusion. Anecdotal evidence was not persuasive in countering the results of systematic and reliable survey evidence. Substantial evidence, including survey evidence, also demonstrates that the restrictions actually reduce the quality of eye care by reducing the frequency with which consumers obtain vision care. Again, no substantial evidence was presented to the contrary.

While the studies themselves do not separately describe the effects of particular commercial practice restrictions, such as

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970 See, Statement of Basis and Purpose, Trade Regulation Rule on Credit Practices, 16 CFR Part 444, 49 Fed. Reg. 7740, 7742 (1984).

restrictions on corporate employment or trade name usage, the record contains an abundance of other evidence that describes the manner in which each of the four types of restrictions prevent or restrict the formation and expansion of commercial and volume optometric practices. This includes expert testimony and documentary evidence. Little evidence was offered to the contrary and none was convincing.

Two, the Commission will consider whether the act or practice is prevalent. The record indicates that the restrictions are indeed prevalent. Significant restrictions are found in 44 states: thirty-nine states restrict corporate employment or other business relationships; 32 restrict trade names; 19 impose branch office restrictions and 30 restrict mercantile locations. In general the existence of these restraints is not in dispute.[971]

Three, the Commission will assess whether significant harm exists. The record indicates that the number of eye care consumers and the dollars spent on eyewear is substantial; over half of all Americans use corrective eyewear and over eight billion dollars was spent on eye exams and eyewear in 1983.[972] Given the size of this market, the number of states with restrictions and the magnitude of the price difference and the adverse health consequence caused by the restrictions, it is

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971 Some dispute may exist over the existence or extent of specific restraints in specific states.

972 See supra Section II.A., "Description of the Industry."

clear that the harm is indeed substantial.

Four, the proposed rule must reduce the consumer harm. The proposed and recommended rule attacks the problem directly by prohibiting the restrictions which are the cause of consumer harm. Eliminating the restrictions will permit unfettered development and expansion of commercial firms and other providers, thus allowing vigorous competition from such firms.

Five, the Commission will consider whether the benefits of the rule exceed its costs. In this case, the record establishes that there are no countervailing or offsetting benefits to the restrictions. The survey evidence establishes that the restrictions do not increase the quality of care. The evidence also establishes that the restrictions are not needed to prevent deception. The cost of complying with the rule, if any, would apparently be minimal.

The Commission has also stated that a trade regulation rule which prohibits state restraints is warranted only as a remedy of last resort. We believe that this is such a case. Clear and convincing evidence demonstrates that these restrictions increase prices to consumers without providing any countervailing benefit. In fact, the restrictions decrease the overall quality of care in the market by reducing the frequency with which consumers obtain vision care. Further, consumers cannot avoid the injury. And, states are not acting to remove these restrictions. Thus, without the trade regulation rule, significant numbers of consumers will continue to suffer injury

as a result of these restrictions.[973]

C. Alternatives to Rulemaking

We have carefully considered possible alternatives to rulemaking and have concluded that each has serious drawbacks. One alternative is for the Commission to leave to the states the decision whether to eliminate these restrictions. The Commission could continue to make its studies and other evidence available to state regulatory bodies, or could develop a model state law, in the hope that states would take corrective action in this area. However, the prospects for significant change via this route are dim. The BE Study has been available since 1980. In addition, staff has testified or submitted comments in support of deregulation of commercial practice in a significant number of states.[974] Nevertheless, the record indicates that such restrictions are still wide-spread.[975] It is unrealistic to hope that more than a few states will voluntarily repeal commercial practice restrictions in the foreseeable future.

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[973] Staff's recommendation regarding the prescription release requirement and the bases therefore are discussed supra, in Section IV.B.6, "Spectacle Prescription Release, Recommendations."

[974] Comments regarding restrictions on the commercial practice of optometry have been submitted to at least six states, including California, Oregon, Virgina, New Jersey, North Dakota, and Delaware.

[975] Only one state -- Vermont -- removed its commercial practice restrictions since 1980. A few additional states, such as Texas, have removed some, but not all restrictions.

One reason for this lack of action on the part of the states may well relate to the dynamics of the political process, where the voice of well-organized noncommercial optometry is most likely to be heard. Given the relatively small benefit to an individual consumer from repeal of the restrictions, consumers are unlikely to assume a significant voice in the political process. Indeed, consumer groups have not engaged in a major lobbying effort regarding these restrictions.[976] Individual optometrists, on the other hand, stand to gain or lose a great deal as a result of these restrictions. Thus, optometrists have a greater incentive than consumers to engage in lobbying regarding these restrictions and they have developed well organized trade organizations and lobbying efforts.[977]

Moreover, noncommercial private optometrists appear to have a more effective voice in the political process than commercial optometrists.[978] Noncommercial optometrists account for a larger

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[976] For example, no consumer group chose to participate in this rulemaking proceeding as an interested party entitled to question and cross-examine witnesses. One untimely notice was rejected by the Presiding Officer. Presiding Officer's Order Number 7, A-24. Several consumer groups did present testimony and submit written comments.

[977] See citations in infra note 978.

[978] Organized noncommercial optometry expends considerable resources on lobbying activities in support of favored legislation. D. Staten, Nevada Optometrist, Tr. 1178-79 (Nevada optometrists maintain PAC fund for legislative campaigns, and have successfully lobbyed legislature against repeal of prohibition of optometrists associating with ophthalmologists); R. Alderete, Legislative Committee Chmn, Colorado Optom. Ass'n, Tr. 1742-43 (State Optometric Ass'n participated in optometry sunset review; no consumer groups or commercial optometrists participated); H. Stratton, New Mexico State Representative, Tr. (footnote continued)

share of the market for optometric services than commercial optometrists,[979] and their trade association, the AOA, consists of 25,000 members, with affiliates in all 50 states. Commercial optometrists' numbers have been restricted by the laws at issue in this proceeding, thus reducing their ability to effectively communicate their views and evidence to state legislatures.[980]

A second alternative would be to issue complaints on a case-by-case basis against particular states.[981] However, rulemaking would appear to be the more appropriate regulatory vehicle for a number of reasons, especially since more than 44 states would be affected. Rulemaking procedures permit all affected and interested parties, including all potentially affected states, to participate in a full and open discussion of the issues and to present evidence for and against the proposal. In a rulemaking proceeding, the Commission can assess the implications of the proposal on a nationwide basis more readily than in a case against one state. Rulemaking is prospective in application. In addition, promulgation of a rule would provide more complete

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1745-46, Tr. 1765-66.

[979] In 1983, optometrists, excluding those affiliated with chain firms, accounted for 44.2% of eye exams for eyeglasses. Chain firms accounted for 12.1% of such eye exams. NAOO Comment at p. 10.

[980] NAOO, the largest trade association representing commercial optometrists, consists of 29 member firms, with around 2,500 offices in 49 states. Approximately 2,500 optometrists are members of NAOO or are affiliated with member firms, about 10% of the AOA number. Smaller-scale commercial firms are not organized and have no trade association.

[981] Proceeding against private associations is not a viable option since it would do nothing to remove the restraints at issue in this proceeding.

protection for consumers. Even if an order were issued against a particular state, significant numbers of consumers would be left without relief in other states. Case-by-case adjudication against a number of states would be more time-consuming and costly than rulemaking.

D. Recommended Rule -- Section-by-Section Analysis

Immediately following is a section-by-section analysis of the recommended rule. This explains, in nontechnical language, the intended scope and meaning of the rule provisions which staff recommends that the Commission promulgate. The Eyeglasses II recommended provisions are discussed first, then the prescription release provision. The recommended provisions contain a number of staff modifications to the rule as proposed by the Commission in issuing the NPR.[982]

The full text of (1) the original Eyeglasses I rule with recommended changes and the proposed Eyeglasses II provisions with recommended changes, and (2) the complete recommended rule, are set forth at the end of this section.[983] Also, following the

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[982] All changes and additional provisions proposed by the Commission in the Notice of Proposed Rulemaking are referred to throughout this section as the proposed rule provisions.

All staff modifications to the proposals made by the Commission are referred to as the recommended rule provisions.

[983] In the Notice of Proposed Rulemaking the Commission proposed minor and technical modifications to the Eyeglasses I prescription release requirement. The Commission also proposed the new Eyeglasses II provisions, dealing with commercial (footnote continued)

more general section-by-section analysis of the recommended rule is a more technical section-by-section analysis setting forth the specific changes in language which staff recommends to the original Eyeglasses I Rule and the Eyeglasses II proposed rule, the reasons for these changes, and the intended effect of the changes. This more technical section is intended for those readers who want a more detailed and specific understanding of the technical modification to the rule.

1. Section 456.4 - State Bans on Commercial Practice

a. Corporate Affiliations

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, directly or indirectly:

(1) Prohibit employer-employee relationships, partnerships, joint ownership or equity participation agreements, franchise agreements, landlord-tenant agreements (including agreements under which rental payments are based on a percentage of revenue), or other similar affiliations between optometrists and persons other than optometrists for the purpose of offering optometric services or ophthalmic goods and services to the public;

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practice restrictions. These were proposed as additions to the Eyeglasses I Rule.

§456.5(b) The provisions of section 456.4(a)(1)-(4) are not intended to interfere with any state regulation, including any state regulation to safeguard the health and safety of eye care consumers or any state regulation of unfair or deceptive practices by eye care providers, as long as the state does not engage in the specific practices enumerated in section 456.4(a)(1)-(4). For example, the rule would not interfere with a state's authority to prohibit improper interference in the professional judgment of optometrists; require that the services provided at a branch office be supplied by a person qualified to do so; prohibit the location of optometric practices in areas which would create a public health or safety hazard; require that the identity of an optometrist be disclosed to a patient at the time optometric services are performed; maintain any requirements reasonably necessary to prevent the deceptive use of trade names or to prevent trade name infringement; or discipline any optometrist for providing inadequate care to patients, as long as the state does not engage in the specific practices enumerated in section 456.4(a)(1)-(4).

Section 456.5(b), entitled "Declaration of Commission Intent," clarifies the meaning of §456.4(a)(1)-(4), and so will be discussed here in conjunction with section 456.5(a)(1)-(4).

The rule is intended to permit optometrists to enter into business affiliations with lay persons, lay corporations or other persons[984] who are not optometrists, in order to offer optometric

services or ophthalmic goods and services to the public. Under the rule, lay persons or corporations could employ optometrists. They could also enter into landlord-tenant agreements, including agreements under which rental payments are based on a percentage of revenues. Lay persons could also form partnerships or other equity-sharing or joint-ownership agreements with optometrists. Lay persons could also join with optometrists in optometric franchising agreements.[985] Optometrists and lay persons could also enter into other substantially similar affiliations.

The rule would prevent states[986] from prohibiting such business affiliations. States prohibit such affiliations through a wide variety of statutes, regulations, attorney general opinions, court opinions and enforcement policy decisions by state boards and other state agencies. For example, in some cases, a restriction may not be apparent on the face of the statute but may arise by virtue of State Board interpretation. Regardless of the method used, or which state agency is involved, when a state prohibits such affiliations a rule violation occurs.

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[984] The term "persons" includes individuals, corporations, business affiliations and other entities. See §456.1(g) of the recommended rule.

[985] Franchising is described supra section III.B.1.b.iv., "Franchising."

[986] The rule covers any "state or local governmental entity" which includes any state, state agency or instrumentality, any political subdivision of a state or any official of such state or local government. Throughout this discussion, the word "state" is used to refer to any such entities or officials thereof.

The rule prevents indirect, as well as direct, state prohibitions on such affiliations. An indirect ban would occur where the state precludes activities which are so important to the business affiliation that the affiliation cannot succeed without them or where the state erects such financial or other barriers to engaging in the commercial practice that it effectively precludes commercial practice.

The following three examples provide guidance on the type of situation that would give rise to such an indirect ban. One, implicit in many business affiliations is some degree of lay control over the business aspects of a practice -- for example, control over fees, location, or office hours. Of course, under state law, acts such as examining eyes would have to be performed by a licensed optometrist. However, in many instances, lay persons with an ownership interest in the practice would necessarily exert a degree of control over the business practices commensurate with their interest. If a state precluded such lay control it would effectively prohibit the business relationship. This would violate the recommended rule.

Two, sharing of profits or of gross revenue is an integral part of many of these business relationships. For example, partnership agreements involve distribution of income on a percentage basis. An essential element of franchise agreements is a payment of a percentage of gross revenues by the franchisee to the franchisor -- a so-called royalty payment. A state prohibition on sharing of profits or revenues pursuant to such

business affiliations would effectively preclude such affiliations and would violate the recommended rule.

Three, a rule violation would occur if a state precluded legitimate quality control efforts by a corporation or other affiliation. Such quality control may be essential to the success of commercial firms. For example, some corporations may set mininimum exam standards for the optometrists that they employ, leaving the optometrists free, however, to exceed these standards if they wish. A state prohibition on corporate minimum exam standards could so adversely effect a corporation's efforts to maintain a reputation for good quality that it would effectively preclude corporate employment. Attempts by a state to prevent such legitimate quality control would be prohibited by the rule.

Below, we provide some examples of state restrictions and explain whether or not they are covered by the recommended rule. One, many states prohibit optometrists from employing agents to solicit business -- so-called "capping and steering." Some states may interpret this to prohibit an optometrist from employing a person to distribute leaflets to prospective customers. While such a prohibition could well be unlawful for other reasons,[987] it would not be covered by the recommended rule since it is not a prohibition on an affiliation "for the purpose of offering optometric services or ophthalmic goods or services

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[987] Such laws may well be unconstitutional or could be "unfair" within the meaning of section five of the FTCA.

to the public," but rather is for the purpose of advertising or solicitation. On the other hand, a state prohibition on optometrists affiliating with a chain firm which solicits optometric business would be prohibited by the recommended rule since this effectively prohibits corporate affiliations.

Two, some states prohibit referrals of patients between optometrists and opticians. State prohibitions on referrals between optometrists and opticians would, in general, not be covered by the recommended rule, since such referral arrangements would not be affiliations for the purpose of offering optometric services to the public. However, if a state prohibited referrals from the optical department of an optometric corporation to an employed or leasing optometrist within that corporation, or vice versa, a rule violation would occur. In order for corporate optometric practice to be viable, consumers must be made aware of the availability of optometric services at a retail location.

Three, many states prohibit optometrists from giving or receiving kickbacks or rebates in return for referral of patients. Prohibitions on deceptive rebates and kickbacks would not be covered by the recommended rule.[988] However, if states interpreted this to prevent referrals or sharing of revenues between optometrists and nonoptometrists within an employment or

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[988] A deceptive rebate or kickback might occur, for example, if an optician received a fee from an optometrist for a referral and the existence of the fee was not disclosed to a consumer who was under the impression that the referral was not based on any financial considerations.

partnership arrangement, a rule violation would occur.

Section 456.5(b) is intended to make clear that the rule would not interfere with any state regulation as long as the state does not engage in the specific practices enumerated in §456.4(a)(1)-(4). Thus, the rule would not interfere with a broad range of state regulation to safeguard the health and safety of eye care consumers, and state regulation to prevent unfair and deceptive practices by eyecare providers, including commercial practitioners.[989] For example, many states specify minimum procedures that must be performed in any optometric exam or minimum equipment that must be present in an optometrist's office. Many states require that optometrists refer cases of suspected pathology to ophthalmologists, or require that optometrists verify the accuracy of lenses prepared according to their prescriptions. All states prohibit fraud and deception in the practice of optometry and virtually all require that optometrists practice "competently."[990] The rule would not interfere with a state's ability to regulate optometry, including commercial practice, through such regulations.

The rule also would not interfere with a state's ability to prohibit improper lay control of the professional judgment of an optometrist or of the practice of optometry, as long as

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989 By listing specific regulations, the staff does not intend to imply that the regulations are either desirable or undesirable, but merely that states would not be precluded from adopting them under the rule.

990 See chart at pp. 33-46 and accompanying discussion.

"professional judgment" or the "practice of optometry" are interpreted to include only matters bearing a bona fide relationship to the quality, as opposed to the business, aspect of the practice of optometry. The quality aspect would include, for example, determining the correct prescription and examining the eyes for potential pathologies.[991] However, some states interpret such laws to prohibit lay interference in such matters as office hours, patient fees and types of materials in stock.[992] Since lay control or influence of such business practices is a necessary attribute of lay employment, partnerships, or similar business arrangements, such a state interpretation would be a prohibition on lay affiliations and would violate the recommended rule.

Under the recommended rule, states could regulate or prohibit certain forms of compensation for optometrists employed by nonoptometrists -- for example, compensation based on the number of exams given or prescriptions written by the optometrists. The record does not establish that a ban on such compensation schemes effectively precludes lay employment.[993]

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991 However, as noted above, a state could not interpret "interference in professional judgment" to preclude legitimate quality control efforts by a corporation.

992 See e.g., Fla. Admin. Code 21Q-3.08; Kan. Admin. Regs. §65-7-12(a); Tex. Health & Safety Code, Ann. title 71, §4552-5.11.

993 However, it is clear that such compensation schemes create no more incentive to overprescribe than already exists for all traditional private optometrists who dispense optical goods and generate additional profits for themselves as they give additional exams and prescribe more lenses and eyeglasses.

Similarly, states could prohibit employers from setting quotas for the number of exams which optometrists must perform.[994]

States could also regulate specific lease provisions. For example, they could prohibit lease provisions setting quotas on the number of exams to be performed. States could not, however, prohibit leases which require that rental payments be based on a percent of revenue.

In short, under the recommended rule, states retain broad authority to regulate optometry and commercial-practice in order to protect the health and safety of their citizens and to prevent consumer abuses. They are only prevented from prohibiting certain business affiliations between optometrists and persons who are not optometrists.

b. Branch Offices

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, directly or indirectly:

(2) Limit the number of offices which may be owned or operated by an optometrist or by any entity formed by an affiliation covered by §456.4(a)(1) of the rule;

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994 On the other hand, agreements whereby optometrist-employees have an equity interest in the lay corporation, such as stock ownership plans, would be protected by the recommended rule, as described above.

The recommended rule would permit optometrists to own, operate or practice in any number of offices. Corporations or other entities which offer optometric services through affiliations between optometrists and lay persons, as allowed by §456.4(a)(1) of the rule, would also be permitted to own or operate any number of offices.

The proposed rule would preclude states from indirectly, as well as directly, limiting the number of branch offices. For example, some states require optometrists to remain in personal attendance at all branch offices for a specific percentage of time. Since this effectively limits the number of branch offices which an optometrist may own, such a requirement would be prohibited under the recommended rule.

Some states require optometrists to obtain a permit before opening a branch office;[995] whether or not such a requirement would violate the recommended rule would depend on whether or not it is used to limit branch offices. The record does not establish that a permit requirement, per se, effectively limits branch offices. Permit requirements could be interpreted to require only registration with permits being routinely and expeditiously granted. There is no evidence that such an interpretation would limit branch offices and so such a requirement would not violate the recommended rule.

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[995] With regard to many states, the record does not disclose how these requirements are interpreted and enforced.

