



Office of the Chairman

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

April 29, 2003

The Honorable Ward Crutchfield
Senate Majority Leader
Legislative Plaza Suite 13
Nashville, Tennessee 37243

Dear Senator Crutchfield:

The Federal Trade Commission is pleased to respond to your invitation for comments on Senate Bill 855, which would amend Tenn. Code Ann. § 63-8, the portion of the Code regulating the practice of optometry.¹ The FTC is charged by statute with enforcing laws prohibiting unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.² Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including optometry, to the maximum extent compatible with other state and federal goals. The Commission has had a long-standing interest in the effects on consumers and competition arising from the regulation of optometry.³ Indeed, the Commission has conducted a series of extensive analyses and rulemakings focused on the kind of regulation contemplated in Senate Bill 855, and we hope our findings will be of use to Tennessee legislators as they consider this Bill.

The proposed legislation

Senate Bill 855 begins with the statement that optometrists “shall be free from any influences that would interfere with their exercise of professional judgment,” and that “optometrists shall not be associated with any person or persons in any manner which might degrade or reduce the quality of visual care received by the citizens of this state.”⁴ The next section then states: “A manufacturer, wholesaler, or retailer of ophthalmic materials who leases

¹ The Commission’s vote to approve this letter was 5-0.

² Federal Trade Commission Act, 15 U.S.C. § 45.

³ See, e.g., 16 CFR Part 456 (prescription release rule); *Mass. Bd. of Registration in Optometry*, 110 F.T.C. 549 (1988); Comments of the Staff of the Federal Trade Commission, Intervenor, before the Connecticut Board of Examiners for Opticians (Mar. 27, 2002), available at <<http://www.ftc.gov/be/v020007.htm>>.

⁴ Bill, section 1.

space to an optometrist shall not, directly or indirectly, control or attempt to control the professional judgment, manner of practice, or practice of an optometrist.”⁵

The Bill’s explicit goal is to prevent commercial entities from interfering with the optometrist’s professional judgment in ways that would reduce the quality of eye care. The Bill lists ten specific arrangements that would constitute impermissible attempts to control the practice of an optometrist. This list prohibits some forms of control that could plainly have a negative effect on the quality of care, such as “Restricting an optometrist’s access to leased office space when the optometrist needs such access to provide emergency care to a patient.”⁶

The Bill also prohibits other negotiations and collaborative arrangements whose impact on the quality of patient care is less clear. These prohibitions would not allow an optical store leasing space to an optometrist to specify the optometrist’s professional fees or office hours,⁷ to restrict the use of after-hours appointments,⁸ or to share “telecommunication services” or clerical staff unless the optometrist supervises said clerical staff.⁹ These restrictions would apply to all manufacturers or sellers of ophthalmic materials who lease space to optometrists, thus limiting the relations between optometrists and the optical store in which some may choose to practice.

Senate Bill 855 would likely reduce competition

Senate Bill 855 would likely constrain competition from commercial optical chains that seek to partner with optometrists in offering a combination of professional services and ophthalmic goods that some consumers prefer. These effects would likely occur because the bill would tend to make the operation of commercial optometric practice more difficult and would hamper chain optical stores particularly. Chains operate by creating a generalized business model that aims to reduce both operating costs and the costs to consumers of finding and purchasing ophthalmic goods and services. Optical chains succeed in the marketplace when they offer consumers some combination of cost and quality that consumers prefer. The proposed restrictions would likely reduce competition by impairing the creation of uniform, chain-wide business policies on basic business matters like prices, hours of operation, and services offered.

⁵ Bill, section 2, *creating* new code section 63-8-125(a).

⁶ Bill, section 2, *creating* new code section 63-8-125(b)(7).

⁷ Bill, section 2, *creating* 63-8-125(b)(1) (ban on “attempting to set the professional fees or office hours of an optometrist”).

⁸ *Id.* at (b)(2) (ban on “attempting to restrict an optometrist’s discretion to schedule appointments at times convenient to the optometrist’s patients”).

⁹ *Id.* at (b)(4) (ban on “Sharing . . . telephone lines or other telecommunication services; provided, however, nothing in this section shall preclude an optometrist from entering into a business arrangement involving the delegation of clerical tasks and functions to persons who are not employees of the optometrist but under the optometrist’s general supervision...”).

Unfettered competition is at the heart of the American economy. Vigorous competition forces producers to minimize costs and prices and to increase quality. Through this dynamic, consumer welfare is maximized because consumers reap the benefits of lower prices, greater variety, and higher quality goods and services. The United States Supreme Court has observed, "ultimately, competition will produce not only lower prices but also better goods and services. The heart of our national economic policy long has been faith in the value of competition."¹⁰ The Court has also explicitly noted that competition benefits consumers of professional services.¹¹

Restraints on competition from optical chains may make consumers better off if such restrictions improve the quality of eye care or lead to other consumer benefits that would not be produced by firms operating in a competitive marketplace. Senate Bill 855 would create net benefits for consumers if the value to consumers of any improvement in the quality of eye care attributable to the Bill is greater than the harm imposed on consumers by the reduction in competition. We respectfully urge the Tennessee legislature to weigh the impact on competition of the prohibitions in Senate Bill 855 against any benefits that the Bill's restrictions might create for consumers.

Empirical evidence suggests restrictions on commercial optometry reduce competition without increasing the quality of care

The Federal Trade Commission itself has engaged in such an evaluation of many restrictions on commercial optometry chains, and our findings may be of help to the Tennessee legislature. Research and rulemakings conducted by the Federal Trade Commission indicate that many such restrictions tend to increase costs while producing no offsetting consumer benefit.¹²

¹⁰ *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978) (citing *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1950)); accord, *Federal Trade Commission v. Superior Court Trial Lawyers Association*, 493 U.S. 411, 423 (1990).

¹¹ *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975); *National Society of Professional Engineers*, 435 U.S. at 689.

¹² The Commission addressed issues relating to the commercial practice of optometry in the course of promulgating the Ophthalmic Practice Rules, commonly known as "Eyeglasses II." An earlier rulemaking – Eyeglasses I – considered two relatively narrow types of competitive restrictions but also revealed the existence of other restraints on eye care providers that appeared to limit competition unduly, increase prices, and reduce the quality of eye care provided to the public. See *Advertising of Ophthalmic Goods and Services*, Statement of Basis and Purpose, 43 Fed. Reg. 23992 (June 2, 1978) (promulgating 16 CFR Part 456) ("Eyeglasses I"). The Eyeglasses I Rule prohibited bans on nondeceptive advertising and required vision care providers to furnish copies of prescriptions to consumers after eye examinations. On appeal, the rule's prescription release requirement was upheld but the advertising portions were remanded for further consideration in light of the Supreme Court decision in *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977) (finding state supreme court rules against attorney advertising violated the First Amendment). *American Optometric Assn. v. FTC*, 626 F.2d 896 (D.C. Cir. 1980). The FTC has continued to address advertising restrictions through administrative litigation. See, e.g., *Mass. Bd. of Registration in Optometry*, 110 F.T.C. 549 (1988).

Eyeglasses II considered many of the same issues presented by Bill 855, including such topics as whether the lay

Two major studies by FTC staff examined many of the same issues presented in Senate Bill 855. These studies, plus several others conducted by independent researchers using the FTC staff's data, are the most recent empirical investigations of the consumer impact of commercial optometry restrictions.

The first study, published in 1980 by the FTC's Bureau of Economics, compared the price and quality of optometric goods and services in markets where commercial practices were subject to differing degrees of regulation.¹³ This study was conducted with the help of two colleges of optometry and the Director of Optometric Services of the Veterans Administration. It compared four dimensions of quality in markets with chain firms and markets without chain firms: 1) the thoroughness of the eye examination; 2) the accuracy of the prescription; 3) the accuracy and workmanship of the eyeglasses; and 4) the extent of unnecessary prescribing. The study found that optometric practice restrictions in a market resulted in higher prices for eyeglasses and eye examinations but did not improve the overall quality of care in that market, as measured by these four attributes. Later analyses of the FTC data by academic researchers came to similar conclusions.¹⁴

The second study, published in 1983 by the Bureaus of Consumer Protection and Economics, compared the price and quality of the cosmetic contact lens fitting services of commercial optometrists and other provider groups.¹⁵ It concluded that, on average,

business partners of optometrists could properly be involved in "setting of fees, salaries, or minimum office hours; location of the practice; choice of suppliers of material, equipment, services, and laboratory work; . . . and other activities that involve business judgments to a similar degree." The Commission found that "The record . . . demonstrates that lay control over the business aspects of an optometric practice is an integral element of commercial practice." See Ophthalmic Practice Rules ("Eyeglasses II"), Statement of Basis and Purpose, 54 Fed. Reg. 10285 (Mar. 13, 1989) ("Commission Statement") at 10300. (The Statement of Basis and Purpose is attached to this letter.) The Eyeglasses II Rule – put into effect in 1989 – was intended to limit the ability of states and state optometric boards to restrict the commercial aspects of optometric practice. The D.C. Circuit struck down the Rule on the grounds that the FTC Act did not give this agency such authority over the states. See *California Bd. of Optometry v. FTC*, 910 F.2d 976 (D.C. Cir. 1990). The Court's decision should not be read as a rejection of the factual underpinnings of the FTC effort. Because the Court vacated the Rule solely on jurisdictional grounds, it did not address the factual underpinnings of the FTC effort.

¹³ Bureau of Economics, Federal Trade Commission, *The Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry* (1980) ("Bureau of Economics Study").

¹⁴ John Kwoka, "Advertising and the Price and Quality of Optometric Services," *American Economic Review* 74(1), 211-16 (1984); and Debra Haas-Wilson, "The Effect of Commercial Practice Restrictions: The Case of Optometry," *Journal of Law and Economics* 29(1), 165-86 (1986). Both of these studies examined differences in quality across markets with varying degrees of commercial restrictions. Philip Parker ('*Sweet Lemons: Illusory Quality, Self-Deceivers, Advertising, and Price*, JOURNAL OF MARKETING RESEARCH, Vol.32, Aug. 1995, at 291-307) offers a somewhat contrary view. Using the same FTC dataset, he questioned the robustness of the previous research's price results, finding that some alternative formulations failed to find a significant price effect due to differences in commercial restrictiveness. Parker did not, however, directly dispute the key quality finding of the FTC report – that restrictions on commercial optometric practice did not influence average quality levels for eye exams.

¹⁵ Bureaus of Consumer Protection and Economics, Federal Trade Commission, *A Comparative Analysis of Cosmetic Lens Fitting by Ophthalmologists, Optometrists, and Opticians* (1983) ("Contact Lens Study").

"commercial" optometrists (for example, optometrists who were associated with chain optical firms, used trade names, or practiced in commercial locations) fitted cosmetic contact lenses at least as well as other fitters, but charged significantly lower prices.

Thus, three findings emerge from the FTC staff studies that may be of interest to Tennessee legislators as they consider Senate Bill 855:

- Restrictions on commercial optometry tend to make commercial optometric practice more difficult and therefore to drive up prices.¹⁶
- The higher prices lead many price-sensitive consumers to defer seeking eye care, and thus affirmatively harmed that group of citizens.¹⁷
- There is no evidence that restrictions on the commercial aspects of optometric practice raise the quality of services for those people who do obtain them.¹⁸

On the basis of these studies and other evidence assembled in that rulemaking proceeding,¹⁹ the FTC concluded that unnecessary restrictions on commercial practices by eye care providers resulted in significant consumer injury, in the form of monetary losses and less frequent vision care, without providing consumer benefit.²⁰ The Commission concluded that "the record is quite clear on this central issue: There is no difference in the average quality of care available to consumers in restrictive and nonrestrictive markets."²¹ The Commission also found

¹⁶ See Commission Statement, *supra* n.12, at 10286 ("prices for eye care are 18 percent higher in markets where chain firms are totally restricted than in markets where chain firms operate freely"). Changing market circumstances could make the size of the price effect today smaller than 18 percent. Nevertheless, we have identified no change in the marketplace that economic analysis suggests would likely reverse or eliminate the price effect if a new study were conducted with more recent data.

¹⁷ See Commission Statement, *supra* n.12, at 10290 (a survey of 10,000 people "found that significantly fewer individuals purchased eyeglasses in a given year in states with higher prices than in states with lower prices"); *id.* (testimony by the AOA suggests that "85 percent of all serious injuries sustained by persons 65 and older are caused by falls; 25 percent of these relate directly to uncorrected vision problems").

¹⁸ In fact, studies of professional services have often found little relationship between professionals' business practices and the quality of service they provide. See C. Cox and S. Foster, *The Costs and Benefits of Occupational Regulation*, FTC Bureau of Economics Staff Report, October 1990.

¹⁹ In the course of the Eyeglasses II rulemaking, the FTC received 287 comments and heard testimony from 94 witnesses. The commenters and witnesses included consumers and consumer groups, optometrists, sellers of ophthalmic goods, professional associations, federal, state and local government officials, and members of the academic community. See Commission Statement, *supra* n.12, at 10287.

²⁰ Commission Statement, *supra* note 12, at 10285.

²¹ Commission Statement, *supra* n.12, at 10290-91.

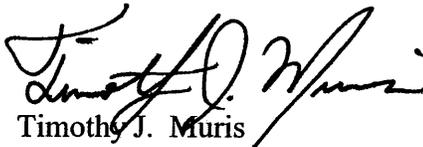
that of the more than \$8 billion consumers spent on eye exams and eyewear in 1983, a substantial portion was attributable to inefficiencies resulting from state regulation that reduced competition.²² The evidence from the FTC's rulemaking record thus provides a strong argument for avoiding unnecessary restraints on the commercial practice of optometry.

The rulemaking studies took place over 20 years ago, and some aspects of the market have undoubtedly altered over time. For example, the changing patterns of insurance coverage may alter the price effects of practice restrictions; advertising is more widespread²³; and chain stores and mass merchant sellers of ophthalmic goods have become more common. Nevertheless, no persuasive empirical evidence alters the rulemaking's most important conclusion – the absence of positive quality effects from restrictions on commercial practice.

Conclusion

Senate Bill 855 includes several restrictions on the commercial practice of optometry. Economic analysis and the most recent empirical evidence available suggest that such restrictions on optical chains tend to increase prices, but the restrictions produce no improvement in the quality of eye care that consumers receive. Therefore, the commercial restrictions probably would not benefit and likely would harm consumers. Consumers generally benefit from robust competition among optometric care providers, and a statute that unnecessarily restricts that competition is likely to harm consumers in the state of Tennessee. For these reasons, we urge Tennessee legislators to consider carefully the impact of Senate Bill 855 on consumers and competition.

By direction of the Commission.


Timothy J. Muris
Chairman

²² Commission Statement, *supra* note 12, at 10285-86.