On the other hand, a rule violation would occur if permit requirements were used to effectively limit branch offices. For example, some states require branch office applicants to demonstrate that there is a "need" for the office.[996] If permits are denied because the applicant failed to demonstrate a "need", the state would be limiting the number of branch offices an optometrist may own or operate, and hence, a rule violation would occur. As another example, substantial delay, uncertainty or expense connected with the permit process to the extent that it deterred persons from seeking or receiving permits would constitute a rule violation.

Under the recommended rule, states retain broad authority to regulate health and safety and prevent consumer abuses.[997] For example, states could require that optometric services or ophthalmic goods or services provided at each offices be supplied by a person qualified to do so. As another example, states could regulate the services provided at each office by requiring minimum eye examination procedures, minimum equipment or a specific level of sanitation. States retain broad authority and are only prohibited from directly or indirectly limiting the number of branch offices.

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996 See e.g., 49 Pa. Admin. Code §23.44 (1979). The record does not disclose how "need" is interpreted. Most likely, the definition varies from state to state.

997 Section 456.5(b) of the rule is intended to make this clear.

c. Mercantile Locations

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, directly or indirectly: . . .

(3) Prohibit an optometrist, or any entity formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing in a pharmacy, department store, shopping center, retail optical dispensary or other mercantile location;

The rule would allow optometrists to locate their practice inside optical retailers, department stores or other mercantile establishments. Optometrists could also locate in shopping malls and close to optical retailers. Under the recommended rule, corporations and other entities which offer optometric services by employing optometrists or otherwise affiliating with optometrists, pursuant to §456.4(a)(1) of the rule, could also locate in mercantile locations.

The recommended rule would prevent states from indirectly prohibiting mercantile locations, as well as from directly doing so. For example, some states prohibit optometrists from leasing space from opticians. This effectively prohibits optometrists from locating inside optical dispensaries.[998] As another

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[998] State prohibitions on such leases would also be prohibited under §456.4(a)(1) of the proposed rule.

example, some states prohibit optometrists from leasing space under leases that require a percentage of revenue to be paid as rent. Such leases are often required in shopping malls.[999] Since such prohibitions may prevent optometrists from locating in shopping malls, in such cases they would violate this section.[1000]

The recommended rule would allow optometrists to locate inside mercantile establishments. Consequently, the rule would eliminate so-called "two-door" or "side-by-side" requirements, which stem from state prohibitions on optometrists locating inside mercantile establishments. These requirements mandate separate offices for the optometrist and the optician, including, in some instances, separate doors, separate facilities and personnel, and solid partitions between the two offices. Under the recommended rule, states could not require separate offices, separate entrances, duplicate facilities, or solid floor-to-ceiling partitions, nor could they prohibit sharing of personnel between the two offices.

Under the recommended rule states retain broad authority to ensure health and safety of eye care patients and to prevent consumer abuses.[1001] For example, they could promulgate and

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[999] See supra sections III.B.1.b.ii., "Fee-splitting and Leasing," and III.B.3., "Restrictions on Mercantile Locations."

[1000] Prohibitions on such percentage leases would also be prohibited under §456.4(a)(1) of the proposed rule.

[1001] Section 456.5(b) is intended to make this clear.

enforce general zoning laws and prohibit practice in any areas which would create a public health or safety hazard. States are not restricted except in their authority to prohibit mercantile locations.

d. Trade Names

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, directly or indirectly: . . .

(4) Prohibit optometrists, or any entities formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing or holding themselves out to the public by advertising or otherwise under any nondeceptive trade name, including any name other than the name shown on their license or certificate of registration.

The rule would allow optometrists to practice under any nondeceptive trade name. Thus, for example, optometrists employed by a chain firm could practice and hold themselves out to the public under the nondeceptive corporate name of the chain firm. Optometrists working for other optometrists could practice under the name of their employer. Optometric franchisees could practice under the franchise name. Solo practitioners could adopt any nondeceptive trade name. Corporations and other entities which offer optometric services through affiliations with optometrists, pursuant to §456.4(a)(1) of the rule, could

also practice under any nondeceptive trade names.

Below we provide two examples of state prohibitions on nondeceptive trade names which would be prohibited by the rule. One, some states require that any trade name include the name of one or more of the optometrists practicing under the trade name or practicing at an advertised location.[1002] Such requirements would violate the recommended rule since they prohibit use of a wide variety of nondeceptive trade names, including some that are well established in the industry.

Two, some states require that all trade names used by optometrists include the word "optometric" or "optometrist." Trade names which do not include these terms, such as "Smith Optical Center," are not, in general, deceptive. Hence, such requirements would be prohibited under the recommended rule since these laws prohibit the use of nondeceptive trade names.[1003]

The recommended rule would also allow optometrists to hold themselves out to the public under a trade name, including by advertising in a nondeceptive manner and otherwise. Optometrists could display their trade names on signs and use the trade name in advertising, in a nondeceptive manner. Similarly, chain firms

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[1002] See e.g., Mo. Admin. Code Tit. 4, CSR 210-2.060(4)(E); Ore. Admin. R. 852-30-115; La. Rev. Stat. Ann. §1112.

[1003] In fact, use of the terms "optometric" in the trade names of large chain firms could well be confusing to consumers since the term may imply that optometric services are available at all the chain's retail locations when, in fact, this may not be the case.

offering eye exams could advertise optometric services under the trade name.

The following are examples of a state requirement which indirectly prohibits optometrists from advertising under a trade name in a nondeceptive manner. Some states require that any trade name advertisement include the names of all the optometrists practicing under the trade name. Other states require disclosure in advertising of the names of the optometrists practicing at any locations which are mentioned in the advertisements. As discussed elsewhere, the record established that these disclosure requirements effectively prohibit much trade name advertising. The record further establishes that these laws are not necessary to prevent deception. Therefore such requirements would be prohibited under the recommended rule.

Some states require that optometrists obtain permits before using trade names; whether or not such requirements violate the recommended rule would depend on whether they are used to prohibit trade name use. There is little evidence to indicate how these permit requirements are interpreted and enforced.[1004] The record does not establish that a permit requirement, per se, constitutes a sufficient burden on trade name use that it amounts to a prohibition on trade name use. For example, a permit

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[1004] In some cases the statute specifies certain conditions for granting the permit, such as a board finding that the trade name is not misleading. E.g., Cal. Bus. & Prof. Code §3125.

requirement could be interpreted merely to require registration of the trade name, with permits being expeditiously and routinely granted. Such an interpretation would not constitute a prohibition on trade names and hence would not be covered by the rule. On the other hand, a rule violation would occur if permit requirements were used to effectively prohibit optometrists from practicing under nondeceptive trade names.

The states would retain broad authority to regulate trade name deception and to remedy other problems.[1005] For example, states could prohibit any trade names reasonably found to be deceptive. States could also regulate the use of trade names, including trade name advertising, in any manner reasonably necessary to prevent deception. Thus, for example, states could require trade name registration to ensure that the state could identify and hold accountable the specific optometrists practicing under a trade name. States could also require that the identity of an optometrist be disclosed to a patient at the time an eye examination is performed, that optometrists wear name tags or post their licenses, or that the examining optometrist's name appears on the patients' records, invoices and receipts. States could also impose disclosure requirements on trade name advertising as long as such requirements did not effectively prevent nondeceptive trade name advertising.[1006] States could

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[1005] Section 456.5(b) is intended to make this clear.

[1006] One state requires that whenever professional services are advertised by a corporation, the name of the optometrist in charge must appear prominently. Mich. Admin. Code R 338.270. (footnote continued)

continue to adopt and enforce a broad array of regulations reasonably necessary to prevent deceptive trade name use and trade name infringement.

e. Enforcement

Section 456.4(b) states that if any state or local governmental entity or officer violates any of the provisions of §456.4(a)(1)-(4) that person will not be subject to any monetary liability under Section 5(m)(1)(A) or 19 of the Federal Trade Commission Act. This means that the Commission would not seek either civil penalties or monetary consumer redress from any state, state agencies or state officials. The Commission could enforce the rule by, for example, seeking an injunction against enforcement of the state law.[1007]

Section 456.5(c)[1008] states that it is the Commission's intention that the rule may be used, among other ways, as a defense to any proceeding brought against any optometrist for

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Whether or not this requriement effectively precludes nondeceptive trade name advertising would have to be determined on a case-by-case basis, depending upon the specific interpretation of this requirement and the effects upon trade name advertising. For example, if large chain firms were permitted to designate one supervising optometrist for all their retail outlets, such a requirement may have little effect on the ability of such firms to engage in trade name advertising. On the other hand, if firms were required to identify an optometrist actually practicing at each retail outlet, such a requirement could impose a severe burden on large-scale advertising.

[1007] Federal Trade Commission Act, §13(b), 15 U.S.C. §53(b).

[1008] This was §456.5(f) of the proposed rule.

engaging in the specified commercial practices. Thus, for example, if a state board attempted to or did revoke an optometrist's license for affiliating with a lay corporation, the optometrist could argue that since the rule preempts the state prohibition on such affiliations, there is no valid basis on which to revoke the license. Section 456.5(c) is not intended to create a private right of action. Rather, by including §456.5(c) in the rule, the Commission would merely be expressly stating what would in any event be the legal effect of a Commission rule preempting state law. Where a state law conflicts with the federal rule it is preempted and thus would provide no basis for state disciplinary proceedings or other state enforcement action.[1009]

2. Prescription Release Requirements

§456.2 Separation of Examination and Dispensing

It is an unfair act or practice for an ophthalmologist or optometrist to:

(a) Fail to provide upon request to the patient one copy of the patient's spectacle lens prescription. The obligation to provide the prescription begins after the eye examination is completed and ends one year from the date of the examination or when the prescription expires, whichever comes first.

1009 See supra section V.B., "Preemption of State Law."

The recommended rule would modify the prescription release requirement of the Eyeglasses I Rule. Under the recommended rule, optometrists and ophthalmologists (refractionists) would only have to release the eyeglass prescription upon request of the patient. The request would have to come from the patient, not from an optician or other person, and the prescription would only have to be released to the patient, not to opticians or other persons.[1010] Optometrists and ophthalmologists would be required to release only one copy of the prescription; duplicate copies would not have to be released.

The obligation to release the prescription would extend for one year from the date of the exam or until the prescription expires, whichever comes first. Refractionists would remain free to place expiration dates on their prescriptions and would not be required to release outdated prescriptions. Thus, for example, if an optometrist determined that a prescription would expire in 9 months, he or she could place such an expiration date on the prescription and the obligation to the release the prescription would extend for 9 months.

[1010] Release of the prescription over the telephone to opticians might create problems. For example, if eyeglasses were incorrectly made by the optician who had no written prescription on record but had obtained the prescription over the telephone, it could be difficult to determine the source of the error -- e.g., whether the prescription received by the optician was incorrect or whether the optician had failed to properly fill the prescription.

E. Technical Modifications

Complete texts of (1) the original Eyeglasses I Rule with recommended changes and the Commission's proposed Eyeglasses II provision with recommended changes, and (2) staff's recommended rule provisions are shown at the end of this section. Recommended changes to the proposed rule are also shown in this section-by-section analysis, where applicable. Additions recommended by staff are underlined and deletions are crossed-out.[1011]

1. Section 456.1 - Definitions

Section 456.1 contains definitions of certain terms used in the rule. Many of these terms are contained in the Eyeglasses I rule, and relate to the prescription release requirement. The proposed rule incorporated some minor and technical modifications to some of the definitions in the Eyeglasses I rule, and staff recommends adopting these. In addition staff now recommends additional changes to the definitions. Below we describe all recommended changes.

Paragraph (a) - The recommended rule substitutes the term "patient" for the term "buyer" in the original Eyeglasses I

[1011] The recommended rule contains several other minor technical changes in addition to those discussed below. The purpose of these changes is generally to clarify the intended effect of the rule or to ensure that all rule provisions are consistent.

prescription release Rule, in order to conform more closely to industry usage. This change was in the proposed rule as well. The term "patient" covers any person who has undergone an eye exam.

Paragraphs (b), (c) and (d) - The definitions of the terms "eye examination," (section 456.1(c) of the Eyeglasses I Rule), "ophthalmic goods," (section 456.1(d) of the Eyeglasses I Rule), and "ophthalmic services" (section 451.1(e) of the Eyeglasses I Rule), remain unchanged from the original rule definitions.

Recommended rule paragraphs (e) and (f) replace section 456.1(h) of the original Eyeglasses I rule, which used the term "refractionist" to define those categories of providers -- namely Doctors of Medicine, Optometry and Osteopathy -- who are qualified under state law to perform eye examinations. The recommended rule deletes the word "refractionist" and substitutes the terms "optometrist" and "ophthalmologist," as proposed in the NPR. There are two reasons for this. First, since the term "refractionist" is not generally used by consumers or the industry, its use in the original rule has caused confusion. Second, certain provisions of the recommended rule permitting commercial practice do not apply to ophthalmologists. The recommended rule eliminates the term "refractionist" so that this distinction is made clear.[1012]

[1012] The term "ophthalmologist" is defined to include osteopaths.

Paragraph (g) - Staff recommends that the definition of "person" be modified as follows:

> (g) A "person" means any ~~party over which the Federal Trade Commission has jurisdiction. This includes~~ individuals, partnerships, corporations, ~~and professional~~ associations, or other entity.

The term "person" was originally used in section 456.6 of the Eyeglasses I rule which prohibited "persons" from imposing restraints on advertising of ophthalmic goods and services. This section of the rule was remanded by the Court and is no longer in effect.[1013] Therefore, the original definition of the term is no longer relevant.

The term "person" is now used in the recommended commercial practice provisions. For example, section 456.4(a)(1) removes state prohibitions on affiliations between optometrists and persons other than optometrists. The term is intended to cover any individual, partnership, corporation, association or other entity.[1014] Whether or not the FTC has jurisdition over the person is no longer relevant for purposes of the recommended rule.

Paragraph (h) - The term "prescription" is defined in the

[1013] American Optometric Association v. FTC, 626 F.2d 897 (D.C. Cir. 1980).

[1014] The term "other entities" was added in the proposed rule.

recommended rule as those specifications necessary to obtain spectacle lenses, as proposed in the NPR. Thus, the prescription which is released to the patient need only contain the data on the refractive status of the patient's eyes, and any information, such as the date or signature of the examining optometrist that state law requires in a legally fillable eyeglass prescription.

The recommended rule amends the definition to delete all references to contact lenses. This change will end the confusion that was generated by the original definition concerning the obligation of optometrists and ophthalmologists to place the phrase "OK for contact lenses," or similar words, on prescriptions. The recommended language makes clear that no such obligation exists. This change will also clarify the fact that the prescription release requirement does not affect state laws regulating who is legally permitted to fit contact lenses.

Staff recommends deleting paragraph (i) of the original Eyeglasses I rule, defining the term "seller." This term was used in the remanded portions of the Eyeglasses I rule. The term was also used in the proposed provisions on commercial practice. As discussed below, staff recommended deleting this term from the commercial practice sections. Therefore, the definition is no longer needed.

Staff also recommends deleting paragraph (j) of the proposed rule, containing a definition of a "trade name ban". The recommended rule incorporates the substance of the definition into §456.4(a)(4), which bars states from prohibiting trade name

use, thus rendering a separate definition unnecessary. This point is discussed further in conjunction with the discussion of section 456.4(a)(4) below.

Staff recommends adding this section to the rule:

Section 456.1(i) <u>"Optometric Services" are any acts or practices which are included within the definition of the practice of optometry under state law.</u>

This term is used in recommended §456.4(a) which is intended to allow affiliations between optometrists and other persons for the purpose for offering "optometric services" to the public. The term is intended to cover the full range of services which may be provided by an optometrist under state law. The precise meaning of the term could vary from state to state since states may differ in what they include within the definition of the practice of optometry. The term is intended to include services provided by an optometrist, not by other professionals such as ophthalmologists who may also be licensed under state law to provide such services.

The new term is needed because the terms in the proposed rule did not cover the full range of services which may be provided by optometrists. The term "ophthalmic services" (§456.1(d)) covers only the measuring and fitting of eyeglasses or contact lenses subsequent to the eye exam. The term "eye exam" (§456.1(b)) covers tests and procedures to determine the

refractive status of the eyes. Optometrists are licensed to perform other services, however. For example, optometrists may prescribe eye exercises to deal with eye muscle problems. All such activities are included under the term "optometric services." The need for this term in the rule is discussed in conjunction with recommended §456.4(a)(1) in which it is included.

2. Section 456.3 - Federal or State Employees

The proposed and recommended changes to the original rule provision (section 456.8) delete references to the remanded portions of the Eyeglasses I Rule, and clarify the intended effect of this section. This section exempts practitioners who work for any federal, state or local government from the rule's release of prescription requirements. If practitioners work only part-time for the government, the exemption only applies when they are engaged in their governmental duties.

3. Lay Association

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, ~~enforce any law, rule or regulation which~~ directly or indirectly:

(1) Prohibit~~s~~ employer-employee relationships, partnerships, joint ownership or equity participation agreements,

franchise agreements, landlord-tenant agreements (including agreements under which rental payments are based on a percentage of revenue), or other similar affiliations between optometrists and persons other than optometrists for the purpose of offering optometric services or ophthalmic goods and services to the public;

§456.5(b) The provisions of section 456.4(a)(1)-(4) are not intended to interfere with any state regulation, including any state regulation to safeguard the health and safety of eye care consumers or any state regulation of unfair and deceptive practices by eye care providers, as long as the state does not engage in the specific practices enumerated in section 456.4(a)(1)-(4). For example, the rule would not interfere with a state's authority to prohibit improper interference in the professional judgment of optometrists; require that the services provided at a branch office be supplied by a person qualified to do so; prohibit the location of optometric practices in areas which would create a public health or safety hazard; require that the identity of an optometrists be disclosed to a patient at the time optometric services are performed; maintain any requirements reasonably necessary to prevent the deceptive use of trade names or to prevent trade name infringement, or discipline any optometrist for providing inadequate care to patients, as long as the state does not engage in the specific

practices enumerated in section 456.4(a)(1)-(4).

The staff recommends a number of modifications to the rule proposed by the Commission. Staff recommends that the rule state that it is an unfair practice for any state to "prohibit" certain affiliations. The proposed rule made it an unfair practice for a state "to enforce any law" which prohibits such affiliations. The recommended rule specifies more accurately and clearly the unfair practice involved.

The recommended language does not entail a significant substantive change from the proposed language. Under the recommended version, a state would actually have to "prohibit" the affiliations. Therefore, a statutory prohibition that was clearly not being enforced and had no effect would not violate the rule.

The staff recommendation also includes the addition of the phrase "directly or indirectly" to §456.4(a). The proposed rule was intended to cover state restraints which directly or indirectly prohibit commercial practice.[1015] The recommended proposal, by adding this language to §456.4(a), is intended to make this clear.