²³ See, e.g., James H. Love and Frank H. Stephen, "Advertising, Price and Quality in Self-Regulating Professions: A Survey," 3 Intl. J. Econ. Bus. 227 (1996). This 1996 survey of empirical economics literature on professional advertising revealed that most studies find advertising tends to reduce the price of professional services without reducing quality. On price, the authors concluded, "the overwhelming impression from the results reviewed...is of advertising having a downward effect on professional fees." On quality, they concluded that the empirical literature generally shows that advertising does not lead to lower quality.

Effective June 1, 1989
 Boise, ID—Boise Air Terminal (Gowen Field), VOR/DME or TACAN RWY 28L, Amdt. 1
 Boise, ID—Boise Air Terminal (Gowen Field), LOC/DME BC RWY 28L, Amdt. 3
 Muscatine, IA—Muscatine Muni, VOR RWY 5, Amdt. 4, CANCELLED
 Muscatine, IA—Muscatine Muni, VOR RWY 23, Amdt. 5
 Muscatine, IA—Muscatine Muni, VOR RWY 30, Amdt. 4, CANCELLED
 Muscatine, IA—Muscatine Muni, VOR/DME RWY 12, Amdt. 4, CANCELLED
 Muscatine, IA—Muscatine Muni, NDB RWY 5, Amdt. 11
 Muscatine, IA—Muscatine Muni, RNAV RWY 23, Orig.
Effective May 4, 1989
 Colusa, CA—Colusa County, VOR-A, Amdt. 4
 Santa Rosa, CA—Sonoma County, VOR/DME RWY 14, Amdt. 1
 Atlanta, GA—The William B. Hartsfield Atlanta Intl, RADAR-1, Amdt. 31
 Calhoun, GA—Tom B. David Fld, LOC RWY 35, Amdt. 1
 Calhoun, GA—Tom B. David Fld, NDB RWY 35, Amdt. 1
 DeKalb, IL—DeKalb Taylor Muni, VOR/DME RWY 27, Amdt. 3
 DeKalb, IL—DeKalb Taylor Muni, NDB RWY 27, Amdt. 1
 Marion, IN—Marion Muni, VOR RWY 4, Amdt. 11
 Marion, IN—Marion Muni, VOR RWY 15, Amdt. 8
 Marion, IN—Marion Muni, VOR RWY 22, Amdt. 14
 Marion, IN—Marion Muni, ILS RWY 4, Amdt. 5
 Cherokee, IA—Cherokee Muni, NDB RWY 36, Amdt. 3
 New Bedford, MA—New Bedford Muni, LOC (BC) RWY 23, Amdt. 8
 New Bedford, MA—New Bedford Muni, NDB RWY 5, Amdt. 10
 New Bedford, MA—New Bedford Muni, ILS RWY 5, Amdt. 23
 Romeo, MI—Romeo, VOR/DME-A, Amdt. 5
 Columbus, OH—Port Columbus Intl, NDB RWY 10L, Amdt. 6
 Columbus, OH—Port Columbus Intl, NDB RWY 10R, Amdt. 6
 Columbus, OH—Port Columbus Intl, ILS RWY 10L, Amdt. 14
 Columbus, OH—Port Columbus Intl, ILS RWY 10R, Amdt. 5
 Georgetown, SC—Georgetown County, NDB RWY 05, Amdt. 4
 Arlington, TN—Arlington Muni, NDB RWY 15, Amdt. 6
 Arlington, TN—Arlington Muni, NDB RWY 33, Amdt. 6
 Jacksboro, TN—Campbell County, NDB RWY 23, Amdt. 3
 Jacksboro, TN—Campbell County, RNAV-A, Amdt. 3
 Waukesha, WI—Waukesha County, VOR-A, Amdt. 14
 Waukesha, WI—Waukesha County, LOC RWY 10, Amdt. 3
 Waukesha, WI—Waukesha County, NDB RWY 28, Amdt. 2

Effective April 6, 1989
 Wiscasset, ME—Wiscasset, NDB RWY 25, Amdt. 4
 Grand Island, NE—Central Nebraska Regional, LOC/DME BC RWY 17, Amdt. 8
 Grand Island, NE—Central Nebraska Regional, ILS RWY 35, Amdt. 8
 Kenosha, WI—Kenosha Muni, NDB RWY 6L, Orig.
 Kenosha, WI—Kenosha Muni, ILS RWY 6L, Orig.
Effective March 1, 1989
 Atlanta, GA—Fulton County Airport-Brown Field, ILS RWY 8, Amdt. 14
Effective February 28, 1989
 Mesquite, TX—Phil L. Hudson Muni, LOC RWY 17, Amdt. 1
 Mesquite, TX—Phil L. Hudson Muni, NDB RWY 17, Amdt. 2
Effective February 21, 1989
 Bangor, ME—Bangor Intl, VOR/DME RWY 33, Amdt. 6
Effective February 16, 1989
 Hyannis, MA—Barnstable Muni-Boardman/Polando Field, VOR RWY 6, Amdt. 4
 [FR Doc. 89-5629 Filed 3-10-89; 8:45 am]
 BILLING CODE 4910-13-M

FEDERAL TRADE COMMISSION

16 CFR Part 456

Trade Regulation Rule; Ophthalmic Practice Rules

AGENCY: Federal Trade Commission.
ACTION: Final Trade Regulation Rule.

SUMMARY: The Federal Trade Commission issues a final rule that removes restraints imposed by state law on certain specified forms of commercial ophthalmic practice. The Commission has concluded that these restrictions are unfair acts or practices within the meaning of Section 5 of the Federal Trade Commission Act and are appropriately remedied by the Trade Regulation Rule promulgated today. The rule bars four types of state restrictions on commercial practice: (1) Prohibitions on certain forms of lay association with or control over optometric practices; (2) limitations on the number of branch offices which optometrists may own or operate; (3) prohibitions on the practice of optometry in commercial locations; and (4) prohibitions on the practice of optometry under a nondeceptive trade name. The rule also incorporates, with minor technical changes, the prescription release requirement originally promulgated as part of the Trade Regulation Rule on Advertising of Ophthalmic Goods and Services.

Published here are the Rule's Statement of Basis and Purpose, which

incorporates a Regulatory Analysis, and the text of the final rule.

EFFECTIVE DATE: September 1, 1989.

ADDRESS: Requests for copies of the Rule and the Statement of Basis and Purpose should be sent to the Public Reference Branch, Federal Trade Commission, 6th Street and Pennsylvania Avenue, NW., Washington, DC 20580.

FOR FURTHER INFORMATION CONTACT: Richard Kelly, Renee Kinscheck, or Patricia Brennan, Division of Service Industry Practices, Bureau of Consumer Protection, Federal Trade Commission, Washington, DC 20580 (202) 326-3304, (202) 326-3287, or (202) 326-3274.

SUPPLEMENTARY INFORMATION:

List of Subjects in 16 CFR Part 456

Eyeglasses, Ophthalmic practice, Trade rules.

By direction of the Commission, Chairman Oliver dissenting.

Donald S. Clark,
 Secretary.

Statement of Basis and Purpose

I. Introduction

A. Overview of the Rule
1. Commercial Practice Restrictions. Some state-imposed restrictions on the commercial practice¹ of optometry cause significant injury to consumers. While justified as necessary to protect consumers, these restrictions actually work to deprive consumers of necessary eye care, restrict consumer choice, and impede innovation in the eye care industry.

The monetary cost—likely to be millions of dollars annually—is great. Over half of all Americans and more than 90 percent of elderly consumers use corrective eyewear, and over eight billion dollars was spent on eye exams and eyewear in 1983.² A significant

¹ Optometric practices range across a continuum from what can be characterized as strictly traditional (e.g., solo practitioner operating in an office building under own name) to highly commercial (e.g., large chain optometric firm, with offices in many states). For purposes of this proceeding, an optometrist is considered to be in "commercial practice" if he or she is associated with or employed by a nonoptometrist, uses a trade name, operates more than a single office, or practices at a mercantile location.

² NAOO, H-78, at 7 (figure derived from the annual National Consumer Eyewear study conducted by the Optical Manufacturers Association). The NAOO anticipated that 1985 sales would exceed nine billion dollars.

All documents on the rulemaking record have been given alphanumeric designations based upon the system established by the Presiding Officer. A full explanation of these designations is given at the beginning of Bureau of Consumer Protection,

Continued

proportion of these costs can be attributed to the inefficiencies of an industry protected from competition by state regulation. A study done by the FTC's Bureau of Economics shows that prices for eye care are 18 percent higher in markets where chain firms are totally restricted than in markets where chain firms operate freely.

State restrictions on commercial practice are pervasive. Some restrictions are statutory. Others are found in regulations promulgated by state boards of optometry.³ This rule declares unfair four specific types of state restrictions on competition among optometrists and other vision care providers:

(1) *Restrictions on Affiliations With Nonoptometrists.* Most states have one or more restrictions on lay affiliations. Such restrictions take many forms, including restrictions on employment of optometrists by business corporations or nonoptometrists, on the forming of partnerships between optometrists and nonoptometrists, on the splitting of optometrists' professional fees with nonoptometrists (which, in effect, can prohibit joint-ownership or equity-participation agreements), and on the forming of franchise agreements and landlord-tenant agreements between optometrists and nonoptometrists, including agreements under which rental payments are based on a percentage of gross revenue.⁴ Some states also prohibit such corporate affiliations by prohibiting nonoptometrists from exercising any control over the business aspects of an optometric practice.⁵

(2) *Restrictions on practice in mercantile locations.*⁶ Over twenty

Federal Trade Commission, Ophthalmic Practice Rules: State Restrictions on Commercial Practice, (1986), L-1 (hereinafter referred to as "Final Staff Report"). For example, documents in the H category are written comments filed by providers or sellers of ophthalmic goods or services and by ophthalmic organizations. Documents in the J category are written witness statements, transcripts of the hearings and hearing exhibits. Hearing transcripts, which appear on the rulemaking record as J-71, are cited by page number (e.g., "Tr. 999").

³ In still other cases, attorney general opinions, judicial interpretations, and board interpretations may reveal restrictions not apparent from the face of the statute or regulation.

⁴ The sharing of profits or of gross revenues 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 payment of a percentage of gross revenues by the franchisee to the franchisor, often referred to as a "royalty."

⁵ Some degree of lay control over the business aspects of a practice is an essential element of these relationships.

⁶ As used herein, "mercantile location" refers to shopping malls and to retail establishments such as department stores and optical outlets.

states impose one or more bans that appear to explicitly prohibit the practice of optometry in mercantile locations. The most common ban explicitly prohibits optometrists from practicing in or leasing space from a retail establishment, such as a department store or optical store. Most states that prohibit optometrists from practicing in a retail establishment permit optometrists to locate in or next to that business only if there is a separate entrance to a public street or hallway, in what is known as a "two-door" or "side-by-side" arrangement. In addition, several states appear to restrict practice in shopping malls.⁷

(3) *Restrictions on branch offices.* Many states restrict the number of offices that an optometrist may own or operate. Some impose flat limitations on the number of offices that an optometrist may open,⁸ while others indirectly impose limits by requiring an optometrist to be present a certain percentage of the time a branch office is open.⁹

(4) *Restrictions on the use of trade names.*¹⁰ Trade name restrictions generally take one of three forms. First, some states explicitly ban any use of trade names by optometrists.¹¹ Second, some states specify that trade names must include certain words.¹² Third, several states require that the names of all optometrists practicing under a trade name or at any advertised location must be disclosed in all advertisements that use the trade name.¹³

⁷ Two states, Rhode Island and Alaska, apparently prohibit shopping mall practices altogether. 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. Calsen, 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 of Optometry enforces such a restriction. J. Ingalls, President, Western States Optical, J-54, at 3-4.

⁸ See, e.g., Ky. Rev. Stat. section 320.310(3) (1983).

⁹ See, e.g., Or. Admin. R. section 852-10-030(5) (1984).

¹⁰ The Supreme Court's decision in *Friedman v. Rogers*, 440 U.S. 1 (1979), that a Texas statute prohibiting the use of trade names did not violate the First Amendment, does not preclude a Commission finding of unfairness regarding trade name bans. The Commission applies a different standard for purposes of an unfairness analysis under section 5 of the FTCA.

¹¹ See, e.g., Fla. Stat. section 463.014(1)(a); Ind. Admin. R.1-4-1(a).

¹² For example, California requires that all trade names contain the word "optometrist" or "optometric." Cal. Bus. & Prof. Code sections 3125 (b) and (c).

¹³ See, e.g., Mo. Rev. Stat. section 336.200.

As of 1985, at least 44 states had one or more of these four types of restrictions.¹⁴ Thirty-nine states prohibited 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. At least 19 states limited the number of branch offices which may be owned or operated by optometrists, often limiting optometrists to one or two branch offices. Thirty states restricted optometrists from practicing in mercantile locations such as shopping malls, department stores, and other retail establishments. At least 32 states prohibited the use of nondeceptive trade names by optometrists. Each of these restrictions prevents or restricts the development of alternatives to the traditional solo practice.

Evidence gathered during a lengthy investigation and an extensive rulemaking proceeding includes two Commission-sponsored surveys, additional survey evidence, and expert economic, testimonial, and documentary evidence. That substantial body of evidence demonstrates that these restrictions raise prices to consumers and, by reducing the frequency with which consumers obtain vision care, decrease the overall quality of care provided in the market. The rulemaking record establishes that the presence of commercial optometric firms lowers the cost of eye care to patients of both commercial and noncommercial optometrists. The evidence also indicates that these restrictions do not provide offsetting quality-related benefits to consumers.

The Commission has concluded that these restrictions are unfair acts or practices within the meaning of section 5 of the Federal Trade Commission Act and are appropriately remedied by the Trade Regulation Rule promulgated today.

2. *Prescription Release.* The rule continues to require that optometrists and ophthalmologists release eyeglass lens prescriptions to their patients upon completion of an eye examination. The Commission considered a staff proposal

¹⁴ See charts in Final Staff Report, L-1, at 32-46, for a detailed breakdown of state regulation of the practice of optometry. The statistics on commercial practice restrictions cited here and elsewhere in the Statement are based on an analysis of state regulatory practice as of 1985. A sampling of state statutes and regulations, as of October 1988, confirmed that one or more of the restraints at issue here continue to exist in a majority of the states.

to modify this provision to require that prescriptions be released only upon request. After weighing the evidence, we conclude that there is a continuing need for the "automatic release" component of the requirement. However, technical changes have been made in the rule language in order to make clear that this provision is directed only at prescriptions for eyeglass lenses and creates no obligation concerning the release of prescriptions for contact lenses.

B. History of the Proceeding.

This proceeding grew out of an investigation begun in 1975 into state and private restraints on advertising of ophthalmic goods and services. The first phase of the investigation culminated with the promulgation in 1978 of the Trade Regulation Rule on the Advertising of Ophthalmic Goods and Services.¹⁴ As the investigation progressed, the staff began to accumulate evidence that restrictions on advertising were not the only public restraints that appeared to limit competition, increase prices, and reduce the quality of eye care provided to the public. The second phase of this inquiry focused on the commercial practice restrictions described above.