The recommended modifications are also intended to clarify the phrase "other business relationships" which appears in the

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[1015] See, 50 Fed. Reg. 598 (1985). This was also made clear in proposed rule §§456.5(b) and (c).

proposed rule. The staff recommendation lists the specific types of relationships or affiliations which are intended to be covered. It also includes "other similar affiliations," in order to make clear that substantially similar business arrangements are covered even though they may not technically fall into one of the specifically enumerated categories.

The staff recommendation also includes the phrase "for the purpose of offering optometric services or ophthalmic goods or services to the public." "Optometric services" are defined in recommended §456.1(i), as discussed above. The staff recommendation is intended to make clear that only affiliations for this purpose are covered by §456.4(a)(1) of the rule. The proposed rule was intended to allow affiliations for this purpose, and was not intended to cover affiliations for other purposes. For example, the rule was not intended to allow affiliations for the purpose of providing medical services or legal services to the public. The recommended language merely states what was clearly intended.

The staff recommendation also eliminates the term "sellers" from the rule. "Sellers" were defined to include opticians. As a result of this term, the proposed rule would have prohibited state restraints on lay persons employing or otherwise affiliating with "sellers." Our evidence indicates that, currently, the law of one state prohibits such affiliations. The record contains no evidence or comments specifically about this state restriction. Given this, staff recommends deleting such

restrictions from coverage by the rule.

The staff recommendation also eliminates the phrase "ophthalmologist" from the rule. The reason the term "ophthalmologists" was included in the proposed rule was that the rule was not intended to address commercial practices by ophthalmologists. The record evidence centers on commercial optometric practice; there is little evidence concerning commercial practice by ophthalmologists. Under the proposed phrasing the rule would not have prohibited state restraints on affiliations between optometrists and ophthalmologists.

Under the modifications recommended by the staff, the rule would allow ophthalmologists and optometrists to enter into affiliations but only for the purpose of offering optometric services or ophthalmic goods and services to the public. Affiliations for the purpose of offering ophthalmologic services -- services which can only be performed by an ophthalmologist -- would not be covered. This is intended to be made clear by the addition of the phrase "for the purpose of offering optometric services or ophthalmic goods and services to the public" in recommended §456.4(a)(1). This approach is consistent with the evidence. If ophthalmologists, like any other persons, wish to enter into affiliations with optometrists to offer optometric services to the public, the rule would permit them to do so. However, the rule would not cover commercial ophthalmologic practice, including affiliations between ophthalmologists and other persons for the purpose of offering ophthalmologic

services.

Staff also recommends deleting proposed sections 456.5(b)-(e) and substituting recommended section 456.5(b).[1016] This is not intended as a substantive change, but to express more clearly and directly the intent of the rule and to avoid repetition. The proposed sections contained unclear and potentially ambiguous language such as that states could enforce regulations designed to control "specific harmful practices," and was repetitious. The recommended version is intended to avoid such problems.

4. Branch Offices

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, ~~enforce any law, rule or regulation which~~ directly or indirectly:

(2) Limits the number of offices which may be owned or operated by an optometrist ~~or which may own or operate~~ or by any entity formed by an affiliation covered by §456.4(a)(1) of the rule;

The staff recommendation adds the phrases "or by any affiliation covered by §456.4(a)(1) of the rule" to §456.4(a)(2). The proposed rule was intended to prohibit

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[1016] Proposed section 456.5(f) would be renumbered as §456.5(c) and proposed section 456.5(g) would be renumbered as §456.5(d).

restrictions on the number of branch offices which could be owned or operated by an optometrist, seller or any other person, including a corporation, who offers eye exams or ophthalmic goods and services to the public.[1017] Proposed section 456.5(c) included the phrase "any other person," which was clearly broader than intended, while section 456.4(a) inadvertently ommitted this phrase. The staff recommendation is intended to clarify this.

The staff recommendation also deletes coverage of state restrictions which limit the number of offices which may be opened by sellers, or opticians. The proposed language would have included such restrictions. Currently, there appear to be no state with a restriction on branch offices by opticians. No comment or evidence was offered on this specific type of restriction during the rulemaking proceeding. Therefore, the staff recommendation deletes the word "seller," meaning that the recommended rule does not cover state restrictions on the number of offices which a "seller" may operate.

5. Mercantile Locations

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, ~~enforce any law, rule or regulation which~~ directly or indirectly:

(3) Prohibit~~s~~ an optometrist, or any entity formed by an

[1017] See, 50 Fed. Reg. 598, 601.

affiliation covered by §456.4(a)(1) of the rule, from practicing in a pharmacy, department store, shopping center, retail optical dispensary or other mercantile location;

The staff recommendation adds the phrase "or any affiliation covered by §456.4(a)(1) of the rule" to sections 456.4(a)(3). Since the proposed rule expressly covered only state prohibitions on mercantile locations by optometrists, arguably states could have restricted such locations by affiliations between optometrists and lay persons. The recommended version is intended to make clear that affiliations between optometrists and lay persons are covered. Optometrists should not lose the rule's protection by affiliating with lay persons, as permitted by section 456.4(a) of the rule.

6. Trade Names

§456.4(a) It is an unfair act or practice for any state or local governmental entity to, ~~enforce any law, rule or regulation which~~ directly or indirectly:

(4) Prohibit optometrists, or any entities formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing, or holding themselves out to the public by advertising or otherwise, under any nondeceptive ~~the~~ trade name, ~~of the person by whom they are employed or a~~ including any name other than the name shown on their license or

certificate of registration.

The recommendations make clear that the rule is intended to allow optometrists to use any nondeceptive trade name. Under the original wording, it was not clear whether states could ban the use of some nondeceptive trade names as long as they permitted use of other trade names.

As explained above, some states allow limited types of trade names, while prohibiting a wide range of nondeceptive trade names, including some which are widely used within the industry. Such a regulatory scheme limits or even precludes the benefits of trade name usage and hinders the development of chain firms. The modifications make clear that such a scheme would be prohibited by the rule.

The recommendations also make clear that the rule would protect the ability of optometrists to use trade names in advertising. Whether or not the proposed rule would have covered trade name advertising was never made totally clear. The proposed rule would have permitted optometrists to "hold themselves out to the public" under their trade names. At a minimum this phrase would have permitted optometrists to display their trade names on signs at their retail locations. While it could have been interpreted to cover advertising, this was never addressed.[1018]

[1018] In the NPR, the Commission raised a question concerning the effect of certain restrictions on trade name advertising. The (footnote continued)

As section III.B.4. - Trade Name Bans - makes clear, the record demonstrates that the benefits of trade name practice are inextricably linked with trade name advertising. The discussion there of the benefits of trade names to consumers assumes that trade name advertising is permitted. Thus, significant restrictions on trade name advertising would necessarily cause the same consumer harm as restrictions on trade name practice in general. As explained in section V.A. infra, staff concludes that prohibitions on nondeceptive trade name advertising are "unfair" under the FTCA.

Further, as discussed in section III.B.4. - Trade Name Bans - at least five states have enacted disclosure laws which effectively prohibit much large-scale advertising by large chain firms. The evidence demonstrates that these laws are not needed to prevent deception.

Commission also indicated that it retains the authority to promulgate a final rule which differs from the proposed rule in ways suggested by these questions and based upon the rulemaking record. 50 Fed. Reg. at 602.

Text of Proposed Rule with Recommended Changes

16 C.F.R. Part 456

Advertising of Ophthalmic Goods and Services

[Ophthalmic Practice Rules]

§ 456.1 Definitions

(a) A "patient" "patient" is any person who has had an eye examination.

(c) (b) An "eye examination" is the process of determining the refractive condition of a person's eyes or the presence of any visual anomaly by the use of objective or subjective tests.

(d) (c) "Ophthalmic goods" consist of eyeglasses, or any component of eyeglasses and contact lenses.

(e) (d) "Ophthalmic services" are the measuring, fitting, and adjusting of ophthalmic goods to the face subsequent to an eye examination.

(e) An "ophthalmologist" is any Doctor of Medicine or Osteopathy who performs eye examinations.

(f) An "optometrist" is any Doctor of Optometry.

(f) (g) A "person" means any party over which the Federal Trade Commission has jurisdiction. This includes individuals, partnerships, corporations, and professional associations, or

other entity.

(g) (h) A "prescription" is the written specifications for ophthalmic spectacle lenses which are derived from an eye examination, The prescription shall contain all of the information necessary to permit the buyer to obtain the necessary ophthalmic goods from the seller or his choice. In the case of a prescription for contact lenses, the refractionist must include in the prescription only those measurements and directions which would be included in a prescription for spectacle lenses. All prescriptions shall include including all of the information specified by state law, if any, necessary to obtain spectacle lenses.

(h) A "refractionist" is any doctor of Medicine, Osteopathy, or Optometry or any other person authorized by state law to perform eye examinations.

(i) A "seller" is any person, or his or her employee or agent, who sells or provides ophthalmic goods and services directly to the public.

(j) A "trade name ban" is any state law, rule or regulation which prohibits optometrists from practicing or holding themselves out to the public under assumed names, the name of the person by whom they are employed, or a name other than the name shown on their license or certification of registration.

§456.1(i) "Optometric Services" are any acts or practices which are included within the definition of the practice of

optometry under state law.

§456.7 2 Separation of Examination and Dispensing

In connection with It is an unfair act or practice for *a retailer* an ophthalmologist or optometrist to:

Fail to *give* provide upon request to the *buyer* patient *a* one copy of the *buyer's* patient's spectacle lens prescription. *Immediately after the eye examination is completed* The obligation to provide the prescription begins after the eye examination is completed and ends one year from the date of the examination or when the prescription expires, whichever comes first. **PROVIDED:** *A retailer* An ophthalmologist or optometrist may refuse to give the *buyer* patient a copy of the *buyer's* patient's prescription until the *buyer* patient has paid for the eye examination, but only if that *retailer* ophthalmologist or optometrist would have required immediate payment from that *buyer* patient had the examination revealed that no ophthalmic goods were required;

(b) Condition the availability of an eye examination to any person on a requirement that the *person* patient agree to purchase any ophthalmic goods from the *retailer* ophthalmologist or optometrist;

(c) Charge the *buyer* patient any fee in addition to the *retailer's* ophthalmologist's or optometrist's examination fee as a condition to releasing the prescription to the *buyer*

patient. **PROVIDED:** ~~A reflractionist~~ An ophthalmologist or optometrist may charge an additional fee for verifying ophthalmic goods dispensed by another seller when the additional fee is imposed at the time the verification is performed; or

(d) Place on the prescription, or require the ~~buyer~~ patient to sign, or deliver to the ~~buyer~~ patient a form or notice waiving or disclaiming the liability or responsibility of the ~~refractionist~~ ophthalmologist or optometrist for the accuracy of the eye examination or the accuracy of the ophthalmic goods and services dispensed by another seller.

§456.~~8~~ 3 Federal or State Employee

~~Nothing in this part shall be construed to prohibit any federal, state or local government entity from adopting and enforcing standards or requirements concerning the dissemination of information and release of prescriptions by sellers or refractionists employed by those governmental entities.~~

The requirements of §456.2 of this rule do not apply to ophthalmologists and optometrists in the employ of any federal, state or local governmental entity.

§456.4 State Bans on Commercial Practice

(a) It is an unfair act or practice for any state or local governmental entity to, ~~enforce any law, rule or regulation which~~ directly or indirectly:

(1) Prohibits employer-employee relationships, partnerships, joint ownership or equity participation agreements, franchise agreements, landlord-tenant agreements (including agreements under which rental payments are based on a percentage of revenue), or other similar affiliations between optometrists and persons other than optometrists for the purpose of offering optometric services or ophthalmic goods and services to the public;

(2) Limits the number of offices which may be owned or operated by an optometrist or by any entity formed by an affiliation covered by §456.4(a)(1) of the rule;

(3) Prohibits an optometrist, or any entity formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing in a pharmacy, department store, shopping center, retail optical dispensary or other mercantile location;

(4) Prohibits optometrist, or any entities formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing, or holding themselves out to the public by advertising or otherwise, under any nondeceptive trade name, including any name other than the name shown on their license or certificate of registration.

(b) If any state or local governmental entity or officer violates any of the provisions of §456.4(a)(1)-(4), that person

will not be subject to any civil penalty, redress, or any other monetary liability under sections 5(m)(1)(A) or 19 of the Federal Trade Commission Act.

§456.5 5 Declaration of Commission Intent

(a) In prohibiting the use of waivers and disclaimers of liability in §456.2(d) 456.2(d), it is not the Commission's intent to impose liability on a retailer an ophthalmologist or optometrist for the ophthalmic goods and services dispensed by another seller pursuant to that retailer's ophthalmologist's or optometrist's prescription.

(b) It is the purpose of this rule to allow ophthalmologists or sellers of ophthalmic goods and services to work for non-professional corporations or for unlicensed persons. The rule is not intended to interfere with a state's ability to enforce any law, rule, or regulation designed to control specific abusive practices such as interference in the professional judgment of ophthalmologists or sellers or compensation schemes used to pay employed ophthalmologists or sellers which encourage overprescription so long as the law, rule, or regulation does not directly or indirectly prohibit ophthalmologists or sellers from working for non-professional corporations or unlicensed persons.

(c) It is the purpose of this rule to allow ophthalmologists, sellers, or any other person to own or operate any number of offices. The rule is not intended to interfere with a state's ability to enforce any law, rule, or regulation requiring that ophthalmic goods, services or eye examinations provided at each

office be supplied by a person qualified under state law to do so or regulating the services provided at each office, as long as states do not directly or indirectly limit the number of offices which an optometrist, seller or any other person may own or operate.

(d) It is the purpose of this rule to allow optometrists to locate any office in a pharmacy, department store, shopping center, retail optical dispensary or other mercantile location. The rule is not intended to interfere with the state's ability to enforce general zoning laws or any law, rule, or regulation which prohibits the location of optometric or optical practice in areas which would create a public health hazard.

(e) It is the purpose of this rule to allow optometrists to practice or hold themselves out to the public under trade names. The rule is not intended to prevent states from controlling specific abusive practices which may occur so long as the state does not directly or indirectly prohibit the use of a trade name. For example, the rule would not prevent states from enforcing any law, rule, or regulation which requires that the identity of an optometrist be disclosed to a patient at the time an eye examination is performed or ophthalmic goods or services are dispensed. This rule also is not intended to prohibit states from enforcing any state law, rule, or regulation that is reasonably necessary to prevent the deceptive use of trade names in advertising.

§456.5(b) The provisions of §456.4(a)(1)-(4) are not

intended to interfere with any state regulation, including any state regulation to safeguard the health and safety of eye care consumers or any state regulation of unfair and deceptive practices by eye care providers, as long as the state does not engage in the specific practices enumerated in §456.4(a)(1)-(4). For example, the rule would not interfere with a state's authority to prohibit improper interference in the professional judgment of optometrists; require that the services provided at a branch office be supplied by a person qualified to do so; prohibit the location of optometric practices in areas which would create a public health or safety hazard; require that the identity of an optometrists be disclosed to a patient at the time optometric services are performed; maintain any requirements reasonably necessary to prevent the deceptive use of trade names or to prevent trade name infringement, or discipline any optometrist for providing inadequate care to patients, as long as the state does not engage in the specific practices enumerated in §456.4(a)(1)-(4).

§456.5(f) (c) **Enforcement**

The Commission intends the rule to be as self-executing as possible. To that end, it is the Commission's intent that this rule may be used, among other ways, as a defense to any proceeding of any kind which may be brought against any seller or optometrist, or any entity formed by an affiliation under §456.4(a)(1) of the rule, for practicing under a using a nondeceptive trade name, working for or associating affiliating

with a nonprofessional corporation of unlicensed person who is not an optometrist, operating branch offices or practicing in a mercantile location.

(f) (d) In this part, The rule, each subpart, and the Declaration of Commission Intent and their application are separate and severable.

Text of Recommended Rule

16 C.F.R. Part 456

OPHTHALMIC PRACTICE RULES

Part 456-Ophthalmic Practices Rules

§456.1 Definitions

(a) A "patient" is any person who has had an eye examination.

(b) An "eye examination" is the process of determining the refractive condition of a person's eyes or the presence of any visual anomaly by the use of objective or subjective tests.

(c) "Ophthalmic goods" consist of eyeglasses, or any component of eyeglasses and contact lenses.

(d) "Ophthalmic services" are the measuring, fitting, and adjusting of ophthalmic goods to the face subsequent to an eye examination.

(e) An "ophthalmologist" is any Doctor of Medicine or Osteopathy who performs eye examinations.

(f) An "optometrist" is any Doctor of Optometry.

(g) A "person" means any individual, partnership, corporation, association or other entity.

(h) A "prescription" is the written specifications for spectacle lenses which are derived from an eye examination, including all of the information specified by state law, if any, necessary to obtain spectacle lenses.

(i) "Optometric Services" are any acts or practices which are included within the definition of the practice of optometry under state law.

§456.2 Separation of Examination and Dispensing

It is an unfair act or practice for an ophthalmologist or optometrist to:

(a) Fail to provide upon request to the patient one copy of the patient's spectacle lens prescription. The obligation to provide the prescription begins after the eye examination is completed and ends one year from the date of the examination or when the prescription expires, whichever comes first. **Provided:** An ophthalmolgoist or optometrist may refuse to give the patient a copy of the patient's prescription until the patient has paid for the eye examination, but only if that ophthalmologist or optometrist would have required immediate payment from that patient had the examination revealed that no ophthalmic goods were required;

(b) condition the availability of an eye examination to any

person on a requirement that the patient agree to purchase any ophthalmic goods from the ophthalmologist or optometrist;

(c) charge the patient any fee in addition to the ophthalmolgoist's or optometrist's examination fee as a condition to releasing the prescription to the patient. **Provided:** an ophthalmolgoist or optometrist may charge an additional fee for verifying ophthalmic goods dispensed by another seller when the additional fee is imposed at the time the verification is performed; or

(d) Place on the prescription, or require the patient to sign, or deliver to the patient a form or notice waiving or disclaiming the liability or responsibility of the ophthalmologist or optometrist for the accuracy of the eye examination or the accuracy of the opthalmic goods and services dispensed by another seller.

§456.3 Federal or State Employees

The requirements of Section 456.2 of this rule do not apply to ophthalmologists and optometrists in the employ of any federal, state or local governmental entity.

§456.4 State Bans on Commercial Practice

(a) It is an unfair act or practice for any state or local governmental entity to, directly or indirectly:

(1) Prohibit employer-employee relationships, partnerships, joint ownership or equity participation agreements, franchise agreements, landlord-tenant agreements (including agreements under which rental payments are based on a percentage of revenue), or other similar affiliations between optometrists and persons other than optometrists for the purpose of offering optometric services or ophthalmic goods and services to the public;

(2) Limit the number of offices which may be owned or operated by an optometrist or by any entity formed by an affiliation covered by §456.4(a)(1) of the rule;

(3) Prohibit an optometrist, or any entity formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing in a pharmacy, department store, shopping center, retail optical dispensary or other mercantile location;

(4) Prohibit optometrists, or any entities formed by an affiliation covered by §456.4(a)(1) of the rule, from practicing or holding themselves out to the public by advertising or otherwise under any nondeceptive trade name, including any name other than the name shown on their license or certificate of registration.