To obtain further evidence on these issues, staff conducted two comprehensive studies. The first, published in 1980 by the Bureau of Economics, compared the price and quality of optometric services in restrictive and nonrestrictive markets.¹⁵ The second study, published in 1982 by the Bureau of Consumer Protection and Economics, compared the price and quality of cosmetic contact lens fitting services of commercial optometrists and

other provider groups.¹⁷ At the same time, the staff conducted a study measuring compliance with the prescription release requirement of the Eyeglasses Rule.¹⁸

In July 1980 staff published the results of its investigation on commercial practice restrictions in an initial staff report.¹⁹ Based on this report and other evidence gathered, the Commission published an Advance Notice of Proposed Rulemaking ("ANPR") in December 1980, that requested comments on the issues presented by the investigation and on what action, if any, the Commission should take.²⁰

Based on the survey evidence, the initial staff report, and the comments received in response to the ANPR, the Commission published on January 4, 1985, a Notice of Proposed Rulemaking initiating this rulemaking proceeding ("Eyeglasses II").²¹ During the proceeding, 243 written comments were received: 12 from consumers and consumer groups; 159 from optometrists, sellers of ophthalmic goods, and their professional associations; 89 from federal, state, and local government officials; and 3 from members of the academic community. Ninety-four persons testified during three weeks of public hearings.²² Twenty-four rebuttal comments were filed in response to that testimony.

The staff reviewed the entire record and published its final report in October 1986.²³ The report recommended the promulgation of a rule that would eliminate the four types of commercial practice restrictions described above and modify the prescription release provisions in the Eyeglasses Rule. The Presiding Officer's Report, released in December 1986,²⁴ recommended against

adopting a rule that would proscribe commercial practice restrictions, and also recommended against modifying the prescription release requirements of the Eyeglasses Rule. After review of these comments, the staff submitted its final recommendations to the Commission in July 1987.²⁵

On November 5, 1987, the Commission heard oral presentations from several rulemaking participants who had asked to present their views directly to the Commission as provided in § 1.13(i) of the Commission's Rule.²⁶ The Commission met on February 10, 1988, and voted to promulgate a rule that prohibits four specified types of state bans on commercial practice and retains the prescription release requirement from the original Eyeglasses Rule.

II. Factual Basis for the Rulemaking

A. Evidentiary Standards for an Unfairness Rulemaking²⁷

The Commission requires that a preponderance of the evidence support the factual propositions underlying a determination that an existing act or practice is legally unfair. Before promulgating an unfairness rule the Commission requires answers to the following questions: (1) Is the act or practice prevalent? (2) Does the act or practice injure consumers? (3) Is the proposed rule likely to reduce that injury? (4) Is the injury to consumers outweighed by countervailing benefits that flow from the act or practice at issue? and (5) Can consumers reasonably avoid the injury?²⁸

Rule of Ophthalmic Practice Rules (1986), L-2 (hereinafter cited as "Presiding Officer's Report").

¹⁴ Bureau of Consumer Protection, Federal Trade Commission, Ophthalmic Practice Rulemaking: Final Recommendations (July 31, 1987), O-1(b) (hereinafter cited as "Staff's Final Recommendations").

¹⁵ The participants were: The American Optometric Association (hereinafter cited as the "AOA"); The California Optometric Association (hereinafter cited as the "COA"); The National Association of Optometrists and Opticians (hereinafter cited as the "NAOO"); The Opticians Association of America; The American Association of Retired Persons; U.S.A. Lens, Inc.; and 20/20 Optical.

¹⁶ See infra section III. A. for a discussion of the statutory basis and evolution of the Commission's unfairness authority.

¹⁷ *American Financial Services Ass'n v. Federal Trade Commission*, 787 F.2d 957, 971 (1985); Rule on Sale of Used Motor Vehicles, Statement of Basis and Purpose, 49 FR 45692, 45703 (1984); Credit Practices Rule, Statement of Basis and Purpose, 49 FR 7740, 7742 (1984); Letter from Federal Trade Commission to Senators Wendell H. Ford and John C. Danforth (Dec. 17, 1980) (hereinafter cited as "Unfairness Statement"). In issuing the Credit Practices Rule, the Commission acknowledged that the evidence necessary to answer these questions will vary depending on the circumstances of each rulemaking and the characteristics of the industry involved. 49 FR 7740, 7742 n. 4.

¹⁴ 16 CFR Part 456 (hereinafter cited as "Eyeglasses Rule"). The Commission found public and private bans on nondeceptive advertising by vision care providers and the providers' failure to release eyeglass lens prescriptions to be unfair acts or practices in violation of section 5 of the FTC Act. The rule prohibited bans on nondeceptive advertising and required vision care providers to furnish copies of prescriptions to consumers after eye examinations. Subsequently, the U.S. Court of Appeals for the District of Columbia in *American Optometric Association v. FTC*, 626 F.2d 896 (D.C. Cir. 1980), upheld the prescription release requirement but remanded the advertising portions of the Eyeglasses Rule for further consideration in light of the Supreme Court decision in *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977). After further consideration, the Commission has addressed the few remaining advertising restrictions through administrative litigation rather than rulemaking.

¹⁵ Bureau of Economics, Federal Trade Commission, *Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry* (1980), B-2-31 (hereinafter cited as "BE Study"). That study showed that commercial practice restrictions resulted in higher prices for eyeglasses and eye examinations, but did not increase their quality.

¹⁷ Bureau of Consumer Protection and Economics, Federal Trade Commission, *A Comparative Analysis of Cosmetic Lens Fitting by Ophthalmologists, Optometrists, and Opticians* (1983), B-5-1 (hereinafter cited as "Contact Lens Study"). That study showed that commercial optometrists charged significantly lower prices for fitting cosmetic contact lenses and fitted such lenses at least as well as other fitters of contact lenses.

¹⁸ Market Facts Public Sector Research Group, *FTC Eyeglasses Study: An Evaluation of the Prescription Release Requirement* (1981) (hereinafter cited as "Market Facts Study").

¹⁹ Bureau of Consumer Protection, Federal Trade Commission, *State Restrictions on Vision Care Providers: The Effect on Consumers* (1980), B-2-1 (hereinafter cited as "1980 Staff Report").

²⁰ 45 FR 78,823 (1980). During the 80-day comment period, 247 comments were received.

²¹ 50 FR 598 (1985).

²² Some organizations sponsored several witnesses; 74 organizations or individuals presented testimony.

²³ Final Staff Report, *supra* note 2.

²⁴ James P. Greenan, Presiding Officer, Report of the Presiding Officer on Proposed Trade Regulation

As a matter of policy, the Commission has set an even higher standard for promulgation of a rule that directly challenges state law. Out of deference to the principles of federalism, the Commission will take such action as a remedy of last resort, appropriate only if substantial consumer injury is clearly shown; the benefits of the state laws are minimal or absent; and the states are not acting on their own to change the laws.²⁹

In this proceeding, the record clearly supports affirmative answers to each of the above-mentioned questions. First, at least 44 states have one or more of the four types of restrictions at issue here. Second, comprehensive and reliable evidence shows that the restrictions cause significant harm to consumers by increasing prices and reducing the frequency with which consumers obtain care. Third, by declaring that such restrictions are unfair, the rule removes such restrictions and thereby eliminates the harm to consumers. Fourth, comprehensive and reliable evidence indicates that the restrictions do not provide consumer benefits since they fail to increase the quality of care received by consumers. Fifth, consumers cannot avoid the adverse effect of these state-imposed and state-enforced restrictions.³⁰

The Commission has a responsibility to see that the best evidence reasonably available is included on a rulemaking record before promulgating a rule.³¹ The best evidence will often be surveys or other methodologically sound quantitative analyses. The Commission may also consider other reliable evidence and expert testimony.

The quantity and quality of evidence in this proceeding supports promulgation of the rule under standards set by the Commission and the courts. The need for the rule is demonstrated by the BE and Contact Lens Studies.³² The rule is further supported by additional studies, by documentary and testimonial evidence, and by the absence of any substantial or persuasive contrary evidence. The cumulative impact of this evidence persuades us that the rule is necessary and will provide substantial benefits to consumers.

²⁹ Letter from Federal Trade Commission to Senator Robert Packwood, Chairman, Committee on Commerce, Science and Transportation, United States Senate (March 5, 1982).

³⁰ See *infra* section VI.A.

³¹ Trade Regulation Rule on Sale of Used Motor Vehicles, Statement of Basis and Purpose, 49 FR 45692, 45703 (1984); Credit Practices Rule, Statement of Basis and Purpose, 49 FR 7740, 7742 (1984).

³² See *infra* section II.D. for a detailed discussion of the methodology used in these studies.

B. Evidence Regarding Harm to Consumers Caused by Commercial Practice Restrictions.

1. *Higher Prices.* The evidence on the record demonstrates that commercial practice restrictions raise prices for eye care goods and services.³³ By impeding competition from commercial firms, the restrictions result in higher average prices for both commercial and traditional practitioners and at all levels of quality. This conclusion is supported by a preponderance of the evidence, which shows: (1) That average prices for eye exams and eyeglasses are lower in markets with chain firms than in markets without chain firms; (2) that chain firms and other large-volume providers charge significantly lower prices than noncommercial providers; and (3) that each of the restrictions imposes unnecessary costs on commercial practice that impede its development and raise prices to consumers. No reliable evidence contradicts these conclusions.³⁴

The BE Study found that prices for eye exams and eyeglasses were 18% higher in markets without chain firms than in markets with chain firms. In markets with chain firms, both traditional and commercial optometrists charged lower prices, and prices were lower at all levels of quality.³⁵ An earlier study by Professors Lee and Alexandra Benham also concluded that prices of eyeglasses were substantially higher in states with restrictions than in states without restrictions.³⁶

Additional evidence demonstrating that commercial firms—generally chain firms or other large-volume providers—charge significantly lower prices for equivalent quality goods and services than noncommercial optometrists includes: (1) The Contact Lens Study, which found that commercial optometrists charged significantly less for cosmetic contact lens fitting than noncommercial optometrists;³⁷ (2) a

³³ See Final Staff Report, L-1, at 157-178.

³⁴ *Id.* at 165-178.

³⁵ *Id.* at 101-107.

³⁶ Benham and Benham, *Regulating Through the Professions: A Perspective on Information Control*, 18 J. L. & Econ. 421 (1975), B-2-29. See Final Staff Report, L-1, at 164 for a further discussion of the Benhams' study. In the 1980 Staff Report and the Final Staff Report, staff acknowledged several potential methodological shortcomings with the Benham data which indicate that the study, standing alone, would not be sufficient to support this rulemaking. Final Staff Report, L-1, at 165; 1980 Staff Report, B-2-1, at 48, 58-59. Despite these potential shortcomings, the record indicates that the Benham data provides useful information to corroborate the findings of the BE Study. Final Staff Report, L-1, at 164-165. See also 1980 Staff Report, B-2-1, at 58-59.

³⁷ The results showed that commercial optometrists charged prices that were on average

survey submitted by the California Optometric Association, which found that chain optometric firms charged less for eye exams than private optometrists;³⁸ and (3) extensive documentary and other evidence demonstrating that large-volume providers frequently take advantage of economies of scale to charge lower prices for equivalent goods and services.³⁹

Finally, as summarized below, the record demonstrates that each of the specific restrictions at issue here imposes unnecessary costs on optometric providers and hinders the development of high-volume practices, resulting in fewer such firms in the market, higher prices to consumers, and decreased access to eye care.

While the studies on the record do not separately describe the effects of each particular commercial practice restriction, the record contains an abundance of other evidence that supports a Commission finding that each of the four types of restrictions inhibits or restricts the formation and expansion of high-volume optometric practices.⁴⁰ In addition, the record establishes how the restrictions decrease efficiency and increase prices for volume practitioners that manage to enter the market in spite of the restrictions.

(1) Restrictions on lay associations prohibit optometrists from obtaining capital from nonoptometrists by entering into partnerships, joint ownership agreements or other associations with such persons or entities, a constraint which inhibits capital development. This, in turn, impedes the development of large-scale practices that can take advantage of volume purchase discounts and other economies of scale.⁴¹ These

20% lower than noncommercial optometrists and over 30% lower than ophthalmologists.

³⁸ Consumer Study of Optometric Practices in Metro-Atlanta Area, J-67(a) (Attachment to Statement of California Optometric Ass'n) (hereinafter cited as "Atlanta Survey"). The survey was conducted by John H. Thomas and Associates, Atlanta, Georgia. See Final Staff Report, L-1, at 161-163 for a further description of this survey.

³⁹ For example, 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. Department of Consumer Affairs, State of California, Commercial Practices Restrictions in Optometry 8-11, 13 (1982), J-24(b). See also Final Staff Report, L-1, at 59-67, 177-178.

⁴⁰ See Final Staff Report, L-1, at 49-100.

⁴¹ The record indicates that the use of volume discounts by high-volume practices can reduce significantly the costs of equipment, material, and supplies. For example, the NAOO stated that through the use of volume discounts, an office could

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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.⁴²

(2) Restrictions on practicing in mercantile locations, such as department or drug stores, also raise prices to consumers by inhibiting the formation of high-volume commercial practices. Mercantile locations, which are generally more convenient to consumers, generate a high volume of consumer traffic. Restrictions on practicing in mercantile locations may also impose unnecessary space, construction, or personnel costs that must be passed on to consumers.⁴³ These burdens fall both on optometric chain firms and on individual practitioners.

(3) Restrictions on branch offices create barriers to expansion both by individual optometrists and by lay optometric firms. These restrictions reduce the total volume of patients that a practice might otherwise be able to serve. This reduced volume of patients prevents optometrists from taking advantage of economies of scale that arise from volume purchasing discounts and reduced per office advertising costs. Also lost are the potential savings that multi-branch practices may achieve through more efficient management techniques.⁴⁴

be equipped for about two-thirds of the standard retail price. Moreover, materials such as frames and lenses can be discounted as much as 25% when purchased in volume. See Final Staff Report, L-1, at 60-61.

⁴² Id. at 57-67.

⁴³ For example, in those states that mandate a two-door or side-by-side arrangement, optometrists typically must maintain an office that is separate from the optical dispensary and that also has a separate entrance to a public street, corridor, or hallway. This results in higher construction costs, requires more space and thus more rent, and increases frontage costs.

The NAOO estimates that the cost of constructing, equipping, and fixturing a side-by-side office is 15-20% higher than for an equivalent one-door office. NAOO, H-78, at 35. This cost, which typically might amount to \$10,000 per office, includes duplicating the heating, cooling, bathroom, waiting room, and other facilities. See also Final Staff Report, L-1, at 84-88.