(b) If any state or local governmental entity or officer violates any of the provisions of §456.4(a)(1)-(4), that person will not be subject to civil penalty, redress, or any other monetary liability under sections 5(m)(1)(A) or 19 of the Federal Trade Commission Act.

§456.5 Declaration of Commission Intent

(a) In prohibiting the use of waivers and disclaimers of liability in §456.2(d), it is not the Commission's intent to impose liability on an ophthalmologist or optometrist for the ophthalmic goods and services dispensed by another seller pursuant to the ophthalmologist's or optometrist's prescription.

(b) The provisions of §456.4(a)(1)-(4) are not intended to interfere with any state regulation, including any state regulation to safeguard the health and safety of eye care consumers or any state regulation of unfair or deceptive practices by eye care providers, as long as the state does not engage in the specific practices enumerated in §456.4(1) - (4). For example, the rule would not interfere with a state's authority to prohibit improper interference in the professional judgment of optometrists; require that the services provided at a branch office be supplied by a person qualified to do so; prohibit the location of optometric practices in areas which would create a public health or safety hazard; require that the identity of an optometrist be disclosed to a patient at the time optometric services are performed; maintain any requirements reasonably necessary to prevent the deceptive use of trade names or to prevent trade name infringement; or discipline any optometrist for providing inadequate care to patient, as long as the state does not engage in the specific practices enumerated in §456.4(a)(1) - (4).

(c) The Commission intends that this rule may be used, among other ways, as a defense to any proceeding of any kind which may be brought against any optometrist, or any entity formed by an affiliation under §456.4(a)(1) of the rule, for using a trade name, working for or affiliating with a person who is not an optometrist, operating branch offices or practicing in a mercantile location.

(d) The rule, each subpart, and the Declaration of Commission Intent and their application are separate and severable.

APPENDIX A

BE Study Methodology

Introduction

Numerous commenters discussed the methodology of the BE Study; some stated their approval of the Study,[1] many others questioned the validity of the methodology either by raising general concerns,[2] or providing specific reasons for their views. The most lengthy and technical of the comments about the Study was submitted by Robert R. Nathan and Associates (hereinafter Nathan),[3] a firm of consulting economists hired by the AOA for this proceeding. Below, we discuss the major points raised by commenters; in general, we begin by explaining the BE Study methodology on the point in question and then describe the comments made and the record evidence.[4]

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[1] NAOO Comment at p. 20 and Appendix A; H. Snyder, West Coast Director, Consumer Union, J-24(a) at p. 1; J. Ryan, Attorney, NAOO, J-48(a) at p. 3.

[2] D. Shea, Kansas Optometrist, H-134 at p. 1; M. Todd, Kansas Optometrist, H-152 at p. 1; E. McCrary, Vice President, Maryland Optometry Ass'n, J-5 at p. 1; N. Varnum, Secretary, Maine Board of Optometry, J-18 at p. 3; N. Class, Professor-Emeritus, Univ. of Southern California, F-2 at p. 4; C. Richards, California Optometrist, H-7 at p. 1; K. Nash, President, South Carolina Optometric Ass'n, H-56; R. Marks, Kansas Optometrist, H-69; P. Morse, Maine Optometrist, H-72 at p. 2; A. Gorz, President, Wisconsin Optometric Ass'n, H-40 at p. 2; G. Easton, President-elect, AOA, Tr. 147.

[3] Nathan study, Vol. I - III.

[4] Many of the points addressed by Nathan are of a technical (footnote continued)

In summary, the record discloses that the BE Study provides reliable evidence regarding the effects on consumers of excluding chain firms from the market.

Validity of Study's Quality Measure

The BE Study measured the quality of eye exams in terms of the accuracy of prescriptions, the workmanship of eyeglasses, the extent of unnecessary prescribing, and the thoroughness of eye exams or the ability of optometrists to detect or diagnose eye problems. The Study directly assessed the first three aspects of quality by examining the quality of the optometrist's product or service or "output". The Study did not directly assess the fourth aspect of quality and thus, was not an "outcome" study on this aspect of quality. However, it did indirectly measure an optometrist's ability on this aspect by measuring the completeness of the inputs or "process" - i.e., the completeness of the tests performed which would lead to the detection of eye problems.

Further, in one situation the BE Study did assess outcome in evaluating the ability of optometrists to diagnose more complex eye problems. Two of the study subjects had a somewhat more difficult but not altogether unusual visual condition, namely, a lack of binocular coordination between the eyes, tending to cause

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nature and are discussed and responded to more fully by the primary author of the BE Study, Dr. Ronald Bond, FTC economist, in his Rebuttal Statement, K-18.

double vision. This problem can be corrected optically when properly diagnosed by means of a group of visual performance tests. Sixty-four observations taken by these subjects were included in the study. Since a more complicated prescription was needed for these subjects, they provided a test of the proper "outcome" on one aspect of exam thoroughness.

The results of these 64 observations of outcomes were analyzed separately and compared to the overall study results to determine whether the quality outcome was affected by the more difficult visual conditions of these patients. The data indicated that the results for these binocular subjects was not statistically significantly different from that of the other subjects.[5] This indicates that the BE Study's quality results would not have been different if "outcome" measures had been used to assess all aspects of quality, or if subjects with more difficult eye conditions had been used.

Some commenters stated that an "outcome" test should have been used to test whether optometrists can make sound clinical judgments, make appropriate referrals or diagnose complex visual problems.[6] According to these critics, simply performing a

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[5] BE Study at p. 68.

[6] AOA Comment at p. 28; Southern California College of Optometry Panel, J-41(a) pp. 8-9; California Optometric Ass'n Panel, J-67(a) at p. 7; D. Crum, Kansas Optometrist, H-20 at p. 3; D. Robbins, Indiana Optometrist, H-59 at p. 3; M. Pickel, Jr., Indiana Optometrist, H-96; K. Arsdall, Indiana Optometrist, H-97 at p. 2; C. Beier, President, Kansas Board of Optometry, J-52 at p. 2; W. Kirby, Indiana Optometrist, H-107 at p. 1; L. Asper, California Optometrist, H-148 at p. 1; C. Shearer, Indiana (footnote continued)

process does not ensure that the examiner is competent or can make a clinically sound judgement.[7] According to some commenters, failure to use an outcome test, with patients with complex eye problems, resulted in a bias in favor of chain firms.[8]

Clearly, it would have been ideal to perform an "outcome" study on all areas of quality. However, after discussion with their consultants,[9] BE Staff concluded that this would not be feasible because individuals with eye pathologies could not have been asked to forego treatment until after the Study was completed.[10] Some commenters disputed this and stated that it is feasible to use subjects with pathologies.[11] In any case, given the fact that a process test was used, the relevant questions are

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Optometrist, H-153 at p. 1; L. Zuern, Member, North Dakota Board of Optometry, J-40 at p. 2. These comments are closely related to the comments, discussed earlier, see supra Section III.C.1.a., "BE Study," that patients with a wide variety of complex visual problems and eye pathologies should have been included.

7 See commenters cited in note 6 supra. These critics note that many factors in addition to the tests performed can affect the proper outcome. See, e.g., Southern California College of Optometry Panel, J-41(a) at pp. 10-11.

8 AOA Comment at p. 27; Nathan study, Vol. I, Ex. 1, p. 79. The only reason given was that chains provide shorter eye exams. The commenters did not elaborate on why this would create a bias in favor of chain firms.

9 The consultants included the College of Optometry of the State University of New York, the Pennsylvania College of Optometry and the Director of the Optometric Services of the Veterans Administration.

10 BE Study at p. 43.

11 See, e.g., California Optometric Ass'n Panel, J-67(a) at pp. 5-6.

whether there is a correlation between input and output and whether there is any reason to suspect a bias in favor of chain firms.

Commenters do not deny that there is a correlation between a correct process and a correct outcome.[12] Further, tests performed by BE Staff on the Nathan New York City Survey data show that input measures are significantly associated with output.[13] The tests also indicate that there is no reason to suspect a bias in favor of chain firms. These tests are described below.

Commenters who claim that there is a bias in favor of chains in the BE Study's use of a process, rather than an output, test imply that while chains may properly perform the procedures, they do not derive the correct result. Thus, in order to show that the BE Study's use of a process test created a bias in favor of chains it must be shown that chains performed more poorly than private optometrists when both perform the same procedures.

Calculations performed by BE staff on the Nathan New York City Survey data tend to show that commercial firms performed as

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12 See, e.g., Southern California College of Optometry, J-41(a) at p. 8. The Nathan New York City survey also considered process along with outcome.

13 Elsewhere, we discuss that contact lens follow-up care, one type of input, may not be associated with output, or that there may even be a negative correlation. See discussion at supra Section III.C.3.c.i.(c)., "Contrary Survey Evidence." The reason why follow-up care may be unique in this respect is discussed there.

well as noncommercial optometrists when they both spend equal time and perform equivalent procedures, and thus, that there is no bias in favor of chain firms in the BE's Study's use of a process test. Using a regression equation, BE Staff found that the commercial firms in the Nathan survey did not exhibit a statistically significant lower pass rate than the private firms, holding constant the time spent on an exam and whether or not a case history was taken.[14] This suggests that commercial firms do not provide lower quality than private optometrists when both perform equivalent procedures and consequently that there is no bias in favor of chain firms in the BE Study's use of a process test.

Validity of Study's Measure of Overprescribing

One of the dimensions of quality which the BE Study tested was the extent of unnecessary prescribing among optometrists. Some subjects went to examinations wearing glasses which the consulting optometrists believed to be appropriate. These subjects told the survey optometrists that they wanted to purchase glasses only if the glasses would make a real difference in their ability to see. Optometrists who prescribed glasses

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[14] In our discussion of the Nathan survey, we conclude that the study results may be biased against chain firms. See, supra section III.C.1.c,iii., "Nathan New York City Survey Evaluation." This may indicate that BE Staff's analysis of the Nathan data is biased against chain firms. If this is true, then chain firms may actually provide more thorough eye exams than noncommercial firms holding time and procedures constant.

were judged to have overprescribed.[15]

One commenter criticized the fact that the BE subjects were instructed to tell the optometrists that they wanted to purchase glasses only if the glasses would make a real difference in the patients' ability to see. This comment stated that the degree of increase should have been quantified and also stated that this is not a valid criterion because optometrists may consider other factors, such as visual comfort, in prescribing glasses.[16]

This comment appears to reflect a misunderstanding of the study's methodology. The subject's comment to the optometrists -- that they wanted to purchase glasses only if the glasses would make a real difference in their ability to see -- made clear to the optometrists that the subjects did not want to change glasses for cosmetic reasons, (e.g., because they wanted a new frame) or for any other reasons such as visual comfort. The current glasses of these patients were judged to be accurate and adequate for these patients by the survey consultants. Therefore, these subjects did not need new glasses, and optometrists who prescribed glasses were judged to be overprescribing.[17]

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15 See, BE Study at p. 20.

16 Southern California College of Optometry Panel, J-41(a) at pp. 13-14.

17 See, BE Study at p. 20.

Nathan's Reanalysis of the BE Quality Data

Nathan presented a "reanalysis" of the BE Study quality data, which, according to Nathan, indicates that markets with chain firms have lower quality than markets without chain firms.[18] In carrying out this "reanalysis", Nathan discarded the BE Study's results showing the average quality in markets with chain firms, stating that the Study's calculation of this market-wide average was invalid.[19] Nathan then used the BE Study's quality results for chain firms and its quality results for restrictive markets and combined these results to create a new market-wide average quality. According to Nathan, this is the quality that would result from the addition of chain firms to markets without chain firms. As Nathan points out, this newly calculated average quality is lower than the BE Study's average for market without chain firms. According to Nathan, this means that the addition of chain firms to a market would result in a lower average quality in that market.[20]

This argument is a sophisticated version of the statement made by other commenters that since the BE Study showed that chain firms give less-thorough exams than nonchain firms, the

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18 Nathan study, Vol. I, Ex. 1, pp. 15, 136-140.

19 See, Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 17.

20 Nathan study, Vol. I, Ex. 1, pp. 15, 136-140.

addition of chain firms to a market will automatically mean that there will be a lower average quality in that market.[21]

In effect, Nathan's calculations and these arguments amount to the creation of a market which is a contradiction in terms -- namely, a market without chain firms which has chain firms. The BE Study examined quality in the markets which actually existed -- markets with chain firms and markets without chain firms. Nathan rejected this data on actual market conditions and instead attempted to create a hypothetical market, which is contrary to logic and the facts. The assumption behind Nathan's reanalysis and similar arguments is that when restrictions are lifted, chains would simply be added to the market and nothing else would change. This ignores market dynamics; the addition of chains to a market necessarily creates changes throughout the market. For example, some optometrists who would otherwise engage in private practice would become associated with the chains, and some private practices would be replaced by chain outlets. For these reasons, Nathan's reanalysis and these arguments are invalid. The results of the BE Study, which measured quality in actual markets, is more reliable.

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[21] AOA Comment at p. 26; R. Fiegel, Kansas Optometrist, H-65 at p. 2; B. Glow, President, New Jersey Optometric Ass'n, H-158 at p. 1; J. Scholles, Ohio Optometrist, AOA trustee, J-31 at p. 7; Southern California College of Optometry Panel, J-41 at pp. 15-16; D. Conner, Director, Department of Legal Affairs, Indiana Optometric Ass'n, Tr. 673.

Possibility of Bias

Nathan stated that the BE Study price results were biased, arguing that many of the high-priced private optometrists in the survey were specialists, and thus, should have been eliminated from the survey.[22] In support of this conclusion, Nathan pointed to the results of an informal survey that they conducted of private optometrists in Washington, D.C. Nathan claimed that this survey showed that nonchain optometrists who charged prices at the higher end of the spectrum generally were specialists.[23]

However, a close examination of the data collected by Nathan in Washington, D.C. reveals that it does not support Nathan's conclusion. First, Nathan asked only seven high-priced optometrists about specialization, so that Nathan's sample is extremely small and nonrepresentative, and cannot be used to determine whether or not high-priced optometrists specialize more frequently than low-priced optometrists. Second, of the seven optometrists sampled, only one nonchain optometrist indicated that he offered truly specialized services.[24] Thus, the record indicates, there is no reason to suspect a bias in the BE Study, as claimed by Nathan.

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22 Nathan study, Vol. I Ex. 1, p. 71.

23 Id. at pp. 71-72.

24 Rebuttal Statement of R. Bond, FTC economist, K-18 at pp. 8-9.

One commenter stated that the BE Study subjects could have been biased "in one direction or another" since they knew the purpose of the study and knew whether an optometrist was commercial or noncommercial.[25] While it is true that the subjects knew the purpose of the study and whether an optometrist was commercial or noncommercial, as the comment itself seems to indicate, there is no reason to assume that the subjects were systematically biased in one particular direction. The subjects were exposed to FTC staff members and to the consulting optometrists at the colleges of optometry and the Veterans Administration. Even assuming that FTC Staff were biased in favor of commercial firms, (although there is no reason to believe that this was the case), the consulting optometrists, if they had any bias, would likely have had a bias against commercial firms. Thus, it is unlikely that the survey subjects were systematically influenced in one particular direction.[26] Further, in order to invalidate the Study results showing that quality was not lower in markets with chain firms it would have to be shown that the subjects were biased in favor of chain firms.[27] This seems unlikely given the extensive interaction

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[25] Southern California College of Optometry Panel, J-41(a) at pp. 11-12.

[26] In this respect, the BE Study differs from the Nathan New York Survey, in which the subjects might have been systematically biased against commercial firms because of excessive involvement with AOA representatives and no exposure to anyone who might be sympathetic toward commercial firms.

[27] If Study subjects were biased in favor of private optometrists, and against chain firms, it would be possible that chain firms actually had relatively higher quality than shown in (footnote continued)

between the subjects and the FTC consultants at the optometry colleges.

One commenter stated that the study was biased because, if the subject could not remember whether a particular test was performed, the test was ignored and considered performed.[28] Actually, the procedure used was that if subjects could not remember whether a procedure had been performed, the points for that procedure were deducted from both the actual score and the possible score. Thus, an exam would score 100 percent if all tests that the subject could remember had been performed.[29] A bias would only be created if subjects systematically forgot more tests performed by one group of optometrists than by the other group. No reason has been alleged why this would have occurred nor can we conceive of one.

Adequacy of Sample Size

Nathan also stated that the BE study had too small a sample size, noting, for example, that the study had only 23 observations for chain firms in the least restrictive markets.[30] While it is true that there were 23 observations for chain firms in the least restrictive market, these 23

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the Study.

[28] Southern California School of Optometry Panel, J-41(a) at p. 13.

[29] BE Study at p. 7 n. 1.

[30] Nathan study, Vol. I, Ex. I, p. 90.

observations were not the only observations used in the analysis. Since regression analysis was used, all of the 280 observations in the study were used in the analysis and the results are derived from the combined 280 observations. The nature of regression analysis is to use all relevant observations holding constant factors that might affect the results. The results regarding chain firms, for example, were derived from an analysis of all 280 observations, holding constant the effects of advertising.[31]

BE Price Analysis -- Calculation of Market-Wide Averages

In order to make its price comparisons, the BE Study calculated market-wide average prices for each type of market. These averages were calculated based on the frequency of each type of optometrist in the market and the average price found to be charged by that type of optometrist.[32] Nathan raised a number of objections to the way in which the market-wide averages were calculated. Nathan stated that these average prices are invalid because the volume of each type of practitioner was not taken into account, arguing that this is important, since some

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[31] Some commenters also objected to the way in which optometrists within each market were classified. See, e.g., AOA Comment at p. 26. This is responded to in Rebuttal Statement of Dr. R. Bond, FTC Economist, K-18 at p. 8.

[32] For example, nonadvertisers were found to constitute 54.9% of optometrists in the least restrictive markets and to charge, on average, $73.44. Rebuttal Statement of R. Bond, FTC economist, K-18, Table A-3.

optometrists, particularly low-priced providers, examine more patients than others.[33]

While it is true that the volume of individual practitioners was not taken into account in the study, we do not believe that this invalidates the results. First, to a large extent, the Study did take into account differences in volume among practices since the Study calculations were based on the frequency of individual optometrists not of offices or firms. Thus, for example, although chain firms examine a higher volume of patients than many traditional optometrists, this is often accomplished by hiring additional optometrists.[34] This was accounted for in the Study.

Secondly, as recognized by Nathan,[35] it is likely that, in general, all lower-priced providers will have a higher volume of patients than higher priced providers.[36] This would be true in restrictive as well as nonrestrictive markets. Further, there is no reason to assume that there would be a higher percentage of low-priced providers in one type of market than the other. Thus, if volume of individual optometrists were taken into account, average prices might be lower in both types of markets, but there

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[33] Nathan study, Vol. I, Ex. 1, p. 87, 137-38; RRNA Rebuttal Statement, K-3 at pp. 3-4.