⁴⁴ For example, branch office restrictions may prevent optometric firms from employing or entering into other business relationships with optometrists at more than the permitted number of locations. NAOO, H-78, at 80. 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. This may prevent these firms from efficiently distributing their optometrists to best meet the needs of the firms' various offices. See Final Staff Report, L-1, at 74-77.

(4) Bans on trade name practice and advertising deprive consumers of valuable information and increase consumer search costs. Trade names are of value to consumers because, over time, the names come to reflect the cumulative experience that consumers have had with a particular firm. As a result, trade names are a valuable asset to firms, and restrictions on their use hinder the growth and development of optometric firms. Trade name bans also make it difficult for high-volume operators to advertise multiple outlets and to allocate advertising expenses over those outlets.⁴⁵

The record also establishes⁴⁶ that state laws which require that all trade name advertisements include the names of all optometrists practicing at a given advertised location or practicing under the advertised trade name effectively ban much nondeceptive trade name advertising. Thus these restrictions have a similar detrimental effect on consumers as outright bans on trade name usage and advertising.

Many states have enacted more than one of these restrictions.⁴⁷ While each of these restrictions may impede the growth and efficiency of chain firms or volume practices, a combination of restrictions may completely bar their entry.

The Presiding Officer also found that the record demonstrated that prices for optometric goods and services are significantly lower in nonrestrictive markets than in restrictive markets.⁴⁸ Commenters did not seriously dispute the evidence that large-volume practitioners can achieve economies of scale unavailable to smaller practitioners,⁴⁹ nor did they submit any

⁴⁵ See Final Staff Report, L-1, at 95-97.

⁴⁶ The evidence shows 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. Similarly, the cost of disclosing the names of all optometrists at particularly advertised locations effectively prevents nondeceptive trade name usage in such advertisements under some circumstances. See NAOO, H-78, at 34-37; G. Black, Arkansas Retail Merchants Ass'n, D-1 at 2; P. Zeidman, Counsel, International Franchise Ass'n, Tr. 617-620; NAOO Panel, Tr. 538; and Final Staff Report, L-1, at 68.

⁴⁷ At least 28 states have at least three of these restrictions. See charts in Final Staff Report, L-1, at 33-48.

⁴⁸ Presiding Officer's Report, L-2, at 182-186.

⁴⁹ Some commenters pointed to limited instances in which smaller-volume practitioners may achieve economies of scale. See e.g., Reponse of the COA to Dept. of Consumer Affairs Report, K-12, at 8 (attachment to Rebuttal of the COA) and Post-record comment of AOA, M-178, at 454. However, even if small discounts are available to small-scale practitioners, that does not contradict the fact that larger discounts may be available to high-volume practitioners.

reliable studies that contradicted the price findings of the BE and Contact Lens Studies.⁵⁰

2. *Less Care.* Commercial practice restrictions harm consumers not only by raising prices but also by decreasing the overall quality of care received by consumers. The record evidence indicates that, as a result of the higher prices in restrictive markets, consumers obtain eye care less frequently than they otherwise would.⁵¹ Some consumers

⁵⁰ See Final Staff Report, L-1, at 165-171. Some survey evidence was presented by the COA and the AOA that ostensibly showed that commercial firms do not charge less and may even charge more than noncommercial optometrists. For instance, the COA claimed that the Atlanta Survey's findings on "mark-ups" showed that "alleged corporate efficiencies (e.g., savings through volume discounts) were not being passed on to consumers" because all the provider groups had equivalent "mark-ups" on materials. However, this "mark-up" data provided no useful insight into the relative prices charged by the different provider groups because of considerable variation in the wholesale costs of the frames and lenses purchased for the survey. *Id.* at 165-68. The AOA also attempted to rely on some data from a 20/20 magazine survey showing that average billings were higher for optometric practices with annual sales greater than \$200,000 a year than for practices with lower annual sales. However, this survey fails to provide meaningful data about differences between chain and nonchain firms. *Id.* at 169-170. It also fails to provide meaningful data about differences between low-volume practices and high-volume practices, as that term has been used in this proceeding—i.e., multi-optometrist, multi-office practice. See Rebuttal Statement of R. Bond, FTC economist, L-18, at 15 n. 6. As explained by the author of the 20/20 article, each group (both over \$200,000 and under \$200,000) most probably includes both chain and independent operations. It is unclear whether the reported gross sales volume refers to per-office volume or per-company volume. If the data is per-office gross sales, the data cannot be used to distinguish low-volume firms from those with a significantly larger volume since large chains may have per-office volume above or below \$200,000, while private practitioners may also be in either category. (This data was calculated based upon figures in Rebuttal Statement of NAOO, H-78a, at 11 and in Ophthalmic Practice Rulemaking Statement and Exhibits—Robert R. Nathan Associates, Inc., J-66(A), at Vol. II, Ex. 1, Appendix E at E-3 (hereinafter referred to as "Nathan Study").) If the data is per company, \$200,000 is too low a figure to provide a meaningful distinction between high and low volume. Many solo practitioners have this volume, but some chain firms have annual sales in the billions. Further, the 20/20 article noted that in this sample, more smaller practices advertised than larger ones; only 40 percent of larger practices advertised. "One probable reason would be the infrequent advertising of many large ophthalmological and optometric practices which still deem advertising to be unprofessional." 20/20 Article; Nathan Study, J-66(a) at Vol. II, Ex. II, Appendix E, at E-2, E-8. This indicates that many traditional private practitioners and small group practices were included in the "over-\$200,000" group.

⁵¹ Professors James Begun and Lee Benham 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 reduced frequency of vision care purchases. See J. Begun, Professor, Virginia Commonwealth University, K-1,

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forego eye care entirely, while others delay the purchase of eyeglasses and eye exams.

Evidence of the rulemaking record shows that some consumers are not obtaining adequate vision care because of financial circumstances. Testifying in favor of Medicare coverage for eye care, the AOA told a Congressional committee in 1976 that many elderly persons go without adequate vision care because of its cost.⁵² In that Congressional testimony, the AOA also provided evidence that uncorrected vision problems can lead to serious injury to older consumers. According to the AOA, 85 percent of all serious injuries sustained by persons 65 and older are caused by falls; 25 percent of these relate directly to uncorrected vision problems.

Survey evidence also demonstrates that higher prices result in reduced purchases of eye care. Based on the results of an extensive nationwide survey, Professors Lee and Alexandra Benham found that significantly fewer individuals purchased eyeglasses in a given year in states with higher prices than in states with lower prices.⁵³ In 1979, a survey of 1,254 families sponsored by General Mills found that families had cut back on annual medical checkups, new eyeglasses, dental treatment, and various preventive health care services because of inflation.⁵⁴

Exhibit 12 (Attachment to Rebuttal Statement of NAOO); Rebuttal Statement of Lee Benham, Professor, Washington University, K-17, at 2; A. Beckenstein, Professor, University of Virginia, at A-7 (Appendix A to Rebuttal Statement of NAOO). Consumers Union stated that removal of the 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. H. Snyder, West Coast Director, Consumers Union, J-24(a) at 2, citing, State of California, Department of Consumer Affairs, Commercial Practice Restrictions in Optometry (1982), J-24(a), at Exh. A at iii (Attachment to Statement of Consumers Union).

⁵² 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. 155 (1976) (Statement of the AOA), B-2-38.

⁵³ Benham and Benham, *Regulating Through the Professions: A Perspective on Information Control*, 18 J.L. & Econ. 421, 438 (1975), B-2-29. This survey consisted of interviews with 10,000 individuals in 1970. The sample was drawn to overrepresent elderly individuals and individuals living in inner cities and in rural areas. Id. at 428.

⁵⁴ Forty-eight percent of families said that they had cut back on such expenditures as a result of inflation; 58% of low-income families, 60% of minorities and 72% of single parents made this statement. M. Kernan, *U.S. Health Profile*, Washington Post, Apr. 26, 1979, B-2-37, at C-1, col. 4.

Finally, Public Health Service data indicate that annual purchase and repair of eyeglasses increases with family income.⁵⁵ This evidence indicates that economic considerations influence vision care expenditures, and 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 purchases. While some pointed to alleged shortcomings of the survey data discussed above, none of the alleged shortcomings prevent the Commission from concluding that commercial practice restrictions, which raise the price of eye care, lead to reduced purchases of eye care.⁵⁶

A few commenters did state that no one is going without eye care since special assistance is available for the indigent.⁵⁷ 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 not eligible for such assistance programs may be delaying or rationing purchases because of higher prices. On the other hand, we find persuasive the testimony of consumer groups that all but the poorest consumers must pay for vision care out of their own pocket without reimbursement by public assistance or

⁵⁵ Data for 1977 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 \$25,000 or more per year. Public Health Service, U.S. Dept. of Health and Human Services, National Health Care Expenditures Study, Eyeglasses and Contact Lenses: Purchases, Expenditures, and Sources of Payment 4 (1979), G-14.

⁵⁶ For example, some commenters criticized the methodology of the Benhams' survey and claimed that none of the surveys showed that commercial practice restrictions caused reduced eye care purchases. See Post-record comment of AOA, M-176, at 422-33. See also Nathan Study, J-66(a), Vol. I, Exh. 1, at 89 n. 1. However, we are not persuaded that the alleged flaws in the Benhams' survey undercut the findings that, in general, higher prices of eye care lead to reduced consumer purchases. See Staff's final Recommendations, 0-1(b), at 12-14. While the AOA acknowledged that the surveys showed that inflation, recession, and available income affect consumer decision-making, it claimed that the surveys did not show that commercial practice restrictions, in particular, result in reduced purchases of eye care. However, because these surveys show that, in general, higher prices of eye care lead to reduced consumer purchases and because other evidence on the record shows that commercial practice restrictions lead to higher prices in the market, we can conclude that commercial practice restrictions result in reduced purchases of eye care.

⁵⁷ See, e.g., Nathan Study, J-66(a), Vol. I, Ex. 1 at 109-110; J. Moye, *Mississippi Optometrist*, Tr. 429-29; J. Robinson, Secretary, North Carolina Board of Optometry, Tr. 3001.

private insurance.⁵⁸ A study by the Optical Manufacturers Association demonstrated that only 10-20 percent of all expenditures for eye examinations, eyeglasses, and contact lenses is paid for by insurers or other third-party payors. The remaining 80-90 percent is paid directly by the patient.⁵⁹

Commercial practice restrictions also affect consumers' access to vision care by restricting the places where an optometrist may locate. The record indicates that commercial optometrists may be more conveniently located⁶⁰ and may be more frequently available on weekends and evenings.⁶¹ These are additional reasons why restrictions on such firms tend to reduce accessibility and the frequency of purchase of vision care.

C. Countervailing Benefits of Commercial Practice Restrictions

The stated justification for commercial practice restrictions is that they are necessary to maintain high-quality vision care.⁶² If this assertion were true, one would expect to find higher quality care in those markets where commercial practice is prohibited or limited. But the record is quite clear on this central issue: There is no difference in the average quality of care available to consumers in restrictive and

⁵⁸ See, e.g., H. Snyder, West Coast Director, Consumers Union, J-24(a), at 2 and Tr. 1059-60; J. Denning, President-elect, American Ass'n of Retired Persons, Tr. 60; E. Egan, Director, American Ass'n of Retired Persons, J-37(a), at 6. Medicare does not, in general, cover vision care.

⁵⁹ Optical Manufacturers Association, National Consumer Eyewear Study III (1984), cited in NAOO, H-78, at 2.

⁶⁰ See NAOO, H-78, at 4.

⁶¹ Id. at 3; NAOO Panel, Tr. 383-84.

⁶² We note that the majority of states where commercial practices exist did not testify in this proceeding. Many of these states submitted written comments, but did not allege abuses by commercial firms. 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. Rimmiller, 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.

There is no apparent a priori reason why one would expect these restrictions on business practices to affect the quality of professional care. Both commercial and noncommercial optometrists have similar educational qualifications and must pass the same licensing examinations in order to practice. Commercial optometrists face the same incentives as noncommercial optometrists to satisfy consumer demand and provide an acceptable level of quality eye care. Private optometrists, like commercial firms, must earn a profit in order to stay in business and both types of practitioners seek to generate profits by selling eyewear. Practitioners in both groups must maintain a good reputation in order to attract and hold the loyalty of patients.

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nonrestrictive markets.⁶³ Our conclusion that commercial practice restrictions do not increase the average quality of care provided⁶⁴ is based primarily on the results of the BE Study, and is also supported by the Contact Lens Study and by the absence of any substantial and reliable contrary evidence.

The BE Study compared eye care quality in markets with and without chain firms and found that the overall level of quality of eye care was not lower in markets where chain firms were allowed to operate.⁶⁵ The study provides reliable evidence covering major areas of eye care provided by optometrists, including the accuracy of prescriptions, the accuracy and workmanship of eyeglasses, the extent of unnecessary prescribing, and the ability to detect eye problems and pathologies.⁶⁶ The study found that there was no significant difference in any of these aspects of quality between markets with chain firms and those without chain firms.⁶⁷

The BE Study did find significant variation in the extensiveness of eye examinations provided by optometrists in both restrictive and nonrestrictive markets. The evidence shows that an equal percentage of optometrists provide more extensive exams and less extensive exams in both types of markets.⁶⁸ In nonrestrictive markets, commercial optometrists, on average, provide more of the less extensive exams than noncommercial optometrists. In restrictive markets, where all optometrists are by definition noncommercial optometrists, an equal percentage of optometrists provide less extensive exams. These optometrists, like the commercial optometrists, provide less costly and less extensive exams, although their prices are significantly higher than those of the commercial optometrists in nonrestrictive markets.

These findings demonstrate that commercial practice restrictions do not affect the distribution of quality within a given market. Other factors such as the forces of supply and demand are most

likely responsible for this distribution. At most, the evidence suggests that there is a group of optometrists in both types of markets that will meet the demand for lower-cost, less-extensive exams. Where commercial practice is restricted, noncommercial optometrists meet that demand, but charge higher prices than commercial practitioners in nonrestrictive markets. Even though commercial firms may, on average, provide less extensive exams than those provided by noncommercial optometrists in nonrestrictive markets, the overall quality of care is no lower in those markets.⁶⁹

The findings of the BE Study on quality of care are supplemented by the Contact Lens Study's conclusion that, on average, commercial optometrists fitted cosmetic contact lenses at least as well as noncommercial optometrists.⁷⁰

Proponents of the restrictions offered no evidence on differences in quality between restrictive and nonrestrictive markets, but instead attempted to show that commercial optometrists provide lower quality of care than noncommercial optometrists.⁷¹ Much of this evidence was anecdotal and was often countered by other anecdotal testimony concerning poor quality of care provided by noncommercial optometrists.⁷²

Moreover, the survey evidence that was presented by proponents of the restrictions was unreliable. The Nathan Study, commissioned by the AOA, was offered as evidence of quality differences between commercial and noncommercial optometrists in one market.⁷³ However, that study failed to

⁶⁹ Moreover, the evidence shows that an increasing number of commercial firms are stressing high quality exams. See Final Staff Report, L-1, at 202-206. The evidence indicates that some commercial firms, just as some private optometrists, provide very thorough exams and treat a full range of patients, including those with complex problems.