[34] See, e.g., R. Zaback, New Jersey Optometrist, J-48(b) at p. 2; B. Davis, Texas Optometrist, J-48(e) at p. 2.

[35] Nathan study, Vol. I, Ex. 1, p. 87.

[36] See, Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 11.

is no reason to assume that the difference in prices between the two types of markets would be affected.[37]

Nathan also stated that the calculation of market-wide averages is invalid because it incorrectly assumes that an accurate classification of all optometrists can be made based on the Yellow Pages.[38] However, BE Staff experienced no difficulties in making classifications based on the Yellow Pages. In the BE Study, optometrists were classified into the following groups: (1) nonadvertisers, (2) advertisers and local chain firms, and (3) interstate chain firms. In most cases, the Yellow Pages and newspaper, which were reviewed over a period of time, were sufficient to determine into which of these categories optometrists belonged. In cases of doubt, telephone calls to the optometrists were made.

Nathan further stated that accurate classification of optometrists could not be made because it is difficult to obtain an accurate count of the number of chain firms offering eye exams in the market since many chains have several offices and many offices provide no examinations.[39] This comment reflects a misunderstanding of the way in which classifications were made. As stated, individual optometrists were counted, not the number of chain firms or the number of offices of chain firms.

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[37] For additional discussion of this point, see Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 11.

[38] Nathan study, Vol. I, Ex. 1, pp. 110-111.

[39] Id.

Nathan also stated that the market-wide averages were invalid because nonprice advertisers were not sampled in market two, although, according to Nathan, they existed in that market.[40] Nathan's argument is based on the incorrect premise that advertising optometrists existed in that market. In fact, they did not. Although nonprice advertising of eyeglasses was found to exist in market two, this advertising was conducted by opticians, not optometrists.[41]

Price Data on More Complex Services

Other commenters stated that the BE Study provides no data on the relative prices of more complex services and materials such as multifocal lenses, low vision aids and visual training, apparently believing that such data might have produced different results.[42] It is true that the Study did not examine these areas of eye care. However, many of the more complex areas of optometry such as low vision aids are not handled by all optometrists, either commercial or noncommercial, but are considered specialties within optometry.[43] In addition, a relatively small number of patients need these services.[44] The

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40 Id. at p. 45.

41 Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 8.

42 See, e.g., AOA Comment at p. 28.

43 See, e.g., B. Davis, Texas Optometrist, Tr. 1945-46; R. Zaback, New Jersey Optometrist, J-48(b) at p. 2; M. Albanese, Illinois Optometrist, Tr. 1966; H. Glazier, President, Maryland Board of Optometry, Tr. 913.
(footnote continued)

BE Study, along with the Contact Lens Study, covered the major areas of practice handled on a daily basis by most optometrists -- i.e., examining eyes, prescribing and dispensing eyeglasses and fitting contact lenses. Also, no evidence has been presented to show that the conclusions of the Study with respect to these areas are not applicable to other, more minor or specialized areas of practice.

Effect of Nonprice Advertising

Nathan noted that the BE Study found that there was no effect on market prices of nonprice advertising and asserted that this result is so questionable that it casts doubt on the entire Study.[45] As proof that this result is questionable, Nathan asserted that testimony from large chains indicated that they virtually never price advertise but do engage in nonprice advertising. According to Nathan, this implies that there must be a benefit from nonprice advertising and that there should be an effect on price.[46]

For several reasons we disagree that the BE Study's result regarding nonprice advertising is questionable. First, Nathan incorrectly characterized the testimony of the chain firms. Only

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[44] See, e.g., L. Zuern, Member, North Dakota Board of Optometry, Tr. 1555.

[45] RRNA Rebuttal Statement, K-3 at pp. 4-6.

[46] Id.

one firm indicated that it did not price advertise and several firms stated that they did price advertise.[47] Secondly, nonprice advertising could provide substantial benefits for a firm even though it does not affect market-wide prices. For example, it could increase market visibility and thus patronage at that firm. Firms could desire to stress features other than price which may be desirable to consumers such as fast service, long hours, good location or high quality. Therefore, we do not believe that this result of the BE Study is unusual or unbelievable and thus does not cast doubt on the Study.[48]

Nathan's Reanalysis of BE Price Data

Nathan reanalyzed the BE price data and concluded that markets with chain firms do not have lower prices than markets without such firms.[49] The record reveals that the Nathan reanalysis cannot be relied upon because of serious methodological flaws. One, Nathan failed to control for factors other than regulation that affect prices across markets. Two, to conduct their analysis, Nathan excluded the BE data pertaining to a large group of optometrists in markets with chain firms. Excluding this group invalidates Nathan's attempt to compute a

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47 NAOO Panel, Tr. 363-366.

48 Nathan stated that this and other "inconsistent" results are not discussed in the BE Study. RRNA Rebuttal Statement, K-3 at pp. 5-6. In fact, they are discussed at pp. 57 and 83-89 of the BE Study.

49 Nathan study, Vol. I, Ex. 1 pp. 106-113.

market-wide average price for such markets.[50]

Effects of Specific State Laws

Finally, Nathan stated that the BE Study does not provide information on the effects of specific state laws, thus questioning the validity of the Study.[51] Contrary to this comment, however, the study utilized the most appropriate methodology for evaluating the effects of restrictions on commercial practice. The initial purpose of the study was to examine specific state restrictions. It soon became obvious, however, the classifying markets based on the existence of statutory or regulatory restrictive language was inadequate. Much statutory language is general or ambiguous and can be interpreted in a number of ways. Some statutes are not enforced. Accordingly, markets were classified on the basis of whether or not optometric chain firms existed in the market. Further, all markets classified as restrictive had restrictive laws on the books.[52]

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50 See, Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 13.

51 Nathan study, Vol. I, Ex. 1 at p. 53.

52 Rebuttal Statement of R. Bond, FTC economist, K-18 at p. 7.

Nathan raised several additional technical objections to the results and methodology of the BE Study. In his rebuttal statement, Dr. Bond discusses these comments and demonstrates why the BE Study methodology is nevertheless sound and why the results are valid. See, id. at pp. 7-11, 16.

Conclusion

The record fails to disclose any evidence that the BE Study should not be relied upon. The record indicates that the BE Study and analysis were carried out in accordance with sound survey and statistical techniques and that there is no reason to believe that the results were affected by any systematic bias. Thus, the record indicates that the BE Study provides sound evidence that prices are higher in markets without chain firms than in markets with such firms, without any increase in quality.

APPENDIX B

Contact Lens Study Methodology

Introduction

Many commenters discussed the methodology of the Contact Lens Study; some stated their approval of the Study,[1] while many stated that the methodology was flawed. The most lengthy and technical of the comments about the Study was submitted by Robert R. Nathan and Associates (hereinafter Nathan),[2] a firm of consulting economists hired in this proceeding by the AOA. These comments are addressed below. In general, we begin by explaining the Study methodology in areas where concerns have been raised. We then describe the comments made and the record evidence concerning the point in question.[3]

Exclusion of Former Wearers from Study

The Study examined the eye health of current contact lens

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[1] See, e.g., Licensure, Brand Names and Commercial Practices as Sources of Quality Control in Medicine, Lee Benham, G-21 at pp. 23-24; P. Elliot, Member, Florida Board of Opticianry, J-22 at p. 5; H. Snyder, West Coast Director, Consumer's Union, Tr. 1062-63; NAOO Comment H-78(a) at p. 20.

[2] Nathan study, Vol. I, Ex. 2.

[3] Many of these points are elaborated upon by one of the primary authors of the Study, Dr. J. Mulholland, an FTC economist, in his Statement, J-19(a), and his Rebuttal Statement, K-23.

wearers. In devising the Study, staff gave serious consideration to trying to measure the quality of fit of former contact lens wearers. However, the consultants could devise no way to examine or assess the eye health and contact lens fit quality for patients who had not worn their lenses for many months or years;[4] there was no point in examining the eyes of such subjects, and the former patients themselves would be unable to provide sufficient information to analyze the quality of fit by their optometrists.[5] Earlier we discussed why our inability to include former wearers should not have affected the Study results.[6]

Nevertheless, AOA pointed to an analysis which they did of former wearers in the FTC's Study, which they claimed showed that commercial optometrists have a higher rate of "unsuccessful wearers" than noncommercial optometrists. These patients were identified as former wearers based on the FTC's survey "screener" questionnaire, which was mailed to 31,219 households in order to identify persons who had been fitted with contact lenses and who could be used in the Study.[7] AOA classified the fitters of these

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[4] Contact Lens Study at p. B-1.

[5] AOA and Dr. Barresi, Director of the Center for Vision Care Policy at the State University of New York, SUNY, suggested interviewing former wearers to assess the reasons why they stopped wearing their lenses. AOA Comment at p. 39; B. Barresi, J-13(a) at p. 6. However, as Dr. Barresi acknowledged during his testimony, many patients would only be able to say that their lenses felt uncomfortable, which could be attributable to a number of factors other than fitter performance. Tr. 571.

Further discussion of this issue is contained in Appendix B of the Contact Lens Report at pp. B-1 through B-3.

[6] See discussion at supra Section III.C.1.b.vi., "Contact Lens Study."
(footnote continued)

former wearers and found that commercial optometrists had a greater proportion of patients in the former wearers group than noncommercial optometrists.[8]

This method of evaluating fitter competence has a number of significant drawbacks. First, and most important, is that factors totally unrelated to the fitter's ability may affect whether a contact lens wearer becomes a former wearer and these factors could create biases in the data.[9] For example, patients who pay less for their lenses may have less incentive to bear the initial discomfort associated with contact lens wear. This could create a bias resulting in a higher drop-out rate among commercial optometrists. This problem alone casts serious doubt on the conclusions that the AOA seeks to draw from their data.

Second, AOA's attempt to classify the fitters of the former wearers was not free from biases and contained inconsistencies.[10] Also, AOA used sources of information which are questionable and cannot be verified.[11] The FTC staff

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[7] Of the 22,512 who returned the "screener" questionnaire, 502 were still wearing their lenses and had their eyes examined in the Study. Another 330 identified themselves as former wearers. Contact Lens Study at p. 24.

[8] AOA Comment at p. 40; Letter from Richard Averill, AOA, to J. Miller III, Chairman, FTC, July 19, 1983, B.5-9.

[9] This is discussed in more detail in Appendix B of the Contact Lens Study. See, also, J. Mulholland, FTC economist, J-19(a) at p. 3; Rebuttal Statement of J. Mulholland, K-23 at pp. 8-9.

[10] See, Rebuttal Statement of J. Mulholland, FTC economist, K-23 at Appendix B.

[11] Because the only data available on the former wearers' (footnote continued)

performed its own classification of the former wearers and the results of that analysis showed no statistically significant difference between the percentage of former wearers among commercial optometrists compared to noncommercial optometrists.[12] While the staff's classification may also be subject to uncertainty because of insufficient data, these differing results highlight the unreliability of the AOA results.[13]

In summary, the Contact Lens Study data on current wearers provides strong evidence that commercial optometrists are at least as good as noncommercial optometrists at providing long term successful cosmetic contact lens fits. No credible evidence has been presented to show that commercial optometrists have a higher percentage of unsuccessful wearers.

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fitters was that contained on the "screener" questionnaire, in many cases there was insufficient information on these fitters to properly classify them. Many patients did not even give the address or full name of the fitter and none identified whether the fitter was an optometrist, optician or ophthalmologist. AOA attempted to remedy this problem by turning to various sources of information, such as AOA members who stated that they were familiar with the fitter in question. See, July 19, 1983 letter to Chairman Miller, FTC, from Richard Averill, AOA, B.5-9.

[12] Contact Lens Study at p. B-4; J. Mulholland, FTC economist, J-19(a) pp. 3-4.

[13] To further support its position that commercial optometrists have a higher percentage of "unsuccessful" wearers, AOA pointed to a survey conducted by Dr. Robert J. Morrison, O.D. Comment of AOA, H-81 at pp. 40-41 and Appendix C; J. Kennedy, Optometrist, J-26 at pp. 3-4. This survey is discussed further at supra section III.C.3.c.i.(c)., "Contrary Survey Evidence." As explained there, this survey does not provide information on the differences between commercial and noncommercial optometrists in their ability to fit contact lenses.

Representativeness of Sample

Survey subjects were identified using consumer mail panel firms.[14] While mail panels are not randomly selected from the entire U.S. population, they are demographically balanced to ensure that they were representative of the population.[15] Subjects were also selected from eighteen urban areas across the country, in part, to obtain a geographic balance.[16] Cities were also originally selected, in part, with reference to the laws governing contact lens fitting by opticians; however, this was to ensure that a sufficient number of optician fits were incorporated in the study, and in no way affects the representativeness of the survey subjects.

Nonetheless, some commenters stated that the Study sample was not representative.[17] However, they could point to no bias in the method of survey subject selection. Thus, there appears to be no reason to conclude that the survey subjects were not representative of contact lens wearers in general.

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14 Contact Lens Study at p. 19.

15 Contact Lens Study at p. 19 n. 39.

16 Contact Lens Study at p. 19 n. 40.

17 Nathan study, Vol. I, Ex. 2, at pp. 9-10; AOA Comment at p. 36; B. Barresi, Professor, State Univ. of New York School of Optometry, J-13(a) p. 8.

Adequacy of the Sample Size

The sample size for the survey was chosen based on advice from statistical and marketing experts. Nevertheless, some commenters stated that the sample size is too small for meaningful comparisons.[18] For example, they pointed out that the optometrist sample, originally designed to be one group, was subsequently further broken down into commercial and noncommercial, reducing the sample size below that originally planned.[19] This reduction in size had no significant effect, however, since, even when subdivided, the noncommercial optometrist and commercial optometrists groups were of comparable size to the original plans for the two other groups that were studied, ophthalmologists and opticians. Further, the statistical tests for significant differences take sample size into account.[20]

Validity of Tests Used to Assess Eye Health

Some commenters stated that additional tests should have been performed to assess eye health or vision.[21] We do not

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[18] Nathan study, Vol. I, Ex. 2, pp. 11-12; B. Barresi, Professor, State Univ. of New York School of Optometry, J-13(a) p. 9; AOA Comment at pp. 36-37.

[19] Nathan study, Vol. I, Ex. 2, pp. 11-12.

[20] See, Rebuttal Statement of J. Mulholland, FTC economist, K-23 at p. 2. See also, J. Mulholland, Tr. 805-06.
(footnote continued)

believe that these comments are valid. One, the methodology which was used was agreed upon by the consultants - i.e. the representatives of the professional associations.[22] If certain tests, for example, were not incorporated, it was because the consultants determined that they were not necessary or not appropriate.[23] Second, no bias in the data has been alleged,[24] and no reason has been advanced to show why the results were affected by not including these additional tests.

Appropriateness of Patient Observations in Data Base

Nathan stated that some of the patients in the data base were inappropriately included in the study[25] and submitted a list of such patient observations. We have examined this list and concluded that, in some instances, Nathan was simply wrong about the facts. For example, in one instance, Nathan alleges that the patient had worn her lenses for the first time in months on the

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21 B. Barresi, Professor, State Univ. of New York School of Optometry, J-13(a) pp. 11-12; AOA Comment at pp. 43-44, J. Kennedy, Minnesota Optometrist, J-26 pp. 6-8, 12; Southern California College of Optometry Panel, J-41(a) pp. 22-23.

22 See, supra Section III.C.1.b.i., "Contact Lens Study, Introduction".

23 See also, G. Hailey, FTC staff attorney, Tr. 202-03; Contact Lens Study at p. 18 n. 38 and p. 25 n. 52.

24 Several witnesses essentially admitted that they could see no reason why the results would be affected. See, e.g. B. Barresi, Professor, State Univ. of New York School of Optometry, Tr. 577; Southern California College of Optometry Panel, J-41(a) p. 24.

25 RRNA Rebuttal Statement, K-6 at pp. 10, 17-18.

day of the exam.[26] In fact, she was wearing them for 17 hours per day virtually every day.

In other instances, the problem alleged by Nathan is not really a problem. For example, Nathan stated that in one instance, the FTC examiner noted that the subject's poor eye condition score was probably not due to contact lens wear; Nathan stated that this was consequently an "inappropriate" patient observation which should not have been included in the Study. In fact, however, inclusion of this patient was consistent with the Study's methodology. As explained above, the examiners were simply to determine the relative presence of the eye conditions and were not supposed to attempt to determine the cause of the eye conditions. Thus, inclusion of this observation is not inappropriate.

Moreover, Nathan does not allege any bias in the data as a result of these "inappropriate" observations and does not show how the results could have been affected.[27]

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[26] Id. at p. 17. This involves patient I.D. No. 160435.

[27] Some commenters also claimed that the adjustments to the price data were inappropriate. Nathan study, Vol. I, Ex. 2, p. 28; AOA Comment at p. 46. This point is responded to briefly by Dr. J. Mulholland, FTC economist, J-19(a) at p. 7, where he explains why the adjustments were indeed appropriate. Since similar adjustments were made to the BE study data, and similar criticisms raised, this point is also discussed by Dr. Bond, FTC economist, in his Rebuttal Statement, K-18, at pp. 12-13, where he explains in detail why the adjustments were appropriate.

Criteria for Classification of Fitters

In order to be classified in the Study as "commercial," an optometrist had to be affiliated with a chain or optical company, or utilize a trade name or practice in a commercial location in conjunction with other attributes of commercialism. The vast majority of "commercial" optometrists were either chains or optical companies offering optometric services.

The following is a more specific description of the criteria used.[28] If the information indicated that the fitter was a major chain or an optical company and the fitter was an optometrist, the fitter was classified as "commerical optometrist." The following were also classified as "commercial": a trade name practice (not the name of an optometrist) in conjunction with display "Yellow Pages" advertising[29] or in conjunction with a shopping center or commercial location; a practice at a commercial location with branch offices and with display "Yellow Pages" advertising. A single private practitioner or partnership with no indicia of commercial practice was classified as "noncommercial."[30]

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[28] See, Memo from J. Bromberg, former FTC staff attorney, to R. Kinscheck, FTC staff, March 22, 1985, J-72, for further discussion of this point.

[29] Display "Yellow Pages" advertising refers to larger display ads and not just a listing of the name, address and telephone number.

[30] Group practices, with no indicia of commercialism, but using (footnote continued)

The staff classified a provider as private or commercial only if the facts clearly indicated that such a classification was appropriate; when faced with doubt, staff placed a fitter in the "unknown" group. Practices with only a few attributes of commercialism were placed in the "unknown" category.[31]

Further, FTC staff met with representatives of the AOA in the beginning of 1983, after staff had prepared the first draft of the report for comment, to discuss and attempt to resolve any disputes regarding the classifications. AOA representatives presented their concerns about some of the classifications and, as a result, staff re-analyzed the data after moving a number of fitters out of the "commercial" group and into the "unknown" category. Again, staff moved all questionable fitters into the "unknown" category.

Nevertheless, the AOA now objects to the Study's classification scheme claiming that some professional optometrists practice under trade names, engage in advertising, practice in shopping centers or operate a limited number of

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very traditional trade names, such as "Optometric Associates," were also included in the "noncommercial" group.

[31] The following are examples of practice types that were classified as "unknown:" a practice with several branch offices and boldface advertising in the "Yellow Pages"; a practice with the corporate name of the optometrist -- e.g. Smith Optometry, Inc. -- and boldface "Yellow Page" advertisings; a practice with significant "Yellow Page" display advertising with branch offices but without trade name usage or clear shopping center location; a practice that is apparently the name of an optometrist employing other optometrists and advertising. See, Memo from J. Bromberg, former FTC staff attorney, to R. Kinscheck, FTC staff attorney, March 22, 1985, J-72.

branch offices and thus, that such optometrists were inappropriately classified as "commercial" in the Study.[32] Another commenter suggested that the Study should have focused only on chain optical outlets and that advertising should not have been used to classify optometrists.[33] These criticisms are invalid for a number of reasons. One, since states restrict trade names usage, commercial locations and branch offices, it is not unreasonable to include these criteria in the definition of "commercial." Two, as explained above, "commercial" optometrists were either associated with a chain firm or optical company, or used a trade name or practiced in a commercial location in conjunction with other attributes of commercialism including advertising. A commercial location, branch offices, a traditional trade name or advertising alone were not sufficient to classify a practice as "commercial."

Classification of Individual Fitters

The original purpose of the report was to compare the quality of fit between ophthalmologists, optometrists and opticians, with no distinction being made between commercial and noncommercial optometrists.[34] Subsequent to the data collection, the staff further classified the optometrist fitters as

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32 AOA Comment at p. 38; RRNA Rebuttal Statement, K-6 at p. 8.

33 B. Barresi, Professor, State Univ. of New York School of Optometry, J-13(a) at pp. 2-3.

34 Contact Lens Study at p. 17.

commercial or noncommercial in order to address issues related to this rulemaking.[35] A questionnaire had been sent to the fitters requesting information to allow staff to determine whether the fitter was an optician, optometrist or ophthalmologist. Because of the sequence of events, no information was requested about the commercial attributes of the practice. Therefore, staff relied on the information available, which included the name of the practice and information in the "Yellow Pages" and the Blue Book of Optometry, a directory of optometrists.[36]

The fact that some differences of opinion might exist about the classifications would not render the Study's classification scheme invalid, since there is no reason to believe that there was any bias in the classifications. None has been alleged.

In their rebuttal statement, Nathan presents a detailed discussion of why many of the Study's classifications are allegedly inconsistent or erroneous.[37] Staff has completed a detailed review of the many alleged errors, inconsistencies and discrepancies in the classification scheme.[38] These allegations

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[35] Memo from J. Bromberg, former FTC staff attorney, to R. Kinscheck, FTC staff attorney, March 22, 1985, J-72.

[36] Id.

[37] Rebuttal Statement of RRNA, K-6 at pp 8-9, 13-16. Nathan also suggested that staff should have obtained better information about the practice attributes of the fitters. J-66(a), Vol. I., Ex. 2 p. 17-18. They also criticized staff's use of the 1979-81 Yellow Pages, although the exams occurred in 1975 through 1978. Id. Again, however, Nathan points to no possible bias in our results from this fact.

[38] Rebuttal Statement of RRNA, K-6 at pp. 6-16. Nathan also (footnote continued)

fall into two basic categories.

One, many of the examples contain no errors or discrepancies, despite Nathan's claim. For example, Nathan notes a number of instances where the same fitter was classified differently in various observations. Our examination showed that this usually involved various branches of a chain optical company, which may have been classified as an "optician" fit in one observation, "unknown" in another, and "commercial optometrist" in another. Such a pattern of classification is entirely logical and consistent however. Although all these patients were fit at the same optical company, our information indicates that one was fit by an optician, another by an optometrist, while for another patient, the information we have is insufficient to decide whether the patient was fit by an optician or an optometrist. In other examples, Nathan claims that the evidence indicates that the optometrist practices under a trade name, yet, in some of the cases cited, we could find no evidence that the optometrist practices under a trade name.

Second, in other cases cited by Nathan, a difference of opinion could exist regarding the correct classification, and judgment calls had to be made. For example, Nathan suggests that

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pointed to alleged discrepancies between classifications of the current wearers and the former wearers. Id. at p. 5. As noted above, the data on former wearers fitters was unreliable and many of the fitters had to be classified as "unknown." Thus, it is highly likely that there were fitters which could be classified in the current wearers data, but could not be classified (as an optometrist, optician or ophthalmologist fit) in the former wearers analysis.

optometrists practicing in optometric school settings should have been classified as "unknown" rather than as "noncommercial." Nathan suggests that since the Study classified optometrists who practice in HMO's as "unknown," to be consistent, the Study should also have classified optometrists at schools of optometry as "unknown."[39] Nathan also points to alleged discrepancies or possible differences of opinion regarding the classification of fitting that was done by opticians working under the supervision of, or in the office of, an optometrist or ophthalmologist.[40] Here again, since there are a number of steps in the fitting process, and various degrees of supervision may be exercised over some or all of these steps, differences of opinion may exist and judgment calls may have to be made as to how to classify the fitter.

The fact that there may be some differences of opinion regarding some of the classifications does not suggest that the results are invalid, however. No bias in the Study's classification scheme has been allege, nor can we see any way in which the alleged errors have biased the results. In fact, some of the alleged errors seem to favor noncommercial optometrists. For example, optometrists at schools of optometry are generally believed to provide high quality. Nathan claims that these optometrists were erroneously included in the "noncommercial" group rather than the "unknown" category. This "error" would

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[39] Rebuttal Statement of RRNA, K-6 at p. 8.

[40] Id. at p. 9.

likely increase the quality of scores of the noncommercial group, not decrease their scores.

Further, while assigning the classifications, the Study staff had no knowledge of how the optometrists had scored on the quality index.[41] Thus, there is no reason to believe that any bias of FTC staff affected the classifications. In conclusion, there is no reason to believe that any alleged "errors" have influenced the study results.

Conclusion

The record fails to disclose any valid evidence why the Contact Lens Study should not be relied upon. The record indicates that the study was carried out in accordance with sound survey and statistical techniques and that there is no reason to believe that the results were affected by any systematic bias.

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[41] Affidavit of Jonathan Bromberg, Oct. 2, 1985, K-23, Appendix B. (Attachment to Rebuttal Statement of J. Mulholland, FTC economist).

APPENDIX C

Methodology of Robert R. Nathan and Assoc.

New York City Survey of Optometrists

Introduction

Extensive evidence and commentary was received during the rulemaking proceeding concerning the methodology of the Nathan New York City survey. Nathan presented detailed information about the methodology, including extensive background information and underlying materials such as the debriefing forms which were used in the survey. A number of survey and marketing experts, including an FTC consultant and several members of the academic community who were not affiliated with any parties in this proceeding, also submitted their evaluation of the survey.

Below, we discuss the major areas of the survey where the evidence raises concerns. In each section below, we begin by describing the methodology which Nathan employed. We then summarize other evidence concerning the area in question and describe the comments made by the experts.

Selection of Sample Frame

According to the Nathan hearing exhibit,[1] in order to prepare the sample frame -- i.e., the list of optometrists from

which the optometrists to be surveyed were chosen -- listings under the opticians and optometrists headings in the 1984-85 Yellow Pages were typed into a computer file, and sorted and cross-checked in order to delete multiple listings for a single location. These reduced listings, each of which represented a single location, were then classified by the AOA into six groups: private practices, commercial practices, retired or out of business, exams given by ophthalmologists, no exams given and status unknown. The listings of the private practices and of the commercial practices constituted the final sample frames used in the survey.

The testimony of the Nathan panel revealed that AOA representatives Drs. Earle Hunter and James Scholles contacted an optometrist in each borough to classify the optometrists in that borough.[2] These optometrists were familiar with the optometrists in their boroughs.[3] The three optometrists who did the classifications are all listed as AOA members[4] and apparently are private, solo practitioners who have no affiliation with commerical firms. The testimony also revealed that some of them were told by AOA about the purpose of the survey.[5] Neither commerical optometrists nor non-AOA member optometrists were

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1 Nathan study, Vol. I, Ex. 3.

2 S. Schneider, Economist, Nathan and Assoc., Tr. 2732-2733.

3 Id. at Tr. 2812-2815.

4 See, 1985 Blue Book of Optometry.

5 S. Schneider, Economist, Nathan and Assoc., Tr. 2816.

asked to participate in the classification. Further, there is no evidence on the record to suggest that Nathan verified or checked the AOA classifications.

Evidence discussed earlier indicates that the AOA representatives left out of the private sample frame a large number of private optometrists who apparently should have been included.[6] This suggests that bias could have affected the construction of the private sample frame.

While the evidence regarding problems with the commercial sample frame is not as compelling, it does raise questions about the representativeness of this frame and about what criteria were actually used to construct this frame. In order to obtain more information about the validity of Nathan's classification of the commerical practitioners, staff asked NAOO to classify all commercial optometrists in the three boroughs.[7] While NAOO's classification may also be subject to charges of bias since NAOO is an interested party, unexplained discrepancies do exist between the NAOO classifications and those of AOA.

According to the Nathan hearing exhibit, the Study included as "commercial" firms all optometrists employed by lay entities and all chains with five or more locations.[8] A comparison of the

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[6] See supra Section III.C.1.c., "Nathan New York City Survey."

[7] Memo from J. Ryan, NAOO counsel, Sept. 11, 1985, attached to letter from J. Ritchie, NAOO counsel to R. Kinscheck, FTC, Sept. 12, 1985, K-21, Appendix E (attachment to Rebuttal Statement of J. Mulholland and R. Kinscheck, FTC staff).

(footnote continued)

NAOO classification and the Nathan sample frame reveals a close correlation between firms categorized as "chains" by NAOO and firms included in the Nathan sample frame. According to the NAOO classification, however, there are a large number of optical companies offering eye exams which were not included in Nathan's sample frame. While the NAOO classification does not indicate whether the optometrists at these firms are employed by the firm or whether they leased space there, it is possible that at least some of these companies may have employed optometrists to provide eye exams and, if so, should have been included in Nathan's commercial sample frame. Questions remain, therefore, regarding whether the criteria actually used by the AOA representatives to construct the frame was consistent with Nathan's definition, and whether the representatives were familiar with the arrangements of these optical companies with the associated optometrists. AOA declined to provide witnesses who could answer these questions.[9]

Several survey and marketing experts commented upon the significant potential for bias which is raised by AOA's control over the sample frame construction and by Nathan's failure to take steps to avoid this problem. One of these experts was Gary Ford, Ph.D., a Professor of Marketing in the Kogod College of Business Administration at the American University.[10] Dr. Ford

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[8] Nathan study, Vol. III, p. A-1.

[9] See sources cited in supra section III.C.1.c.iii., "Nathan New York City Survey Evaluation."

[10] Previously, Dr. Ford was Chairman, Faculty of Marketing, in the College of Business and Management at the University of Maryland. Dr. Ford has published numerous articles on marketing (footnote continued)

stated that it is very unusual to delegate this type of decision to the client sponsoring the research, particularly when the client has a vested interest in the outcome of the study. According to Dr. Ford, the fact that this occurred here raises concerns about the objectivity with which the samples were developed.[11] Further, he noted that the finding by the staff of 14 additional private practitioners which were not included in Nathan's sample raises serious questions about the representativeness of the sample.[12] Dr. Ford also noted that Nathan made no attempts to avoid this problem, although they could have. Dr. Ford suggested that at a minimum Nathan could and should have checked the accuracy of the AOA-developed frames.[13]

According to Dr. Thomas Maronick,[14] head of the FTC's Impact Evaluation Unit, the sample frames were not random samples of all practitioners in the three boroughs.[15] He noted the possibility

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research in scholarly publications such as the Journal of Marketing. Dr. Ford has consulted regularly as a marketing expert for the Bureau of Economics, FTC, and prepared his comments in this proceedings as a consultant to the FTC staff. Rebuttal Statement of G. Ford, Professor, American University, K-20.

11 Rebuttal Statement of G. Ford, Professor, American University, K-20 at p. 7.

12 Id. p. 8.

13 Id. pp. 6-7.

14 Dr. Maronick, who has a Ph.D. in Business Administration, with a major in marketing, was formerly tenured Associate Professor of Marketing at the University of Baltimore, and has published numerous scholarly articles on marketing, market research, and related topics. See, T. Maronick, J-20(a), attachment.
(footnote continued)

that the AOA representatives could have skewed the sample by including the highest quality private optometrists and the lowest quality commercial firms.[16]

Professor James Begun,[17] and Professor Lee Benham,[18] both of whom have done extensive research in the area of professional regulation and are independent experts in the field, also commented on AOA involvement in sample selection. Dr. Begun noted that reasonable efforts were not taken by Nathan to avoid bias.[19] Dr. Begun stated that, as a result of the procedures used, it is possible that the sample frames consisted of practitioners at the extreme end of the spectrum; thus, the differences in quality found are probably exaggerated compared to differences, if any, between average private and average commercial practitioners.[20] Professor Benham noted that as a

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15 Rebuttal Statement of T. Maronick, Ph.D., FTC staff, K-19 at pp. 2-3.

16 Id.

17 Memorandum from James W. Begun, Ph.D., to Richard Morrison, Commission of Health Regulatory Boards, Commonwealth of Virginia, July 18, 1985, K-1, Exhibit 12 (attachment to Rebuttal Statement of NAOO). Dr. Begun is an Associate Professor at the Medical College of Virginia, Virginia Commonwealth University and has published several significant articles in the field of economics and optometry. He is a totally independent expert in this proceeding.

18 Dr. Benham is a Professor in the Department of Economics, Washington University in St. Louis, Missouri. He has published a number of significant articles and studies regarding the effects of laws restricting advertising and commercial practice. Rebuttal Statement of L. Benham, K-17.

19 Memorandum of J. Begun, supra note 17, K-1, Ex. 12.

20 Id. at p. 2.

result of the procedures used the potential for systematic bias was introduced.[21]

The record remains unclear as to precisely how the three AOA optometrists made the classifications. It is possible, for example, that AOA representatives classified only optometrists that they were personally familiar with as "privates," and classified optometrists unknown to them personally as "unknown." Nevertheless, this could have resulted in an unintentional bias. Those private optometrists known to the AOA representatives -- through involvement in AOA activities and continuing education and through long-standing practice in the community -- may well be those with better reputations for quality eyecare among the privates. Since the commercial group apparently consisted of all the large chains, the same bias would not necessarily have affected this group.

In conclusion, the evidence indicates that generally recommended and accepted procedures were not used to guard against the possibility of bias. The evidence indicates that the private sample frame was incomplete. Also, questions remain unanswered about possible problems with the commercial sample frame. The incompleteness of the private sample frame is of

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[21] Rebuttal Statement of L. Benham, Professor, Washington Univ., K-17. Dr. Alan Beckenstein, a marketing expert and consultant to NAOO, stated that AOA involvement resulted in a lack of objectivity in the research process. Rebuttal Statement of NAOO, K-1 at Appendix A. Dr. Beckenstein is a Professor of Business Administration at the Colgate Darden Graduate School of Business Administration, University of Virginia and has published extensively. He presented his comments as a consultant to NAOO.

particular concern given that AOA representatives had sole responsibility for constructing these frames; there was no participation from commercial firms or independent persons; and apparently Nathan did not verify the AOA classifications. This raises serious and unanswered questions about the representativeness of these frames, and suggests that bias could have entered into the construction. It cannot be ruled out that the AOA representatives, either intentionally or unintentionally, selected higher quality private optometrists, classifying the others as "unknown."

Patient Bias

The Nathan hearing exhibit also states that, in order to reduce participant bias, subjects were not told the precise nature of the survey, but were merely told that a survey was being conducted to compare the quality of examinations given by various New York City optometrists.[22] This was clearly an important effort to reduct the possibility of bias.

However, the apparently extensive interaction between an AOA representative and the patients may have created an opportunity for bias to have affected the patients. Dr. Whitener, an optometrist who is a staff member of the AOA, was involved in

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[22] Nathan study, Vol. I, Ex. 3, p. 13. Patients were also asked about any association they may have had with an optician, optometrist or ophthalmologist. A. Cahill, Economist, Nathan and Assoc., Tr. 2784.

both patient selection and patient training, as well as debriefing the patients, as discussed below. The patients knew that Dr. Whitener was an AOA Staff member,[23] and that the AOA was funding and conducting the survey.[24] Ms. Cahill, a Nathan staff member and an economist, and Dr. Whitener, interviewed all of the patients to determine their suitability for inclusion in the study.[25] Further, Ms. Cahill and Dr. Whitener both participated in the training session which each participant was required to attend prior to the start of the survey.[26] As a result of this interaction between Dr. Whitener and the patients, any bias of Dr. Whitener may have been subtly picked up by the patients.

Debriefing

According to the testimony of Ms. Cahill, subjects were instructed to fill out debriefing forms immediately after each

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[23] A. Cahill, Economist, Nathan and Assoc., Tr. 2810.

[24] The contract which subject were asked to sign states this explicitly. Nathan's New York Survey Subject Patient Contract, K-22, Appendix B (Attachment to Rebuttal Statement of R. Kinscheck).

[25] A. Cahill, Economist, Nathan and Assoc., Tr. 2764-65, 2783. In her testimony, Ms. Cahill stated that she was ultimately responsible for patient selection and Dr. Whitener's role was to look at the eye conditions of the potential patients to determine whether they were suitable for the study.

[26] Nathan study, J-66(a), Vol. I, Ex. 3, pp. 13-14; A. Cahill, Economist, Nathan and Assoc., Tr. 2724, 2782, 2786. Ms. Cahill testified that she was responsible for the training and that Dr. Whitener was present but that he played a very small role in the training, primarily answering medically related questions of the patients. Tr. 2786.

exam.[27] The debriefing forms included the name of the doctor, the firm, the patient and questions such as "what did the optometrist say was wrong" and "what did the optometrist say you need to do." The form contained no question about tests which the optometrist performed.[28]

The evidence reveals that the role of Dr. Whitener in the debriefing process was quite extensive, and that the procedures used created a significant potential for bias. Dr. Whitener and Ms. Cahill debriefed the patients[29] and determined whether the optometrist passed or failed,[30] while they were able to read the name of the commercial firm or optometrist which was written on the debriefing form.[31]

The evidence revealed that Dr. Whitener filled in crucial information on at least some of the debriefing forms.[32] On each debriefing form, the patient was supposed to indicate what the doctor said was wrong. This was crucial in determining whether the optometrist passed or failed. On some forms, however, Dr.

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27 A. Cahill, Economist, Nathan and Assoc., Tr. 2736.

28 See, Nathan study, Vol. III, pp. C-1 et. seq.

29 A. Cahill, Economist, Nathan and Assoc., Tr. 2735, 2763 (except for the final two exams).

30 Id., Tr. 2741, 2745, 2802.

31 Id., Tr. 2791-2793. Our examination of the original debriefing forms reveals that the name of the commercial firms, not merely the name of the individual optometrist, was written on virtually every commercial firm debriefing forms.