⁷⁰ See *infra* section II.D.2. for a fuller discussion of the methodology of this study.

⁷¹ See citations in Final Staff Report, L-1, at 190-96, 196-201. See also Post-record comment on AOA, M-176, at 400; Post-record comment of COA, M-178, at 5-8; and Presiding Officer's Report, L-2, at 174, 182.

⁷² See Final Staff Report, L-1, at 199-206.

⁷³ 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 environment tended to be less comprehensive and lower in quality than those given in private practice settings. Nathan Study, J-90(A), Vol. I, Ex. 3, p. 5.

employ generally accepted and recommended survey techniques 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 survey unreliable.⁷⁴ Furthermore, by focusing on only one market, the Nathan Study fails to address the central issue of whether there is a difference in overall quality between restrictive and nonrestrictive markets. Even if we were to assume that the evidence on quality presented by proponents of the restrictions were reliable or convincing, it would not contradict the findings of the BE Study that there is no difference in the quality of care between restrictive and nonrestrictive markets.⁷⁵

D. Methodology of the BE and Contact Lens Studies.⁷⁶

The findings of the BE and Contact Lens Studies are central to the Commission's conclusions that these restrictions injure consumers and diminish overall quality of care by limiting access to care. The studies drew a great deal of comment, both supportive and critical.⁷⁷ In discussing the significance of the comment on the studies, we will first describe the key components of each study, summarize the major points raised by commenters, and explain why we believe these studies provide the best evidence reasonably available on the quality of care and a sufficiently reliable and comprehensive evidentiary basis for this rule.

1. *The BE Study.* The BE Study was designed to measure the effects on consumers of commercial practice restrictions. The study was conceived and conducted by the Bureau of

⁷⁴ See Final Staff Report, L-1, at 145-56 and Appendix C.

⁷⁵ No evidence presented by proponents of the restrictions compared quality of care provided in the two types of markets.

⁷⁶ A comprehensive analysis of comments devoted to methodological issues in this proceeding is found in Appendixes A and B of the Final Staff Report, L-1, and in Staff's Final Recommendations, C-1(b), at 21-48.

⁷⁷ The most lengthy and technical of the comments about the studies was submitted by Robert R. Nathan and Associates, a firm of consulting economists hired by the AOA for the proceeding. Nathan's three-volume submission contains both comments on specific aspects of the BE and Contact Lens Studies and the results of a survey Nathan conducted of New York City optometrists in an effort to rebut the quality findings of the BE Study. See *supra* notes 71, 72. Appendix C of the Final Staff Report, L-1, contains a detailed description of, and expert comments on, the Nathan survey's methodology.

⁶³ See Final Staff Report, L-1, at 108-113 (discussion of BE Study) and 189-206 (discussion of other quality evidence).

⁶⁴ In fact, as discussed *supra* at section II.E.2, the restrictions have some adverse effect on quality of care because the higher prices associated with restrictions cause consumers to seek eye care less frequently.

⁶⁵ The BE Study is discussed in detail in the Final Staff Report, L-1, at 101-122. See also *infra* section II.D.1 for a description of the study's methodology.

⁶⁶ See *infra* at section at II.D.1.

⁶⁷ See discussion of BE Study in Final Staff Report, L-1, at 112-113.

⁶⁸ *Id.* at 112.

Economics with the expert advice of optometrists on the faculties of two major colleges of optometry (the College of Optometry of the State University of New York and the Pennsylvania College of Optometry) and the Director of the Optometric Service of the Veterans Administration. In the study, nineteen trained survey researchers⁷⁶ posed as consumers and purchased over 400 eye exams and over 230 pairs of eyeglasses from optometrists in twelve different metropolitan areas across the country.⁷⁸

The twelve markets represented 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 "Yellow Pages." Cities were classified as markets with commercial practice if eye examinations were available from large optical chain firms.⁸⁰

Based on the data obtained by the survey subjects, the BE Study's authors calculated the average prices charged for an eye exam and eyeglasses⁸¹ by each type of practitioner in each type of market (e.g., chain firms in nonrestrictive markets, nonadvertisers in nonrestrictive markets). Then, using data regarding the number of optometrists of each type in a particular market, the study's authors calculated market-wide average prices for markets with both advertising and chain firms and for markets with neither.⁸²

⁷⁶ With two exceptions, the survey subjects had relatively routine visual problems. Some commenters and the Presiding Officer questioned the study's validity because subjects with more complex problems and pathologies were not included. See Post-record comment of AOA, M-176, at 5-7, 227-230, 362-94; Post-record comment of COA, M-178, at 6, 9-14; and Presiding Officer's Report, L-2, at 176-177.

⁷⁸ BE defined the relevant geographical markets as Standard Metropolitan Statistical Areas (SMSA's). The 12 SMSA's 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-St. Paul, Minnesota; Seattle, Washington; and Washington, DC.

⁸⁰ 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.

⁸¹ This amount included any dispensing fees, as well as charges for glaucoma tests or any other exam procedures that were priced separately. In order to minimize variations in the eyeglasses frames, subjects were instructed to purchase a particular unisex metal frame, if possible. BE Study, B-2-31, at 46.

⁸² BE Study, B-2-31, at 5.

Subsequent to the study's publication, its principal author calculated market-wide average prices for markets with chain firms and markets without chain firms.⁸³ These calculations showed that the average prices charged by optometrists for eye exams and eyeglasses were 18% higher in markets without chain firms than in markets with chain firms.⁸⁴

BE staff used multivariate regression analysis to analyze the data for: (1) Differences among markets in the advertising environment,⁸⁵ (2) differences among markets in the supply of optometrists; (3) differences among markets in the demand for optometric services; and (4) differences among 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.⁸⁶

In order to measure any differences in quality between markets with chain firms and markets without chain firms, the study compared: (1) The accuracy of the eyeglass prescriptions; (2) the accuracy and workmanship of the eyeglasses; (3) the extent of unnecessary prescribing; and (4) the ability of the optometrist to detect eye problems and pathologies. Elaborate procedures were established to guarantee an accurate and unbiased assessment of these factors.⁸⁷

On the first three dimensions of quality the study directly examined the optometrist's product or service or "output." For example, the optometrists who acted as consultants for the study performed eye examinations on each survey subject before the subjects went into the field. After examinations,

⁸³ Rebuttal Statement of R. Bond, FTC economist, K-18, at Table A-3.

⁸⁴ See Final Staff Report, L-1, at 105.

⁸⁵ Some commenters noted that the BE Study did not discuss the independent effects of advertising and chain firms. See, e.g., Nathan Study, J-66(a) at 32, 38-39, 47; AOA, H-81, at 24. However, the BE Study did report that neither advertising nor chain firms had any effect upon quality in a market. Also, while the BE Study did not discuss the independent effects of chain firms and advertising upon price, the study was designed to examine these effects separately. R. Bond, FTC economist, Tr. 466; Rebuttal Statement of R. Bond, K-18, at 5. The separate effects of chain firms were derived by performing a simple calculation on the BE Study's underlying data. See Letter from R. Bond, FTC economist, to J. Greenan, Presiding Officer (May 23, 1985), J-76; Rebuttal Statement of R. Bond, FTC economist, at 5 and Appendix A. See also R. Bond, Tr. 466; J. Kwoka, Professor, George Washington Univ., Tr. 500-01. Dr. Kowka, a coauthor of the BE Study, stated his agreement with Dr. Bond's conclusions and methods of analysis. J. Kwoka, J-12(a), at 9 and Tr. 500-01.

⁸⁶ BE Study, B-2-31, at 46-55, 91-93.

⁸⁷ See Final Staff Report, L-1, at 106-112.

prescriptions, and eyeglasses were obtained by the subjects, the consultants compared those prescriptions and eyeglasses to the prescriptions they had written. The consultants also assessed the eyeglasses for the quality of workmanship—e.g., scratches and imperfections on lenses, the quality of the edging and mounting of lenses, and the quality of materials used.

On the fourth aspect of quality, output was not directly examined. That is, the study did not directly examine whether or not optometrists detected eye pathologies since the study did not use subjects with such pathologies. Instead, the study used a "process" test that indirectly measured the likelihood that an optometrist would detect such pathologies by examining whether the optometrist performed the tests and procedures that are designed to detect complex eye problems and pathologies.

This process test was highly sophisticated and did detect meaningful differences in quality between optometrists. For example, the thoroughness index used in the BE Study included over twenty test procedures as well as other aspects of the examination.⁸⁸

The evidence establishes that the use of this process test provided reliable information about differences in quality of care for two reasons. First, there is a close correlation between the use of a correct process and a correct outcome. During the rulemaking hearings, noncommercial optometrists were virtually unanimous in their assessment that more procedures and more time spent during an eye examination is indicative of a higher quality exam.⁸⁹ In fact, some of the same optometrists who criticized the BE Study's use of a process test, nevertheless used the results of that test to demonstrate the alleged differences in quality of care

⁸⁸ Thus, we reject the assessment that the process test measured only a very simple and basic process. See Presiding Officer's Report, L-2, at 175; Post-record comment of AOA, M-176, at 227-49; Post-record comment of COA, M-178, at 9, 13. See also discussion in Staff's Final Recommendations, O-1(b), at 34-35.

⁸⁹ See, e.g., AOA Comment, H-81, at 42; B. Barresi, Professor, Center for Vision Care Policy, SUNY, J-13(a), at 10; COA Comment, J-67(e), at 4; J. Easton, President-elect, AOA, J-4, at 20; H. Glazier, President, Maryland Board of Optometry, J-21, at 2; Tr. 906, 916; J. Izydorek, optometrist, H-130, at 1; J. Kennedy, optometrist, J-26, at 1; D. Kuwabara, Chairman, Hawaii Board of Optometry, J-34, at 3; Nathan Study, J-66(a), Vol. I, Ex. 2 at 38-40 and Ex. 3 at 17-18; W. Scholl, optometrist, H-124, at 1; J. Scholles, optometrist, AOA trustee, J-31, at 7-8; Southern California College of Optometry, J-41(a), at 1; L. Strulowitz, member, New Jersey Board of Optometry, J-1, at 2; D. Sullins, optometrist, AOA trustee, J-39, at 11;

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ere offered by optometrists in nonrestrictive markets.⁹⁰

Second, the evidence shows that the use of a process test creates no bias in favor of chain firms.⁹¹ Such a bias would exist only if commercial optometrists perform equivalent procedures less competently than other optometrists. In other words, it would have to be shown that any differences in quality were due to differences in competence rather than to differences in time spent and procedures performed. The evidence shows, however, that any differences in quality, if they exist, are likely due to time spent or procedures performed and not due to commercial optometrists performing given test procedures less competently than other optometrists.⁹²

The Presiding Officer rejected the quality results of the BE Study. He apparently believed that only an outcome test, using subjects with a wide range of pathologies, would provide reliable evidence. We disagree with this conclusion for two reasons. First, it ignores the BE data discussed above, which permits conclusions about more complex eye problems, and it does not take into account the practical problems presented in conducting a methodologically sound outcome study. Individuals with pathologies in need of immediate treatment could not ethically be used in a lengthy series of field examinations. Finding a large enough sample of individuals who would be suitable survey subjects and who had pathologies not in need of immediate treatment would be prohibitively time-consuming and expensive. Second, there is a significant likelihood that the pathological conditions would change while the survey was being conducted, which would make it impossible to make valid comparisons among the optometrists examining the survey subjects. These obstacles cast serious doubt on the feasibility of conducting an outcome test on this aspect of quality.

⁹⁰ See e.g., Southern California College of Optometry Panel, J-41(a), at 18; AOA Comment, H-81, at 26; Final Staff Report, L-1, Appendix A at 9 n. 21.

⁹¹ Those commenters who alleged bias in the process test provided no persuasive explanation for that assertion. See AOA Comment, H-81, at 27; Nathan Study, J-66(1), Vol. I, Ex. 1, at 79.

⁹² The regression analysis that BE Staff performed on the Nathan survey data indicates that there is no such bias. The analysis 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. This tends to show that commercial firms perform as well as noncommercial optometrists when they both spend equal time and perform equivalent procedures. See Final Staff Report, L-1, Appendix A at 5-6.

The Commission also considered and rejected the assertion that the BE Study would have found that quality was lower in nonrestrictive markets than restrictive markets if its authors had calculated average quality based on the total number of exams given, rather than on number of practitioners. Dr. Kenneth Myers, Director of Optometry Services at the Veterans Administration and a former consultant to the FTC on the BE Study, asserted that the method for calculating average thoroughness of examinations on a market-wide basis was flawed. The BE Study calculated averages by simply averaging the thoroughness scores of all optometrists. Because some optometrists see more patients than others, Dr. Myers believed that the averages should have been weighted to account for the different number of exams performed by individual optometrists. He assumed that such a calculation would lead to a finding of lower average quality in markets with chain firms than the finding reported in the BE Study. However, if one uses Dr. Myers' methodology and his estimate that the typical commercial practitioner performs twice as many exams as the typical noncommercial practitioner, average quality scores for both restrictive and nonrestrictive markets would be lower, but the average score for nonrestrictive markets would still be about the same as that for restrictive markets.⁹³

We find that the process test used in the BE Study to evaluate comparative examination thoroughness provides meaningful information about quality of care. Moreover, that test was only one of four factors used to evaluate quality of care. Our conclusions on the quality of care are based on the record as a whole, and not just individual components of any one study.

2. *The Contact Lens Study.* In this study, the eyes of over 500 cosmetic contact lens wearers in 18 urban areas across the country were examined for the presence of seven potentially pathological eye conditions commonly associated with improper contact lens fitting.⁹⁴ Each of the survey subjects

⁹³ See Staff's Final Recommendations, Addendum to Appendix A, O-1(b), at 8.

⁹⁴ 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). The subjects were also tested for visual acuity to determine whether their prescriptions were adequate. Contact Lens Study, B-5-1, at 20-21.

had been fitted with contact lenses within the preceding three years and was still wearing contact lenses at the time the examinations were performed. The examination procedures were chosen after consultations with representatives of the major eye care professional organizations—the American Academy of Ophthalmology, the American Optometric Association, and the Opticians Association of America.⁹⁵ Those organizations also nominated the expert examiners who performed the eye examinations. Three examiners—an ophthalmologist, an optometrist, and an optician—examined each subject.