32 Id., Tr. 2806.

Whitener filled in this information instead of the patient.[33] Another crucial piece of information was whether the optometrists had done appropriate tests.[34] However, the standard debriefing form contained no question about this. Rather Dr. Whitener or Ms. Cahill wrote in the margin of the forms whether or not such tests had been performed, based on information told to them by the patients.[35]

In some cases there was no indication on the completed form, even in the margin, of whether the optometrist had performed appropriate tests. Thus, there is no way a neutral third party can determine whether an optometrist "passed" or "failed" according to Nathan criteria, based on the information which is on the forms.

The evidence also showed that some patients went to two exams before going to the debriefing.[36] Although Ms. Cahill testified that patients filled in debriefing forms immediately

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[33] See e.g., Nathan study, Vol. III p. C-56; A. Cahill, Economist, Nathan and Assoc., Tr. 2806.

[34] Nathan study, Vol. I, Ex. 3, pp. 15-16.

[35] Id., at Vol. III, pp. C-10, C-50, C-56 and C-102; A. Cahill, Economist, Nathan and Assoc., Tr. 2838-39, 2837, 2805 and 2806.

[36] According to Ms. Cahill's testimony, survey patients went to two exams before being debriefed in those instances where the patient had an exam in the morning in Queens or Brooklyn and a "walk-in" appointment that afternoon in the same borough. Id., Tr. 2788, 2794. Our examination of the patient appointment schedules, submitted to us in confidence by the AOA, reveals that this occurred approximately 13 times (approximately 13% of the time).

after each exam,[37] as indicated, in some instances lines were filled in by Dr. Whitener or Ms. Cahill during the debriefing. Thus, since patients could have been asked to recall the events of two exams, events not always written down, recall problems could have developed. This could have increased the ability of Dr. Whitener to influence the results.

Further, the scoring criteria that were used apparently required considerable interpretation and judgment calls on the part of Dr. Whitener or Ms. Cahill. For example, if the optometrist asked about a problem, such as double vision, this was not considered a "pass;" rather, the optometrist had to tell a patient that he or she had double vision.[38] Also, in some cases, an interpretation from Dr. Whitener was apparently called for in deciding whether the words used by the optometrist to describe a patient's conditions were a correct description of the problem.[39] This magnifies the ability of Dr. Whitener to have influenced the results.

Dr. Ford and Dr. Maronick stated that Nathan should have used a disinterested panel of individuals to grade the debriefing forms. They also stated that there is no justification for allowing the graders to know the classification of the

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37 A. Cahill, Economist, Nathan and Assoc., Tr. 2788.

38 Id., Tr. 2835-36. See also, Nathan study, Vol. III. p. C-70.

39 See Nathan study, J-66(a), Vol. III p. C-154; NAOO Rebuttal Statement, K-1, at p. B-23. (Optometrist had described problem as "Retinal Distortion)."

optometrists while they were grading the forms.[40] Dr. Ford stated that Nathan's failure to use well-known, recommended techniques for guarding against scoring bias is "a fatal error," and that consequently the results cannot be relied upon.[41]

Dr. Maronick also noted that the inexactness of the information sought from the patients increased the possibility that Dr. Whitener could have influenced the results. He noted that the subjects were not trained to recognize the various alternative tests that the optometrists could have performed to detect their conditions. Thus, "Dr. Whitener apparently became the sole determiner of whether a particular test had been given."[42] Thus, it is possible that the results were influenced by any bias that Dr. Whitener may have had.[43]

Dr. Maronick and Dr. Beckenstein also stated that the very close relationship between Dr. Whitener, the selection and training of the subjects, the debriefing of the subjects, and the

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[40] Rebuttal Statement of G. Ford, Professor, American University, K-20 at p. 9; Rebuttal Statement of T. Maronick, FTC staff, K-19 at p. 4.

[41] Rebuttal Statement of G. Ford, Professor, American University, K-20 at p. 9. Dr. Beckenstein noted that the results of the Nathan study depend heavily on patient recall and perceptions, and, in a study such as this "with highly subjective measures of performance (e.g. patient recall) and frequent use of judgmental factors, the prior knowledge of practice by a partisan renders the results wholly invalid." NAOO Rebuttal Statement, K-1 at p. A-2.

[42] Rebuttal Statement of T. Maronick, Ph.D., FTC staff, K-19 at p. 4.

[43] Id. at p. 6.

inexactness of the information sought, all raise the very real possibility that the resulting "data" may have been distorted in a way that reflects the biases of Dr. Whitener.[44]

In conclusion, the evidence reveals that Nathan failed to use generally recognized and accepted techniques for guarding against bias affecting the results. The procedures used afforded Dr. Whitener a great deal of opportunity to exercise any bias that he may have had.[45] Since Dr. Whitener filled in crucial information on the debriefing forms, made judgement calls and graded the briefing forms, all while he was aware of whether the optometrists were commercial or private, Dr. Whitener's role in the briefing process raises very serious questions about bias affecting the results.

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[44] Id. at pp. 4, 6; Rebuttal Statement of NAOO, K-1, Appendix A at p. A-4.

The results of at least one debriefing form may indicate the potential bias of Dr. Whitener. The grading criteria for patients with vertical imbalance was stated to be whether the optometrist performed the pertinent testing procedure and whether the optometrist discussed the subject's vertical imbalance with the patient. Nathan study, Vol. I, Ex. 3, p. 16. Nevertheless, one private practitioner received a "pass" despite the fact that the form gives no indication that the practitioner discussed the problem with the patient and, in fact, the comments on the form indicate that the practitioner did not discuss the problem. Id. at Vol. III, p. C-56. No explanation was provided for why this practitioner passed. Staff questioned Ms. Cahill about this during the hearings but she could provide no explanation. A. Cahill, Economist, Nathan and Assoc., Tr. 2839-40. Nathan had a subsequent opportunity to offer in an explanation, i.e., in their rebuttal comments. They declined to do this, however.

[45] The record does not establish that Dr. Whitener was, in fact, biased. However, he could have been biased and the procedures used did not guard against the possibility that any bias he may have had affected the results.

Scoring Guidelines

For all the eye conditions except astigmatism, in order to "pass," an optometrist had to perform a specified test to detect the condition and had to discuss the subjects' problem with them.[46] For patients with astigmatism, the prescriptions were reviewed to determine whether the optometrist had detected the astigmatism.[47]

According to the Nathan hearing exhibit, the scoring guidelines used to determine whether or not an optometrist should receive credit for detecting the eye condition were developed by a committee of AOA optometrists. Nathan independently "verified the equity" of these guidelines through discussions with three optometrists who are directors of clinical programs or clinics at various optometric schools.[48]

Contacting the optometry schools was clearly an important step in helping to ensure that bias did not affect the choice of scoring guidelines.[49] This procedure may well have been adequate

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[46] Nathan study, Vol. I, Ex. 3, pp. 15-16.

[47] Id.

[48] Id.

[49] It should be noted, however, that there has always been a close association between the AOA and the optometry schools. In general the faculty at these schools oppose commercial practice. See, e.g., Memorandum of J. Begun, Ph.D., Associate Professor, Virginia Commonwealth University, K-1, Exhibit 12 (attachment to Rebuttal Statement of NAOO); M. Albanese, Illinois (footnote continued)

to ensure that the guidelines were not biased. On the other hand, it would have been preferable to involve commercial firms in the development process to remove any possible doubt.

In their rebuttal statement, NAOO disputed the grading criteria used by Nathan. They stated that it is arbitrary and inconsistent with reasonable methods of evaluating patient disposition.[50] They maintained that the only correct way to define quality is by analysis of the patient's prescription and by whether an appropriate referral was made, if needed.[51] NAOO reanalyzed the Nathan data according to these criteria and found no statistically significant difference in the quality of care between commerical and private practices.[52]

As indicated, one of the scoring criterion used by Nathan was whether the patients were told about their eye condition.[53] The criterion was not whether an appropriate prescription was tendered,[54] an appropriate referral made or an appropriate course

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Optometrist, J-48(d) at pp. 2-3. With the exception of Dr. Albanese, all of the faculty members at optometry schools who testified in this proceeding opposed commercial practice. Some had been asked to testify by the AOA or AOA affiliates.

50 NAOO Rebuttal Statement, K-1 at p. 18.

51 Id., pp. 21, B-1. NAOO noted that, because only a few states allow optometrists to use therapeutic drugs, most optometrists must refer patients with eye problems to appropriate medical specialists. NAOO Rebuttal Statement, K-1 at p. 7.

52 NAOO Rebuttal Statement, K-1 at pp. 23, 26-27 and Appendix B.

53 Nathan study, Vol. I., Ex. 3 pp. 15-16.

54 In cases where the patient had astigmatism the prescription was considered but only to determine whether or not the optometrist had found the astigmatism.

of treatment initiated.[55] For example, one of Nathan's debriefing forms indicates that an optometrist failed even though he referred the patient to a specialist, because the patient was not told about her eye problem.[56] According to NAOO this optometrist should have "passed" since an appropriate referral was made.[57] In other cases, it appears that no referral or prescriptive correction, or even treatment, was necessarily needed; nevertheless, in order to "pass" the optometrist had to tell the patient about his or her condition.[58]

NAOO's comments suggest that the study results may reflect differences which may not truly relate to quality. It may be, for example, that commercial optometrists, who give shorter exams on average, may be less inclined to tell their patients about their problems, especially when no corrective steps are needed. This does not necessarily mean that they do not make appropriate referrals or take other appropriate action, where necessary

In conclusion, the procedures used by Nathan to verify the validity of the scoring criteria -- i.e. contacting optometrists

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55 Nathan study, Vol. I, Ex. 3, pp. 15-16.

56 Id. at Vol. III., p. C-145; A. Cahill, Economist, Nathan and Assoc., Tr. 2743-44.

57 NAOO Rebuttal Statement, K-1 at pp. B-19 thru B-20. NAOO points to another case where the optometrist failed because he did not tell the patient about his or her vertical imbalance, although, according to NAOO, the prescription contains a correction for this condition. NAOO Rebuttal Statement, p. 18.

58 See, Nathan study, Vol. I, Ex. 3, p. 16; NAOO Rebuttal Statement, K-1 at pp. B-24 thru B-26 and B-30 thru B-32.

associated with various optometric schools -- may well have been adequate to ensure that bias did not affect the selection of these criteria. Since NAOO is an interested party in this proceeding, their results and comments cannot be accepted without reservation.[59] However, the fact that commercial firms were not involved in developing the criteria, in conjunction with the fact that they are now disputing these criteria, does raise some questions about whether the procedures used fully guarded against bias.

Site Selection

According to the testimony of the Nathan panel, Nathan established certain criteria for the survey site. For example, the city had to have a mature commercial market; the city had to be large enough in size so that an adequate sample size could be obtained; it had to be fairly easy for the patients to get around in.[60] New York was selected based on joint discussions between Nathan and various AOA representatives.[61]

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[59] The NAOO criteria may also be subject to charges of bias since NAOO is an interested party. Because of a lack of medical expertise and insufficient evidence, staff can draw no conclusion about the relative merits of the two approaches at this time.

[60] S. Schneider, Economist, Nathan and Assoc., Tr. 2721-24; J. Gunn, Vice President, Nathan and Assoc., Tr. 2762.

[61] J. Gunn, Vice-President, Nathan and Assoc., Tr. 2723-24, 2762; E. Elliot, Past president, California Optometric Ass'n, Tr. 2881-83. The facts about AOA's involvement in selecting New York City as the survey cite were never made totally clear on the record. There is some mysterious evidence in this connection on the record contained in an affidavit by Dr. David Miller, an (footnote continued)

According to Dr. Schneider of Nathan and Associates, the idea of testing in more than one market was rejected because of financial considerations.[62] Nevertheless, his testimony appears to indicate that testing in more than one city was never seriously discussed. If a survey, confined to one city, is to be used to draw conclusions about commercial practice nationwide, the representativeness of that city becomes crucial.

Dr. Maronick pointed out that New York City is a large, urban area with a high concentration of optometrists. Moreover, optometrists from only three inner-city boroughs were included, excluding practitioners from surburban and rural areas. He noted that the question remains whether the optometrists in the sample are representative of optometrists in other, less concentrated

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optometrist who was employed at the Optometric Center of Baltimore, the cite of the Nathan "pretest," discussed below. According to the affidavit, Dr. Werthamer, an AOA trustee and Executive Director of the Optometric Center of Maryland in Baltimore, visited New York City and received a number of eye examinations around the beginning of March, about two months prior to the New York City survey. According to the affidavit, Dr. Werthamer then spoke about the low quality exams which he had received from three different optometrists in New York City. Affidavit of D. Miller, K-1, Ex. 9 (attachment to NAOO Rebuttal Statement). The record indicates that Dr. Werthamer's alleged trip took place around the same time as discussions between Nathan and AOA representatives, including Dr. Werthamer, regarding the site selection for the study. The testimony indicates that such discussions were held in Feb. and March and that New York was finally decided upon in March or April. E. Elliot, Tr. 2881-86. There is no dispute that Dr. Werthamer participated in these discussions. However, Ms. Cahill testified that Dr. Werthamer never talked to her, or to anyone in her presence, about New York. A. Cahill, Economist, Nathan and Assoc., Tr. 2734. Mr. Gunn of Nathan also stated that it was his understanding that Dr. Werthamer did not go to New York in connection with the study. J. Gunn, Vice President, Nathan and Assoc., Tr. 2800.

62 S. Schneider, Economist, Nathan and Assoc., Tr. 2821.

areas of the country.[63]

Further, a comparison of optometric practices in New York with those in Baltimore -- the site of Nathan's "pretest," described below -- reveals significant differences,[64] suggesting that New York may not be typical even of large urban markets with commercial practice. For example, Cohens Fashion Optical and American Vision Center, which are affiliated,[65] constitute a large percentage of the sample frame in New York (36%); the Baltimore area contains only two American Vision Centers and no Cohen's Optical. And, the Baltimore area has a greater variety of chain firms. Therefore, if Cohen/American Vision is unique or different from other commercial firms in some significant way, or if its dominance of the market is unusual, it is entirely possible that the survey results in New York are not typical of other urban commercial markets.

Baltimore "Pretest"

During the testimony of the Nathan panel it was revealed for the first time that Nathan had sent patients to be examined in Baltimore, just prior to the New York City testing. According to

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63 See, Rebuttal Statement of T. Maronick, Ph.D., FTC staff, K-19 at p. 3.

64 Compare Nathan's Baltimore Optometrist Frames, K-22 Appendix D (attachment to Rebuttal Statement of R. Kinscheck) and Nathan study, Vol. III pp. A-4 thru A-5.

65 J. Ryan, counsel, NAOO, Tr. 2067.

Ms. Cahill, the Baltimore testing constituted a "pretest."[66] No mention of a pretest had been made, however, in Nathan's written statement describing the New York survey in detail.

Under the supervision of Ms. Cahill, patients were sent to have their eyes examined by 43 optometrists, commercial and private, in the Baltimore area in mid April of 1985, approximately a month prior to the New York City testing.[67] Debriefing forms, substantially similar to those used in New York, were completed.

According to Ms. Cahill, Baltimore was never considered as a site for the survey itself.[68] Ms. Cahill also testified about various problems that occurred in Baltimore. She stated that there were problems with the survey subjects -- for example, one was illiterate[69] -- with the survey selection process, the debriefing procedures, and the training process. She stated that the results were "very murky" and "gray."[70] She also stated that

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66 A. Cahill, Economist, Nathan and Assoc., Tr. 2710, 2722. Pretesting is a common component of survey methodology. Prior to the actual survey, the proposed survey methodology is normally tested on a small number of subjects to discover if there are any problems with it and how they can be corrected.

67 A. Cahill, Economist, Nathan and Assoc., Tr. 2709 et seq. Ms. Cahill did not state the number of optometrists involved. This was made clear from an examination of debriefing forms. Nathan's Baltimore Debriefing Forms, K-22, Appendix C (attachment to Rebuttal Statement of R. Kinscheck).

68 A. Cahill, Economist, Nathan and Assoc., Tr. 2722.

69 Id., Tr. 2730, 2759-60.

70 Id., Tr. 2713-14.

her methods of debriefing the patients changed on a daily basis.[71]

Questions remain unanswered about this testing in Baltimore.[72] For example, the 43 observations (exams) sampled in Baltimore appears to be large for a pretest in comparison to the 105 observation sample size in New York City.[73]

In conclusion, some of the evidence raises questions about the objectivity of the site selection process, about the purpose of the Baltimore "pre-test," and about whether the three boroughs of New York are generalizable to the nation. AOA refused to supply any more witnesses during the rulemaking who might have answered the questions raised[74]

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71 Id., Tr. 2780.

72 Dr. Beckenstein noted that questions remain unanswered about the "mysterious" Baltimore "pre-test." A. Beckenstein, Professor, Univ. of Virginia, K-1, App. A at p. A-3 (Appendix to NAOO Rebuttal Statement). He noted that the Baltimore sample of 43 was not substantially smaller than the New York sample of 105. He questioned whether New York replaced Baltimore because it afforded more opportunity to select practices from extreme ends of the spectrum. He stated that the lack of good answers to these questions taints the Nathan study.

73 Nathan study, Vol. I, Ex. 3, p. 4. See also, A. Beckenstein, Professor, Univ. of Virginia, K-1, App. A at p. A-3 (Appendix to NAOO Rebuttal Statement). Also, the frames of optometrists used for the Baltimore testing are large for a pretest in comparison to the frames used for the New York survey site: 93 privates in Baltimore compared to 103 in New York; 107 chains compared to 77. See Nathan's Baltimore Optometrist Frames, K-22, Appendix D (Attachment to Rebuttal Statement of R. Kinscheck); J-66(a), Vol. I., Ex. 3., p. 7.

74 See citations at supra section III.C.1.c.iii., "Evaluation of Survey."

Relationship Between Nathan and AOA

Some AOA representatives testified that AOA was to have no control or input into Nathan's work beyond providing some medical expertise.[75] According to the testimony of various AOA representatives, the survey conducted by Nathan was a "totally independent survey," untainted by any AOA influence or involvement.[76] The Nathan panel further testified that a "ground rule" was established that Nathan would not discuss their analysis with AOA.[77]

The written agreement between Nathan and AOA regarding Nathan's tasks[78] stated that one of Nathan's task was the "design of a survey which would provide reliable information concerning price-quality relationships" between private and commercial optometrists.[79] However, it also stated that Nathan's task was the "development and presentation of expert economic evidence to demonstrate the statistical deficiencies (and possible

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75 D. Sullins, Trustee, AOA, Tr. 1527; J. Scholles, Trustee, AOA, Tr. 1326.