The examiners were instructed to determine which of the five illustrations of each potentially pathological condition in a grading manual most closely resembled the actual appearance of the subject's eyes. The grading manual, which had been designed by the group representatives, was used to minimize inconsistencies in grading by the several dozen examiners. The examiner then recorded a grade of 0, 1, 2, 3, or 4 for each condition. A grade of 0 meant that the condition was absent; a grade of 4 signified that the condition was present to an extreme degree. The number grades for each of the seven conditions for each eye were combined using a weighing formula to create a "summary quality score" for each subject, which would indicate the overall condition of the subject's eyes.⁹⁶

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 (i.e., the grade was 0); a "lower quality" score was assigned if the examination revealed that a particular condition was present to any degree (i.e., the grade was 1, 2, 3, or 4).

In order to compare quality among the different providers, differences in the summary and individual quality scores were computed for commercial optometrists, noncommercial optometrists, ophthalmologists, and opticians. Multiple regression estimation techniques were used in order to control

Also, subjects' lenses were examined to determine their physical condition and cleanliness.

⁹⁵ There is evidence on the record that representatives of all three organizations reached a consensus on the methodology to be used in the study. See Final Staff Report, L-1, at 124 n. 296.

⁹⁶ Since all of the seven conditions are not necessarily equally serious, they were assigned different weights based on the relative severity of that condition.

for the effects of a number of factors other than fitter competence that could have affected the relative health of the study subjects' eyes. These additional factors included the wearers' age, sex, and wearing habits, and the physical condition of the lenses.

The survey subjects were also asked how much they paid for their lenses, the eye exam, follow-up care, and the initial lens care kit.⁹⁷ The final package price figures were then adjusted for cost-of-living differences in the 18 cities in the sample and to account for the fact that the subjects purchased their lenses in different years.

Two additional tests were later conducted by BE staff on the Contact Lens Study data which demonstrated that these price differences were, in fact, associated with the presence of commercial practice and were not due to the effects of advertising or other market forces that could also affect prices. These tests corroborated the general findings of the study that commercial optometrists charged less than noncommercial optometrists.⁹⁸

The major concerns raised by some commenters about the methodology of the Contact Lens Study were that (1) former contact lens wearers (or "dropouts") were not examined;⁹⁹ (2) possible changes in the "k-readings" of the subjects were not evaluated;¹⁰¹ and (3) study subjects were not required to wear their lenses for at least four hours prior to the examination.¹⁰²

⁹⁷ 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. Nathan Study, J-86(a), Vol. 1, Exh. 2, at 14, 15, and 27. No bias 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.

⁹⁸ See J. Mulholland, FTC economist, J-19(a), at 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.

⁹⁹ Presiding Officer's Report, L-2, at 177; Post-record comment of AOA, M-176, at 333-34; Post-record comment of COA, M-178, at 11. This criticism is discussed in the Final Staff Report, L-1, at 135-37.

¹⁰⁰ K-readings, taken with the use of a keratometer, measure the steepest and flattest curvatures of the corneal surface. Contact Lens Study, B-5-1, at 8, 22-23.

¹⁰¹ Presiding Officer's Report, L-2, at 179; Post-record comment of AOA, M-176, at 315-24. This criticism is discussed in Staff's Final Recommendations, O-1(b), at 44-45.

¹⁰² Presiding Officer's Report, L-2, at 179-180; Post-record comment of AOA, M-176, at 344-359. This criticism is discussed in the Final Staff Report, L-1, at 137-140.

Commenters also listed other alleged problems with the Study, which are discussed in the Final

In most instances, the failure to include the specified procedure was unavoidable. For example, consultants and staff wanted to evaluate the care given to former contact lens wearers and to evaluate changes in the k-readings. However, in both instances, the expert consultants could suggest no practical and meaningful way to do so.¹⁰³ The testimony of some witnesses suggests that some transient and less significant eye problems might have been more frequently apparent if subjects had been required to wear their lenses for at least four hours before they were examined.¹⁰⁴ But other more serious and long-term conditions do not disappear overnight and would still have been apparent even if a subject had inserted his or her lenses only an hour or two before being examined.

The Presiding Officer and some commenters appear to have concluded that the study's findings must be entirely rejected because of these alleged methodological shortcomings. Although the Contact Lens Study may fail to provide information on some types of patients, or some types of contact lenses, there is no evidence on the record indicating that the study results would have been different had this additional data been included, or that the absence of that data created a bias in favor of commercial optometrists that affected the overall results of the survey.

Staff Report, L-1, at 133-44 and in Appendix B. Some commenters stated that the study did not include a representative sample and distribution of difficult contact lens patients and fitting problems and that no difficult cases were included. See, e.g., Post-record comment of AOA, M-176, at 296-300, 302; Post-record comment of COA, M-178, at 14. The fact that the study may not contain a representative distribution of difficult cases does not, however, invalidate the data which the study does provide. While some difficult cases were undoubtedly included in the study, the study did not include an assessment of the relative ability of optometrists to fit more difficult lenses such as therapeutic lenses and the more recently available extended wear lenses, toric lenses, or bifocal lenses. See AOA Post-record comment, M-176, at 102. Also, by excluding patients who had previously worn or attempted to wear contact lenses within three years of the survey date, the study excluded many patients with more difficult eye problems who may have experienced prior problems with their lenses. See Contact Lens Study, B-5-1, at A-1. (Excluding these patients also significantly reduced the possibility of bias which could develop if patients who knew they had difficult eye problems tended to select one group of optometrists over another.) Staff determined that it was impractical to include therapeutic lenses, and other more complex lenses could not be included because they were not available at the time the study was conducted. See Final Staff Report, L-1, at 142-43. However, the failure to study these more difficult cases does not detract from the validity of the data which the study does provide on the relative ability of optometrists to fit the less-difficult cosmetic contact lens patient.

¹⁰³ See Staff's Final Recommendations, O-1(b), at 43-45.

¹⁰⁴ Id. at 47 n.166.

The BE and Contact Lens Studies provide reliable information about the relative cost and quality of eye care available in the marketplace. We conclude that the evidence provided by the studies—along with other evidence on the record—meets or exceeds the applicable legal standards. In seeking evidence on the need for a rule, the Commission must balance the benefits and costs of obtaining information that answers all questions with certainty.¹⁰⁵ In this proceeding, the studies were subjected to intense scrutiny, but none of the studies' critics offered evidence that materially discredited the studies' key findings. Our confidence in the soundness of the studies is buttressed by consideration of the record as a whole, which contains substantial testimony and economic analysis that support the conclusions of the authors of the BE and Contact Lens Studies.

III. Legal Issues

A. Introduction

A major issue in this proceeding is the extent of the FTC's authority to declare state laws to be unfair acts or practices. After careful consideration of the legal issues discussed below, we have concluded that the FTC can, in appropriate instances, proceed directly against unfair state restraints.

B. Unfairness

This rule declares certain state-imposed restrictions on commercial practice by optometrists to be unfair acts or practices. The Commission has authority under section 18 of the Federal Trade Commission Act to prescribe:

[R]ules which define with specificity acts or practices which are unfair or deceptive acts or practices in or affecting commerce [within the meaning of * * * section 5(a)(1)].¹⁰⁶

¹⁰⁵ Credit Practices Rule, Statement of Bias and Purpose, 49 FR 7740, 7742 (1984). In upholding the Credit Practices Rule, the court recognized the danger in insisting that all of the Commission's conclusions be based on rigorous, quantitative economic analysis, and quoted language from the legislative history of Magnuson-Moss indicating that the Commission is not required to undertake a full-scale economic investigation prior to promulgation of a rule. "To do so would inordinately delay FTC proceedings and deny relief to the consuming public while indefinite questions of economic prediction were resolved by the Commission." *American Financial Services v. FTC*, 767 F.2d 857, 986-87, citing H.R. Rep. No. 1107, 93rd Cong. 2d Sess. 47 (1974). The court quoted language from the legislative history indicating that the Commission should rely on "its best estimate" of the impact of the rule. Id. at 986-87 citing H.R. Rep. No. 1107, 93rd Cong. 2d Sess. 47 (1974), *U.S. Code Cong. & Admin. News* (1974) at 7729.

¹⁰⁶ 15 U.S.C. 57(a)(1)(B).

When Congress created the FTC in 1914 it gave the Commission power to determine and prevent "unfair methods of competition." From the beginning Congress intended this power to be interpreted very broadly.¹⁰⁷ Congress necessarily recognized that it would be impossible to define or even to predict the infinite ways in which the goals of the statute might be thwarted. Consequently, Congress gave the Commission the tools to deal with problems as they developed. Although the original language focused on competition, it was generally understood that the Act "gave the Commission considerable discretion in identifying unfair consumer practices."¹⁰⁸

The Wheeler-Lea amendments of 1938¹⁰⁹ clarified the FTC's authority to reach acts and practices that injure the public as well as competitors. Those amendments added language to section 5 of the FTC Act to prohibit not only "unfair methods of competition," but also "unfair or deceptive acts or practices."¹¹⁰ In passing that amendment Congress contemplated that the concept of unfairness would be a flexible doctrine, responsive to changing conditions in the marketplace. The courts have repeatedly recognized the breadth of this delegation and have given the Commission significant latitude in defining unfairness.¹¹¹ In its 1980 Unfairness Statement¹¹² the Commission set out the principles that currently guide the Commission in determining whether acts or practices are unfair.

Those principles were accepted by the D.C. Circuit in upholding the Credit Practices Rule.¹¹³ The court's opinion

¹⁰⁷Realizing that it would be impossible to define with specificity all unfair practices, Congress considered and chose not to enact a statutory definition of the term "unfair method of competition." See S. Rep. No. 569, 63d Cong. 2d Sess. 13 (1914) and H.R. Conf. Rep. No. 1142, 63d Cong., 2d Sess. 19 (1914), cited in *American Financial Services v. FTC*, 787 F.2d 957 (1985).

¹⁰⁸See Averitt, *The Meaning of "Unfair Acts or Practices" in section 5 of the Federal Trade Commission Act*, 70 Geo L.J. 225, 230-231, 235.

¹⁰⁹52 Stat. 111 (1938) (15 U.S.C. 46(a)(1)).

¹¹⁰Id.

¹¹¹See, e.g., *Atlantic Refining Co. v. FTC*, 381 U.S. 367, 387 (1965); *FTC v. R.F. Keppel & Bros.*, 291 U.S. 304, 310 (1934); *FTC v. Raladam Co.*, 283 U.S. 643, 648 (1931).

¹¹²See Unfairness Statement, supra note 28.

¹¹³*American Financial Services v. FTC*, 787 F.2d 957 (D.C. Cir. 1985). The court found that the Commission had not exceeded its authority in promulgating the rule, given that the Commission's articulated rationale comported fully with the criteria set out in the Commission's Statement. Id. at 982.

noted that the consumer injury test described in the Commission's Unfairness Statement was "the most precise definition of unfairness articulated by either the Commission or Congress."¹¹⁴

The Unfairness Statement sets out three criteria that must be met in order to find consumer injury: (1) The injury must be substantial; (2) the injury must not be outweighed by offsetting consumer or competitive benefits; and (3) the injury must be one that consumers cannot reasonably avoid.¹¹⁵ The rulemaking record demonstrates that the injury flowing from state restrictions on the commercial practice of optometry clearly meet these criteria.¹¹⁶ As summarized *supra* in sections II. B. and C., these restrictions injure consumers by substantially raising the price of eye care, by limiting its accessibility, and by reducing the frequency with which consumers receive it. Further, no demonstrable benefits have been shown to flow from these restrictions, nor can consumers reasonably escape their injurious effect.

Like other rules promulgated under the Commission's unfairness authority, this rule seeks to halt practices that unreasonably create or take advantage of an obstacle to the free exercise of consumer decisionmaking and, in turn, to a well-functioning market.¹¹⁷ Here, however, the obstacles are created by state governments rather than by private actors. This compels us to consider whether the actions of state governments can be unfair acts or practices.

Through the Magnuson-Moss amendments of 1975 Congress sought to bolster the Commission's existing authority to find acts or practices to be unfair.¹¹⁸ During consideration of the

¹¹⁴Id. at 972. The court noted further that Congress had reviewed the Statement and "ha[d] not seen fit to enact any more particularized definition of unfairness to limit the Commission's discretion." Id. at 982.

¹¹⁵Unfairness Statement, supra note 28 at 5-6.

¹¹⁶See Final Staff Report, L-1, at 306-26.

¹¹⁷Unfairness Statement, supra note 28, at 7-8. See also *American Financial Services, Inc. v. FTC*, 787 F.2d 957, 98 (DC Cir. 1985).

¹¹⁸Magnuson-Moss Warranty—Federal Trade Commission Improvement Act, 83 Stat. 2183 (1975) (15 U.S.C. 57(a)). The amendments extended the FTC's unfairness jurisdiction by adding the "affecting" commerce language to section 5 of the FTCA and by granting rulemaking power through section 18.

Some commentators argued that nothing in the Wheeler-Lea amendments authorized the Commission to find state laws to be unfair, and nothing in the Magnuson-Moss Act broadened the preexisting definition of unfairness. See Post-record comment of AOA, M-176, at 25-27 and Post-record comment of COA, M-178, at 22-29. We read the legislative history of Wheeler-Lea as confirmation of the principle that the unfairness standard must be

rulemaking provisions, Congress repeatedly acknowledged that Commission rules would preempt inconsistent state law.¹¹⁹ The legislative history of Magnuson-Moss reveals that both the sponsors and opponents of the bill recognized the potentially broad reach of the proposed rulemaking authority and contemplated that this power could be used to challenge existing laws directly.¹²⁰ A conclusion that harmful state restrictions could not be deemed "unfair" would be inconsistent with this Congressional understanding. Since the passage of the Magnuson-Moss amendments, Congress' attention has been drawn repeatedly to Commission rulemakings that would reach state laws. Each time the issue has arisen during debates over amendments to the FTC Act, Congress has declined to limit the reach of our unfairness authority under section 18. In fact, in 1985 both the House and Senate expressly stated their understanding that the Commission's unfairness authority extends to prohibiting state restraints through rules such as the proposed Eyeglasses II rule.¹²¹ Against this legislative background, we believe that the Commission's unfairness authority is broad enough to encompass state laws.

C. Preemption

Although the language of the FTC Act does not expressly address the preemptive effect of Commission rules, it is clear that Section 18 trade regulation rules preempt inconsistent state law. Under the Supremacy Clause of the U.S. Constitution (Art. VI, section 2), federal law supersedes inconsistent state law. Validly enacted regulations of federal agencies have the same preemptive effect on inconsistent state

a broad one. That interpretation is then brought to the legislative history of Magnuson-Moss where Congress did express its understanding that Section 18 rules would preempt state laws.

¹¹⁹See Final Staff Report, L-1, at 330-37.

¹²⁰117 Cong. Rec. 39940 (1971). See also discussion in Final Staff Report, L-1, at 339-40.

¹²¹128 Cong. Rec. 2069, 2076-77 (1980). H.R. Rep. No. 99-102, 99th Cong., 1st Sess., 9-10 (1985) and S. Rep. No. 99-81, 1st Sess., 4-5 (1985). The bills accompanying these reports went to conference committee, but were never voted out. Earlier, in 1980, the Senate expressly rejected an amendment sponsored by Senators McClure and Melcher designed to stop the Commission from challenging the kind of state laws at issue in the Eyeglasses Rule and in the Eyeglasses II proceeding. 128 Cong. Rec. 2036 (1980). In defeating the McClure-Melcher amendment, opponents argued that state regulation of professionals was an entirely appropriate subject of FTC trade regulation rulemaking. 128 Cong. Rec. 2089 (1980) (statement of Sen. Matzenbaum); 128 Cong. Rec. 2076-77 (1980) (statement of Sen. Javits); 128 Cong. Rec. 2077 (1980) (statement of Sen. Inouye).

laws as federal statutes, even in the absence of any explicit Congressional statement of intent to preempt.¹²² Where there is irreconcilable conflict between federal and state regulation and no express language about preemption.¹²³ Here that presumption is statute or in the legislative history, the customary Presumption is in favor of preemption.¹²³ Here that presumption is bolstered by the legislative history of the Magnuson-Moss Act and by subsequent court interpretations of Commission rulemaking power.

Those commenters who have insisted that the Commission cannot preempt state laws absent a clear indication of Congressional intent have misunderstood the nature of the rulemaking authority delegated to the Commission by Congress in the Magnuson-Moss Act.¹²⁴ A showing of express Congressional intention to preempt is necessary only where Congress directs an agency to "occupy a field" of regulation.¹²⁵ In enacting the FTC Act and Title II of the Magnuson-Moss Act Congress did not intend that the Commission "occupy the field" of Consumer protection¹²⁶ or antitrust

regulation. In fact, in proposed legislation preceding passage of the Magnuson-Moss amendments, Congress sought to clarify the preemptive effect of Commission rules promulgated under Magnuson Moss by stating that the FTC Act would not occupy the field and that only inconsistent state laws would be preempted.¹²⁷ Throughout the period when rulemaking legislation was being considered, the record shows that Congress was aware of the preemption issue, invariably assumed that Commission rules would preempt inconsistent state law, and took no action to limit that preemptive effect.¹²⁸

Courts that have considered and ruled on the issue have also recognized that FTC rules preempt inconsistent state laws, relying both on general Supremacy Clause principles and on Congressional intent in enacting the Magnuson-Moss Act.¹²⁹

D. State Action

The state action doctrine of *Parker v. Brown*¹³⁰ does not limit the Commission's power under section 18 rules.¹³¹ In *Parker*, the Supreme Court

local government." H.R. Rep. No. 93-1107, 93d Cong., 2d Sess. 45 (1974).

¹²⁷ S. 3201, 91st Cong., 2d Sess. 108 (1970). See S. Rep. No. 91-1124, 91st Cong., 2d Sess. 23 (1970).

¹²⁸ The Magnuson-Moss amendments were passed during the 93d Congress. However, similar measures had been introduced in the two previous Congresses. Language regarding preemption appeared in some, but not all, of the proposed bills and accompanying reports. As a consequence, arguments regarding Congress' ultimate purpose have been raised by a number of commenters. See Brief of the American Optometric Association, *AOA v. FTC*, H-81, App. A at 25-26 (Attachment to AOA comment). Our consideration of all of the evidence leads to the conclusion that Congress understood the traditional preemptive effect of federal rules and the presence or absence of statements in the various bills and reports reflects only Congressional efforts to clarify the scope of the existing preemptive authority. See Final Staff Report, L-1, at 330-37.

¹²⁹ In upholding the Credit Practices Rule, the Court of Appeals in *American Financial Services v. FTC* 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." 787 F. 2d 957, 989-90. The Court in *Katharine Gibbs School v. FTC*, 612 F.2d 658 (2d Cir. 1979), relied on similar reasoning on treating the preemption issue as settled. Although the Court remanded the rule in that case because the Commission had not defined with specificity the unfair acts and practices targeted by the rule, the court indicated that "questions of preemption could be answered with relatively little difficulty." If the Commission identified clearly the acts and practices encompassed by a rule, 612 F. 2d at 86. In the instant rulemaking, we have striven to define the unfair acts or practices with as much specificity as possible.

¹³⁰ 317 U.S. 341 (1942).

¹³¹ Both the AOA and COA have contended that the state action doctrine applies to the federal antitrust laws generally, and therefore must apply to the FTCA. See Post-record comment of the AOA, M-176, at 29 and Post-record comment of the COA, M-178, at 29-30.

refused to construe the Sherman Act as applying to the anticompetitive conduct of a state acting through its legislature.¹³² The doctrine has never been applied to the Commission's unfairness jurisdiction generally nor to our rulemaking authority in particular. Moreover, in enacting the Magnuson-Moss amendments, Congress considered the preemption issue and concluded that Commission rules should have broad preemptive effect. To apply the *Parker* doctrine to section 18 rulemaking would frustrate Congressional intent.¹³³

Important differences between the Sherman and FTC Acts demonstrate that the policy reasons that led the Court to limit the reach of the Sherman Act do not apply to our rulemaking authority under section 18 of the FTC Act. In construing the Sherman Act, the Court recognized that, if the Act were to be applied to certain state actions, widespread and indiscriminate disruption of long-standing state economic legislation would occur. Well-established state economic regulation could be dismantled at the behest of private litigants with no consideration given to important state interests. Implicit in the Court's holding was the realization that if the Sherman Act were to apply to state action, private parties and state officials would be subject retroactively to treble damages and criminal sanctions for obeying otherwise valid state laws.¹³⁴ Given Congressional silence on the effect of the Sherman Act on state law, the *Parker* court concluded that Congress could not have intended such sweeping and possibly chaotic results.

Application of section 18 rulemaking to state legislation would not produce such dire consequences. First, challenges to state laws under section 18 can be initiated only by the FTC, a

¹³² 317 U.S. 341 (1942).

¹³³ The Commission has recognized that the *Parker* doctrine applies to adjudications brought under its unfair methods of competition authority, but only to the extent that the unfair methods of competition challenged consist of traditional Sherman Act violations. See *Massachusetts Furniture & Piano Movers Ass'n v. FTC*, 773 F.2d 391 (1st Cir. 1985); *Indiana Federation of Dentists*, 191 F.T.C. 57, 186 n. 24 (1983). In 1987, both the House and Senate passed versions of FTC authorizing legislation that would codify the Commission's application of the state action doctrine to its unfair methods of competition jurisdiction. In drafting this legislation, however, it is clear that Congress intended that the Commission's authority over unfair acts or practices not be limited by the state action doctrine. H.R. Rep. 271, 100th Cong. 1st Sess., 20 (1987).

¹³⁴ See Verkuil, *Preemption of State Law by the Federal Trade Commission*, 1973 Duke L.J. 225, 231. Note, *The State Action Exemption and Antitrust Enforcement Under the Federal Trade Commission Act*, 89 Harv. Law Rev. 715, 734-736 (1976).

¹²² See, e.g., *Fidelity Federal Savings and Loan Ass'n v. De La Quezta*, 458 U.S. 141, 153-54 (1982). See also discussion in Final Staff Report, L-1, at 327-28.

¹²³ See, e.g., *Paul v. United States*, 371 U.S. 245 (1963); *Free v. Bland*, 369 U.S. 683 (1982).

¹²⁴ For example, both the AOA and the COA claimed that neither the language nor the legislative history of Magnuson-Moss show a clear manifestation of Congressional intent to grant FTC rules preemptive power. See Post-record comment of AOA, M-176, at 10-25 and Post-record comment of COA, M-178, at 22-28. They go on to note that Title I of Magnuson-Moss (i.e., warranty provisions) contains an express grant of preemptive power while Title II (i.e., section 18 rulemaking) contains no such express grant. However, in Title I Congress intended to occupy a portion of the field of warranty regulation and therefore needed to express the preemptive effect. Title II envisions only conflict preemption. The case law cited by these commenters unequivocally establishes that conflict preemption flows automatically from the Supremacy Clause, regardless of any express Congressional intent to preempt. See, e.g., *Fidelity Federal Savings and Loan Ass'n v. De La Quezta*, 458 U.S. 141, 153-54 (1982); *Michigan Canners and Freezers Ass'n v. Agriculture Marketing and Bargaining Board*, 487 U.S. 461, 484-70 (1984); *Florida Lime & Avocado Growers, Inc. v. Paul*, 375 U.S. 132, 142-43 (1963).

¹²⁵ In those instances any state regulation on the same subject as the federal regulation is preempted even if the state regulation does not conflict with the federal requirements. See, e.g., *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 216 (1947). In contrast, this rule dispenses only four specified types of state restraints on the commercial practice of optometry. States continue to have broad authority to regulate the practice of optometry in order to safeguard the health of consumers. See discussion infra, section IV.

¹²⁶ The House Committee Report accompanying Magnuson-Moss noted that the FTC "should not intrude where cases of consumer fraud of a local nature are being effectively dealt with by State or

federal to protect the Congress private parties or the Sherman laws. Section prospectively imposing as those Act,¹³⁵ a private party faith relief laws.¹³⁶ appropriate whether served by adjudicated Act. Under the allows for parties (it develop broader achieved more clo than the is more c public co Finally, t criteria is requires prevalen nature of counterv 18 rulem law that

¹³⁵ The Sherman Act sanctions. A remedy and litigant or factors in d particular s states. See *Department 279 (1973)*. Co., 435 U.S. *Petrofina, I* In *Emplo Labor Stan private par question in redress pre Congress t concluded private par government the federal violations court was provisions fiscal burd responsible action sites *Department 279, 304 (B opinion at**

¹³⁶ The is guided t the public Commission impositor agencies c

federal agency with a mandate to protect the public interest and subject to Congressional oversight. In contrast, private parties seeking to protect private rights or enrich private pockets may use the Sherman Act to challenge state laws. Second, FTC rules apply prospectively, eliminating the danger of imposing retrospective penalties, such as those available under the Sherman Act,¹³⁵ against state officials or against private parties who have acted in good faith reliance on otherwise valid state laws.¹³⁶ Third, rulemaking is a more appropriate vehicle for examining whether federal or state interests are served by regulatory schemes than adjudicative actions under the Sherman Act. Unlike a private action brought under the Sherman Act, rulemaking allows for participation by all interested parties (including state officials) and for development of a record that reflects a broader perspective than could be achieved in private litigation. Because it more closely resembles the legislative than the adjudicative model, rulemaking is more conducive to the formation of public consensus and compromise. Finally, the application of the unfairness criteria in a section 18 rulemaking requires the Commission to consider the prevalence of the acts or practices, the nature of the injury, and any countervailing benefits. Thus, a section 18 rulemaking permits a review of state law that is both more flexible and

potentially more protective of important state interests¹³⁷ than is an action under the Sherman Act, where the focus is exclusively on competition issues. Thus, any disruption of long-standing state economic legislation will not occur unless careful review of the evidence shows that minimal or no benefits flow from that legislation.¹³⁸

Moreover, to the extent that *Parker* is a doctrine based on statutory construction, the clear differences in the legislative histories of the Sherman and Magnuson-Moss Acts support our view that Congress did not intend that *Parker* apply to section 18 rulemaking. While the legislative history of the Sherman Act is devoid of indications that Congress gave any consideration to the effect the Sherman Act would have on state law,¹³⁹ the legislative history of Magnuson-Moss is replete with evidence that Congress considered the relationship between the Commission's section 18 authority and state law.¹⁴⁰

E. State as a "Person"

In order to declare state laws to be unfair acts or practices, we must be able to conclude that a state or its officials are "persons" within the meaning of the Federal Trade Commission Act.

While no federal court has determined this issue within the context of the FTC Act,¹⁴¹ the Supreme Court has found state entities to be persons for the purpose of the Robinson-Patman Act¹⁴² and the Sherman and Clayton Acts.¹⁴³ The Supreme Court has also found states to be persons under selected provisions of the IRS Code.¹⁴⁴

¹³⁷ Letter from Federal Trade Commission to Senator Robert Packwood, Chairman, Committee on Commerce, Science and Transportation, United States Senate, March 5, 1982.

¹³⁸ See discussion *infra* at section IV.

¹³⁹ In a subsequent case, the Court stated that the legislative history actually contains some statements expressing a Congressional intention not to invade the legislative authority of the states. *Southern Motor Carriers Rate Conference v. United States*, 471 U.S. 48, 56 n. 19 (1985).

¹⁴⁰ See discussion of unfairness *supra* at Section III. B. There is also evidence to suggest that, at the time it amended the FTC Act in 1975, Congress was aware that the Commission might use its rulemaking power to challenge state-imposed restrictions on drug price advertising. See 120 Cong. Rec. 38150-52 (1974) (statement of Commissioner Thompson).

¹⁴¹ But see, *California ex rel. Christensen v. FTC*, 1974-2 Trade Cas. (CCH) ¶75,323 (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).

¹⁴² *Jefferson Co. Pharm. Ass'n v. Abbott Labs*, 480 U.S. 150, 155-56 (1983).

¹⁴³ *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 394-97 (1978).

¹⁴⁴ See, e.g., *Sims v. United States*, 359 U.S. 108, 112 (1958); *Ohio v. Helvering*, 292 U.S. 360 (1934).

In determining whether states meet the statutory definition of "person," the Supreme Court has generally looked to the legislative environment of the statute, including such factors as the subject matter, content, legislative history, and executive interpretation of the statute.¹⁴⁵ In addition, the Court has also considered whether exclusion of states from the statutory class of persons would frustrate the purpose of the statute.¹⁴⁶

We have weighed these factors and believe that to exclude states from the reach of the Commission's unfairness authority would defeat the purpose of the FTC Act. The legislative history of the FTC Act indicates that Congress intended an expansive meaning to be given to the word "person."¹⁴⁷ Furthermore, the finding that states are persons within the meaning of section 5 for the purposes of this rulemaking is consistent with recent Commission decisions¹⁴⁸ and our reading of the entire FTC Act and its amendments, including the broad scope of the Commission's unfairness authority, as discussed *supra* at section III.B.¹⁴⁹

IV. Federalism Concerns

As discussed above in section III., we are persuaded that the Commission has the legal authority to prohibit the state restraints at issue in this proceeding. Judicious exercise of that power, however, prompts us to consider whether we should act in this instance. We are keenly aware that this proceeding raises important questions about the proper allocation of power between the states and the federal government. However, after careful consideration, we are convinced that this rule is a proper exercise of federal power and is consonant with the principles of federalism.

¹⁴⁵ *Sims*, 359 U.S. at 112 and *United States v. Cooper Corp.*, 312 U.S. 600, 605 (1941).