76 D. Sullins, Trustee, AOA, Tr. 1527, 1546; J. Scholles, Trustee, AOA, Tr. 1326.

77 P. Parker, Economist, Nathan and Assoc., Tr. 2681.

78 This was memorialized in a letter from Mr. Gunn of Robert R. Nathan and Associates to Albert Bucar, O.D., President, AOA, December 13, 1984, K-22, Appendix A (attachment to Rebuttal Statement of R. Kinscheck). Nathan's understanding was confirmed by a reply letter from A. Bucar, AOA, to J. Gunn, RRNA, Dec. 28, 1984. Id.

79 Id.

deceptions) of those [the FTC] studies" and "the investigation and development of economically sound reasoning to support and advance the positions of your Association."[80] This letter was written just after the preliminary contacts between AOA and Nathan and before Nathan had begun to evaluate the FTC Studies.[81] It does not appear possible that Nathan had, at that time, formed an independent opinion concerning the FTC studies or the economic merits of the AOA position.

The record also reveals that there was extensive contact between Nathan and AOA counsel. For example, Mr. Gunn testified that after Nathan had been hired by AOA to commence work, Nathan was in contact with AOA counsel to report Nathan's progress.[82] Mr. Gunn testified that between early March and through the completion of the data collection in New York, there were weekly or more frequent contacts between Nathan and AOA counsel.[83]

All of this further indicates that AOA representatives may have had the opportunity to influence the results of Nathan's work.

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80 Id.

81 See, J. Gunn, Vice-President, Nathan and Assoc., Tr. 2666 et. seq.

82 Id., Tr. 2667, 2669.

83 Id., Tr. 2775-76.

Conclusion

The record indicates that Nathan failed to follow generally recommended survey techniques to guard against bias and that, as a result, there is a significant possibility that the results of the survey were affected by any bias of the AOA representatives who participated in the survey. AOA representatives had sole responsibility for construction of the sample frames, the lists of commercial and private optometrists from which the optometrists to be surveyed were selected. The possibility that the sample frames were biased in favor of private practitioners cannot be ruled out. Further, an AOA representative participated in debriefing the patients, filled in information on debriefing forms, and determined whether survey optometrists passed or failed, all while he was aware of whether the survey optometrists were private or commercial. According to survey experts, such procedures are totally unacceptable. Finally, some of the evidence raises questions about the objectivity of the scoring criteria and site selection processes and the purpose of the Baltimore "pretest." All of this indicates that the survey results are unreliable because of potential bias.

APPENDIX D

STATEMENT OF WILLIAM MACLEOD
DIRECTOR, BUREAU OF CONSUMER PROTECTION
ACCOMPANYING THE FINAL STAFF REPORT
ON THE
OPHTHALMIC PRACTICES RULES

In the accompanying report, the staff of the Bureau of Consumer Protection (BCP) recommends amending the current Trade Regulation Rule on the Advertising of Ophthalmic Goods and Services.[1] This recommendation would significantly expand the rule's coverage to prohibit certain state restrictions on commercial optometric practices. It would also modify the prescription release requirement of the current rule by requiring eye doctors to release eyeglass prescriptions only upon the request of the patient. The staff report analyzes the vision-care industry, state commercial practice restrictions on optometrists and the substantial benefits the staff maintains consumers would accrue by their removal.

I believe that public comment will be valuable in evaluating the merits of the proposed amendment and in developing final recommendations on the rule. Part I of my statement discusses the history of this proceeding. Part II discusses the commercial practice restrictions the staff proposes to eliminate through an industry-wide rule. Part III discusses the staff's proposed amendment to the prescription release provision of the current rule.

This recommendation comes as we begin the eleventh year of our investigation of the ophthalmic industry. I commend the staff not only for their diligence, but for their hard work in reviewing and analyzing this quite lengthy rulemaking record.

I. History of the Proceeding

The instant recommendation grew out of an investigation of the "adequacy of information disclosure in the retail ophthalmic market" initiated in September 1975. The first phase of this investigation, known as Eyeglasses I, culminated with the

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1 16 C.F.R. Part 456.

promulgation of the Trade Regulation Rule on the Advertising of Ophthalmic Goods and Services. This rule, which went into effect on July 3, 1978, contained three major provisions. First, it preempted state and local laws and regulations that limited truthful advertising of ophthalmic goods and services. Second, it proscribed privately imposed restraints on advertising. Third, it required ophthalmologists and optometrists to release to each of their patients a copy of his or her spectacle prescription regardless of whether the patient had requested it.

On February 6, 1980, the D.C. Court of Appeals remanded the advertising provisions of the rule.[2] This remand was based on the adequacy of the evidentiary record in light of a supervening Supreme Court decision on the First Amendment[3] followed by changes in state and private regulation of professional advertising. Since then, the Commission has declined to repromulgate these regulations, preferring instead to address those few remaining advertising restrictions through administrative litigation.

As the Eyeglasses I investigation progressed, the staff realized that restrictions on advertising were only one part of a larger system of public restraints which appeared to limit competition, increase prices and reduce the quality of care. Broadening the scope of the inquiry, the staff entered the second phase of this investigation, known as Eyeglasses II. Eyeglasses II focused on commercial practice restrictions. These restrictions prevent optometrists from engaging in certain business practices such as working for non-optometrists or corporations, locating practices in certain commercial locations, operating more than one or two offices or practicing under trade names.

During this phase, a number of studies were conducted or commissioned by the staff. The first such study, conducted by the Bureau of Economics (BE), measured the price and quality effects of commercial practice restrictions.[4] This study found that prices, on the average, for eyeglasses and eye exams were higher but the quality of care was not in markets where the commercial practice of optometry was restricted. A 1983 study by BE and BCP measuring the comparative price and quality of

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2 American Optometric Association v. FTC, 626 F.2d 896 (D.C. Cir. 1980).

3 Bates v. State Bar of Arizona, 443 U.S. 350 (1977).

4 "Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry," Bureau of Economics, Federal Trade Commission (April 1980).

cosmetic contact lens fitting services of commercial and non-commercial optometrists corroborated these findings.[5]

During this same period of time, the staff conducted a study measuring eye doctors' compliance with the prescription release requirement of the current rule. This study, known as the Market Facts Study,[6] measured eye doctors' compliance with the prescription release requirement and consumer knowledge about prescriptions. The results of this study, published in 1981, revealed that a large majority of consumers were generally knowledgeable about the availability of eyeglass prescriptions and that eye doctors released prescriptions upon request.

Based upon this and other evidence collected in response to an Advance Notice of Proposed Rulemaking,[7] the Commission initiated the present rulemaking proceeding by publishing a Notice of Proposed Rulemaking on January 4, 1985.[8] The staff now forwards its final report summarizing the survey evidence and all other documentary and testimonial evidence received during the instant proceeeding. On the basis of this evidence, the staff recommends that the Commission amend its current ophthalmic rule by expanding it to prohibit certain state restrictions on the commercial practice of optometry and by modifying the prescription release provision of the current rule to require release only upon the patient's request.

II. Commercial Practice Restrictions

A. The Staff's Analysis of the Record Evidence

Rulemaking must be judiciously applied if it is to be an efficient and effective law enforcement tool. Sensible application of this most intrusive of regulatory tools requires that any rulemaking proposal satisfy a number of factors

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5 "A Comparative Analysis of Cosmetic Contact Lens Fitting by Opthalmologists, Optometrists, and Opticians," Bureaus of Consumer Protection and Economics, Federal Trade Commission (1983).

6 "FTC Eyeglasses Study: An Evaluation of the Prescription Release Requirement," Market Facts Public Sector Research Group (December 1981).

7 45 Fed. Reg. 79,823 (1980).

8 50 Fed. Reg. 598 (1985).

ennumerated in the past by the Commission. First, the act or practice must be prevalent in a particular industry. Second, a significant harm must exist. Third, the proposed rule must directly reduce that harm. Fourth, the benefits of the proposed rule must exceed its costs. With regard to rules preempting state laws, the Commission has preferred to follow an even more stringent standard; the purported benefits of the state law must be minimal or absent.[9] Finally, the proposed rule must solve the perceived problem more efficiently and effectively than market forces or individual enforcement actions. Again, recognizing the importance of concerns arising out of federalism, the Commission imposes further self-restraint here preferring to act only where the states are not acting to change these laws.[10]

The evidentiary standards are stringent. Where possible, surveys or other methodologically sound quantitative studies are preferred, and indeed required to answer certain threshold questions such as the prevalence of a particular practice.

The staff's review of the evidentiary record concludes that commercial practice restrictions are "unfair" under established Commission policy, and that these practices are most efficiently addressed through an industry-wide rule.

1. Prevalence of Practices

The staff's exhaustive review of state law finds that commercial practice restrictions are quite prevalent. The report notes that 44 states have at least one of four types of restrictions, and the majority have at least three. Restrictions in each of these four categories, though they may vary from state to state, are formulated to achieve the same goal.

Specifically, the report states that 39 states impose one or more restrictions that prohibit employer-employee or other business affiliations between optometrists and lay individuals. Some restrictions prohibit lay persons from employing optometrists. Other regulations prohibit business affiliations such as partnerships, joint ownership or equity participation agreements, franchise agreements or landlord-tenant agreements.

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9 Letter from Federal Trade Commission to Senators Packwood and Kasten (March 5, 1982).

10 Id.

Thirty-two states restrict the use of non-deceptive trade names. Some states ban the use of trade names by optometrists in virtually all circumstances. Others allow their use in some circumstances but not in others. For instance, some states permit professional corporations to use them but not optometrists in branch office practices, partnerships or franchises. Still other states indirectly preclude the use of trade names by requiring that advertisements for optometric services disclose the names of all optometrists practicing under the advertiser's trade name.

Nineteen states impose branch office restrictions. These restrictions limit the number of branch offices which may be owned or operated by optometrists. Some states impose flat limitations on the number of offices optometrists may operate. Others instead require an optometrist to remain in personal attendance at all office locations effectively preventing branch office practice.

Finally, 30 states prohibit optometrists from operating practices in mercantile locations. Mercantile locations are shopping malls and retail establishments such as department stores and optical outlets. Some states directly prohibit optometrists from practicing in or leasing space from a retail establishment while other states have promulgated more circuitous restrictions that accomplish the same end. For example, some of these states prohibit the practice of optometry in retail locations where goods other than those needed in the practice of optometry are sold. Other states have adopted restrictions that fall short of explicit bans but could be interpreted to prohibit practice in mercantile locations.

2. Substantial Harm or Injury

Consumer injury is the primary focus of the FTC Act. The staff report concludes that commercial practice restrictions cause substantial harm to consumers because they impede the formation of commercial optometric practices. This results in economic and physical injury, according to the staff. These restrictions economically injure consumers by excluding or limiting commercial optometrists from the market, which in turn results in less competition and higher prices. These restrictions physically injure consumers because higher prices decrease the frequency of care many receive thereby reducing the quality of their care.

The staff has collected systematic survey data which demonstrates that consumer prices for a comprehensive range of optometric services are 18% higher in markets where restrictions are present. These price differences, says the report, result in

substantial injury because over half of all Americans use corrective eyewear and billions of dollars are spent on optometric services each year.[11] This injury is further compounded, says the staff, by other survey evidence that indicates these higher prices result in physical injury by reducing for many the quality of care they receive.

3. Proposed Rule and Harm

The staff proposes to eliminate this injury by prohibiting commercial practice restrictions. These restrictions, according to the staff, impede and in many cases prevent the entry of commercial providers into markets. Once these barriers are removed, commercial providers would enter the market, bring down prices and enhance the overall quality of care.

4. Benefits and Costs

The staff concludes that systematic suvey evidence projectable to the entire industry indicates that removal of these restrictions would greatly benefit consumers without exacting significant costs. The staff reports that the alleged benefits of these state laws, long used to justify their existence, do not exist. The staff indicates that survey evidence demonstrates these restrictions do not increase the quality of care. In fact, the staff report concludes that these restrictions actually decrease the quality of care by raising eye care costs. This leads to a reduction in the frequency of care many receive.

5. Superiority of Rulemaking v. Other Options

Rulemaking, because of its intrusive nature, should always be considered a remedy of last resort. The staff, upon the Commission's instruction, carefully evaluated alternatives to rulemaking and concluded that rulemaking would provide the most efficient remedy.

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[11] For example, the report notes that over eight billion dollars was spent on optometric services in 1983.

The staff considered the advantages and disadvantages of advocacy intervention in appropriate legislative and judicial forums and litigation in administrative proceedings. It concluded that intervention efforts have so far proved unsuccessful. The staff has testified or submitted comments in support of deregulatory legislative proposals in a number of states, but the results, the report notes, have not been encouraging. Further, the staff report states that litigation is too inefficient to address these pervasive practices.

The staff also concludes that natural market forces have not been, and are unlikely to be, sufficient to remove these restrictions. It states that the only way consumers can avoid injury is to travel to non-restrictive states. The report concludes that the price differences involved, however, rarely justify such extreme measures. The staff report further notes that despite survey evidence that has been available since 1980 documenting the significant harm caused and the lack of benefit confered by these restricitons, only a few states have responded by removing them. Based on this record, the staff concludes that it is unrealistic to hope that more than a few states will voluntarily repeal these restrictions.

B. Legal Basis

The legal basis for the staff's recommendation is its conclusion that these restrictions constitute unfair practices according to established Commission policy.[12] The report concludes, as summarized above, that the injury caused by commercial practice restrictions is substantial, is not outweighed by any benefits and cannot be reasonably avoided by consumers.

The staff also evaluates the jurisdictional requirements of Section 5 and concludes that they are met by the proposed rule. The staff cites the Commission's own decisions and the legislative history of the FTC Act in support of its conclusion that the state is a "person" for purposes of the Commission's unfairness jurisdiction. Further, the staff determines that the acts and practices at issue in this proceeding, although they are local in character, meet the "in or affecting commerce" requirement of Section 5 because they affect interstate commerce.

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12 See Policy Statement on Unfairness, reprinted 104 F.T.C. 1072.

The proposed rule would preempt four kinds of commercial practice restrictions currently sanctioned by some state laws. The staff report discusses federal preemption authority and concludes that the proposed rule falls within that authority. The basis for this conclusion rests upon the staff's determination that the proposed rule prohibits specific unfair practices and that only conflicting state laws would be preempted. The staff concludes that rules promulgated under the Magnuson Moss Act, which prohibit specific unfair practices, preempt any conflicting state law.

The staff acknowledges that Congress has restricted the scope of the Commission's preemption authority. The report notes that the legislative history of the Magnuson Moss Act, as judicially interpreted, establishes that Congress did not intend for Commission regulations defining unfair or deceptive acts or practices to "occupy the field" so as to preclude any state regulation.[13] However, the staff concludes that the proposed rule does not present such a scenario. This is because state regulatory schemes are "left intact" except for the four commercial practice restrictions found to be unfair acts or practices that conflict with the proposed rule's prohibitions.

The Commission has stated in the past that its decision to conduct this rulemaking was made sensitive to the states' legitimate interest in the regulation of health care.[14] The Commission has made clear that it would not propose preemption where state regulation was necessary to protect vital state interests, such as quality of care. The staff report states that the proposed rule has been "carefully tailored" so as to correct market inefficiencies without intruding on the states' regulatory authority to ensure the health and safety of its eye care consumers.

The staff report also concludes that the "state action" doctrine of Parker v. Brown[15] would not bar these proceedings because that doctrine does not apply to the Commission's unfairness rulemaking authority under Section 18 of the FTC Act. Furthermore, the report concludes that the Supreme Court's

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13 Katherine Gibb Sch., Inc. v. FTC, 612 F.2d 658 (2d Cir. 1979). When Congress has occupied an area to such an extent as to preclude all but the federal law, it is said to have "occupied the field." When this occurs, all state laws are displaced that fall within the sphere of the federal law. See 1 Mezines, Stein & Gruff, Administrative Law, Section 2.02 (1986).

14 See fn. 8, supra.

15 317 U.S. 341 (1942)

affirmation of a state ban on trade names in Friedman v. Rogers[16] does not preclude the Commission from declaring trade name bans to be unfair practices.

III. Prescription Release Provision

The Eyeglasses Rule currently requires eye doctors to provide patients with copies of their spectacle prescriptions following eye examinations. This automatic release requirement was incorporated into the rule as a remedial measure to increase consumer awareness that eyeglasses could be purchased from someone other than the examining eye doctor. Before the rule, as many as half of all optometrists refused to release prescriptions or imposed additional fees for this service. In the NPR initiating the Eyeglasses II rulemaking,[17] the Commission asked whether the prescription release requirement should be modified to require that prescriptions be provided only when patients requested them. After reviewing public comments responding to this question, the staff now recommends that the Commission do so.

The staff bases this recommendation on its evaluation of the record evidence, most notably the Market Facts Study. According to the staff, this evidence indicates that a large majority of consumers are knowledgeable enough to request a prescription from the examining eye doctor and purchase their glasses elsewhere. The staff, therefore, concludes that the remedial provision of this rule is no longer justified given the large numbers of consumers who are generally knowledgeable about the availability of prescriptions and the small numbers who shop elsewhere when offered or given a prescription they did not ask for.

The Commission also raised three additional questions in the NPR regarding possible extensions of the prescription release requirements. The Commission asked whether the rule should 1) cover contact lens "specifications," 2) require release of duplicate copies of prescriptions, and 3) require eyeglass dispensers to return prescriptions to patients after they are filled.

After evaluating the public comments responding to these questions, the staff recommends not to extend the rule in any of these three areas. According to the staff, the record does not contain sufficient evidence to conclude that refusal to release

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16 440 U.S. 1 (1979)

17 See fn. 8, supra.

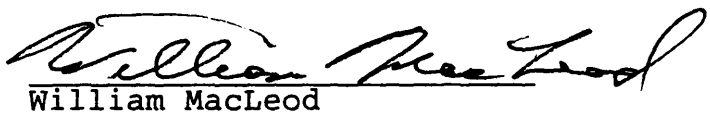
contact lens specifications is either a prevalent practice or that there are no health or safety justifications for refusal to release. Further, the staff report states that the record contains no evidence that eye doctors refuse to release duplicate copies of eyeglass prescriptions or that a substantial number of dispensers refuse to return prescriptions to patients.

IV. Conclusion and Recommendations

The BCP staff has analyzed a tremendous volume of economic and legal information. Many of these issues, such as the quality and price effects of commercial practice restrictions, give rise to a number of conflicting interpretations. As a result, these issues were hotly contested in comments submitted on the record. My preliminary conclusion is that the staff has correctly anaylzed the economic record. The legal issues such as whether the proposed rule exceeds the boundaries of the Commission's preemption authority and the applicability, if any, of the Friedman v. Rogers decision to this proceeding have not received the same level of commentary.

While I believe that the staff has presented a strong case, I am particularly interested in public comments on the proposed application of the Commission's authority in this area and the staff's conclusion that commercial practice restrictions provide no quality-related benefits. I will, therefore, reserve my final conclusions and recommendations pending analysis of the public comments received in response to this report.

Respectfully submitted,



William MacLeod
Director
Bureau of Consumer Protection

Dated: October 31, 1986