¹⁴⁶ See, e.g., *Plumbers' Local 298 v. County of Door*, 359 U.S. 354 (1959); *Union Pacific R.R. Co. v. United States*, 313 U.S. 450 (1941); *United States v. California*, 297 U.S. 175 (1936).

¹⁴⁷ See 51 Cong. Rec. 14,028 (1914); H.R. Rep. No. 553, 63d Cong. 2d Sess. (1914); H.R. Rep. No. 1142, 63d Cong. 2d Sess. (1914). See also Final Staff Report, L-1, at 303-04.

¹⁴⁸ See *Massachusetts Board of Registration in Optometry*, Docket No. 8195 (Final Order, June 13, 1988) and *Indiana Federation of Dentists*, 93 F.T.C. 321 n. 1 (1979) (interlocutory order).

¹⁴⁹ The Commission took the same position when it promulgated the Eyeglasses Rule. Statement of Basis and Purpose for the Trade Regulation Rule on Advertising of Ophthalmic Goods and Services, 43 FR 23992, 24004 (1978). On appeal of that rule, the court reserved judgment on the issue of whether the Commission could exercise jurisdiction over the states. *American Ophthalmic Ass'n v. FTC*, 626 F.2d 896 (D.C. Cir. 1980).

¹³⁵ The retrospective penalties provided for under the Sherman Act are treble damages and criminal sanctions. Courts have considered the nature of the remedy and whether the suit is brought by a private litigant or by the federal government to be relevant factors in determining whether Congress intended particular statutory provisions to apply to the states. See *Employees of the Department v. Department of Public Health and Welfare*, 411 U.S. 279 (1973). Cf. *Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1977); *New Mexico v. American Petrofina, Inc.*, 501 F.2d 363, 367 (9th Cir. 1974).

In *Employees*, the Court was construing the Fair Labor Standards Act, which clearly covered both private parties and state governments. The only question in that case was whether the various redress provisions of the statute were intended by Congress to apply to state governments. The Court concluded that Congress did not intend to allow private parties to seek penalties from state governments although Congress did intend to allow the federal government to sue state governments for violations of this act. In reaching this conclusion the court was influenced by the fact that the penalty provisions "may saddle the states with enormous fiscal burdens," and that "Congress, acting responsibly, would not be presumed to take such action silently." *Employees of the Department v. Department of Public Health and Welfare*, 411 U.S. 279, 304 (Brennan, J., dissenting, quoting majority opinion at 284, 285).

¹³⁶ The imposition of penalties under the FTC Act is guided by FTC discretion, which is informed by the public interest. In § 456.4(b) of this rule, the Commission has stated that it will not seek the imposition of civil penalties against states, state agencies or state officials for violation of this rule.

Because we are dealing with state law, we have proceeded with extreme caution at each step of this rulemaking. Procedural safeguards are built into section 18 rulemakings to ensure that all interested parties have ample notice so that they have an opportunity both to present their views and evidence and to challenge the evidence and views submitted by other parties.¹⁵⁰ In deference to the significant state interests at stake, we solicited the views of state officials as well as industry members and consumers. We gave every consideration to claims that quality of care concerns justify these restrictions and would have deferred to any credible showing of countervailing benefits. In fact, when state laws are the subject of a section 18 rulemaking, the Commission has required that there be an even more rigorous showing of consumer injury and absence of countervailing benefits than is required under the Commission's unfairness standard.¹⁵¹

Nonetheless, as discussed above in section II.C., the record contains no persuasive evidence that commercial practice restrictions have any positive effect on the quality of care consumers receive or that they promote any other legitimate state interest. On the other hand, the record shows that state-imposed restraints on the commercial practice of optometry seriously hinder the provision of eye care to consumers. These restraints impose substantial costs on consumers. The primary effect of this regulation is to protect one category of providers, primarily solo practitioners, from competition from high-volume chain firms—at an annual cost to consumers of millions of dollars. This stifling of competition not only leads to higher prices and less eye care for consumers today, but delays the development of more innovative and

cost-effective ways of providing services tomorrow.¹⁵²

While we are convinced of the injury that these restrictions cause, we are also mindful of the states' traditional role in protecting the health and welfare of their citizens. Therefore, we have drafted this rule narrowly so as not to intrude gratuitously on the legitimate exercise of the police powers of the state.¹⁵³ The extent of our "intrusion" is carefully limited to those regulations that have been shown to be unfair, and should not interfere with the states' ability to protect their citizens from deceptive or abusive practices by optometrists or to ensure that high-quality optometric care is provided.

What the rule does challenge is state regulation that, in effect, insulates local optometrists from competition from large, price-competitive chain firms, most of which operate interstate.¹⁵⁴ Thus, this rule intrudes on no traditional state interest. Rather, it represents an appropriate exercise of the Commission's responsibility, grounded in the Commerce Clause, to protect markets from unfair or deceptive acts or practices.

By empowering the federal government to regulate commerce, the framers clearly sought to limit the extent to which states could restrict the development of interstate markets. Such limits were originally seen as necessary to protect the nascent national economy from the protectionist actions of the states, which the framers feared would lead to a destructive cycle of discrimination against out-of-state goods and the retaliation that would inevitably result.¹⁵⁵ That some policy of

¹⁵² For over thirty years scholars have written at length of the various ways in which excessive state economic regulation—such as these restrictions on the commercial practice of optometry—distorts the operation of markets and harm consumers. See, e.g., P. Verkuil, *State Action, Due Process and Antitrust: Reflections on Parker v. Brown*, 75 Col. Law Rev. 328 (1975); G. Stigler, *The Theory of Economic Regulation*, 2 Bell J. Econ. & Mgmt. Sc. 3 (1971); W. Cellhorn, *Individual Freedom and Governmental Restraints* (1956).

¹⁵³ In response to the cautionary message of the Court of Appeals in the Eyeglasses Rule, we have drafted this rule to focus narrowly on four specific areas of commercial practice. In remanding the advertising portions of the rule, the Court stated that the Commission had preempted the whole field of ophthalmic advertising, and so had "at least approached the outer boundaries of its authority." 625 F.2d 896, 916. The Court went on to state that answers to questions regarding preemption and state action "may depend . . . on the extent to which a federal regulation gratuitously intrudes on the exercise of police powers of the states." Id.

¹⁵⁴ While on their face these restrictions do not discriminate against out-of-state providers, they, in fact, have a disproportionately harmful effect on high-volume practices that operate interstate.

¹⁵⁵ Under the Articles of Confederation, some states engaged in protectionist activities that

limiting state authority over interstate markets, underlying the Commerce Clause, favors Commission action here to prevent states from denying interstate ophthalmic providers access to local markets when the evidence demonstrates that the states' asserted basis for such actions—to protect citizens from poor-quality ophthalmic care—has no substantial basis in fact.¹⁵⁶

In providing the Commission with Section 18 rulemaking authority, Congress has made a limited delegation to the FTC of its legislative authority to protect consumers from acts or practices that unreasonably interfere with the efficient functioning of interstate markets. We find that the existing restrictions on commercial practice are designed to and do impede the efficient flow of interstate commerce, and that they impose significant costs on consumers without providing any countervailing benefits. Thus, they constitute the kind of unfair acts or practices that Congress authorized the FTC to challenge in section 18 rulemaking.

We also believe that promulgation of this rule is consistent with a recent Executive Order on federalism.¹⁵⁷ That Order sets out certain policymaking criteria to guide executive agencies in the formulation of federal policy. In particular, the Order directs executive departments and agencies to act in strict adherence to constitutional principles and limit the policymaking discretion of states only where there is clear and certain constitutional authority and only where there is a problem not merely common to the states, but national in scope. In addition, the Order directs that any regulatory preemption of state law be limited to the minimum level necessary to achieve the objectives of the statute.

While the FTC is not bound by the requirements of this Order, we believe

threatened to affect the development of a vital interstate economy. For example, New York imposed port fees and tonnage duties on vessels from Connecticut and New Jersey, increasing the cost of farm products coming from those two states. In retaliation, New Jersey taxed the property for the lighthouses at Sandy Hook that New York had built, while Connecticut merchants suspended commercial dealings with New York for one year and imposed fines on those who disregarded the boycott. A. Giescke, *American Commercial Legislation Before 1789*, 134-135 (1910). See also C. P. Nettie, *The Emergence of a National Economy, 1775-1815*, 72-73 (1977).

¹⁵⁶ We take no position on whether the commercial practice restraints that are the subject of this rulemaking could be challenged successfully by private parties using a Commerce Clause theory and the evidence on this record.

¹⁵⁷ Exec. Order No. 12,612, 52 FR 41685 (1987).

¹⁵⁰ The Magnuson-Moss amendments impose additional safeguards beyond those mandated by the Administrative Procedure Act. These include additional hearing requirements and expanded scope of review by the courts. 15 U.S.C. 57a. See also Verkuil, *Preemption of State Law by the Federal Trade Commission*, 1976 Duke L.J. at 242-43; Note, *The State Action Exemption and Antitrust Enforcement under the Federal Trade Commission Act*, 89 Harv. L. Rev. 715, 745-50 (1978).

¹⁵¹ Letter from Federal Trade Commission to Senator Robert Packwood, Chairman, Committee on Commerce, Science and Transportation, United States Senate, March 5, 1982. Our decision to forego remedies normally available for violations of the FTC Act is a further indication of our recognition that the actions of states and their officials, as opposed to actions by private citizens, merit special consideration in an unfairness proceeding. See discussion of Commission's enforcement policy *infra* in section V.

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this rule conforms to the policymaking criteria outlined in the Order. We have proceeded under the clear and enumerated power of Congress to protect interstate commerce. The legislative history of the Magnuson-Moss amendments and subsequent Congressional action provide clear authority for this rule. We have identified a serious problem amenable to solution only at the national level; we have carefully examined the proffered claims of state interest; and we have fashioned a narrowly drawn deregulatory response that does not intrude on the legitimate interests states have in protecting the health and safety of their citizens.

V. Section-by-Section Analysis

The following section-by-section analysis explains the intended scope and meaning of each of the rule provisions adopted by the Commission.

Section 456.1: Definitions

This section defines certain terms used in the rule. Many of these terms are contained in the Eyeglasses Rule and relate to the prescription release requirement. The rule makes some modifications to terms used in the Eyeglasses Rule and includes some new definitions.

Paragraph (a): The term "patient" has been substituted for the term "buyer" to conform more closely to industry usage. The term covers anyone who has undergone an eye examination.

Paragraphs (b), (c), and (d) remain unchanged from the original rule definitions.

Paragraphs (e) and (f) replace § 456.1(h) of the Eyeglasses Rule. The specific terms "ophthalmologist" and "optometrist" in paragraphs (e) and (f) have been substituted for the general word "refractionist" used in § 456.1(h) of the Eyeglasses Rule to define those categories of providers—Doctors of Medicine, Osteopathy and Optometry—who are qualified under state law to perform eye examinations. This change was made for two reasons. First, the use of the term "refractionist" in the Eyeglasses Rule has caused confusion because it is not generally used by consumers or by industry members. Second, the provisions of the Eyeglasses II Rule relating to commercial practice apply to optometrists, not ophthalmologists. The term "refractionist" has been deleted so that this distinction is clear.

Paragraph (g): The definition of the term "person" has been changed. This term was originally used in § 456.3 of the Eyeglasses Rule. That rule provision is no longer in effect, so the original

definition of the term is no longer relevant. The term "person" is now used only in the rule provisions concerning commercial practice. The definition has been changed to make it clear that the term covers any individual, partnership, corporation or other entity, whether or not the FTC has jurisdiction over the "person."

Paragraph (h): The term "prescription" is defined as those specifications necessary to obtain lenses for eyeglasses. Thus, under the rule, the prescription that 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 or ophthalmologist, that state law requires in a legally fillable eyeglass prescription. The definition deletes all references to contact lenses. This change is intended to end the confusion generated by the definition in the Eyeglasses Rule concerning the obligation of optometrists and ophthalmologists to place the phrase "OK for contact lenses" (or similar words) on eyeglass prescriptions. No such obligation exists under the rule. 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. This change does not affect the requirement that optometrists and ophthalmologists offer prescriptions for lenses for eyeglasses to all patients whose eyes they examine, including those patients who wear or intend to purchase contact lenses.

Paragraph (i): The definition of "optometric services" is new. It 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 may vary slightly from state to state since states define the practice of optometry differently. The term only includes 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 rule as originally proposed did not cover the full range of services which may be provided by optometrists. The term "ophthalmic services," as defined in § 456.1(d), covers only the measuring and fitting of eyeglasses or contact lenses subsequent to the eye exam. The term "eye examination," as defined in § 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 or, in many states, prescribe topically applied prescription drugs to treat certain forms of eye disease. All such activities are included under the term "optometric services."

Section 456.2: Separation of Examination and Dispensing

This section requires that optometrists and ophthalmologists give prescriptions for eyeglass lenses to their patients immediately after completing an eye examination. Except for minor changes in terminology, this section is identical to the prescription release requirement contained in the Eyeglasses Rule (originally § 456.7).

Paragraph (d) addresses the use of waivers or disclaimers of liability. As the Commission makes clear in its declaration of intent (§ 456.5(c)), the rule does not impose liability on an ophthalmologist or optometrist for the ophthalmic goods and services dispensed by another individual pursuant to the ophthalmologist's or optometrist's prescription. By its terms, the rule proscribes only "waivers or disclaimers" of the physician's or optometrist's own responsibility. The Commission has interpreted this portion of the rule to permit nondeceptive affirmative statements concerning responsibility. For example, a written statement that "the person who dispenses your eyeglasses is responsible for their accuracy" would not violate § 456.2(d). However, such an affirmative statement cannot be coupled with a waiver or disclaimer of the optometrist's or ophthalmologist's own liability.¹⁵⁹

Section 456.3: Federal or State Employees

This section (originally § 456.3 of Eyeglasses Rule) deletes references to the remanded portions of the Eyeglasses Rule and clarifies the intended effect of this section. This section exempts practitioners who work for any federal, state, or local government agency from the rule's prescription release requirements. If practitioners work only part-time for the government, the exemption only applies when they are engaged in their governmental duties.

Section 456.4: State Bans on Commercial Practice¹⁵⁹

Paragraph (a)(1): Lay Association. The purpose of this section is to

¹⁵⁹ 43 FR 46296-46297 (1978).

¹⁵⁹ State bans may arise from a variety of sources: statutes, regulations, attorney general opinions, court opinions, and enforcement policy decisions by state boards and other state agencies. Regardless of the method used or the state entity involved, the rule prohibits such bans.

invalidate state prohibitions on optometrists' entering into certain designated business associations with nonoptometrists that make it possible to provide optometric services and ophthalmic goods and services to consumers in more efficient ways.

As originally proposed, § 456.4(a)(1) proscribed state prohibitions on "employer-employee or other business relationships" between optometrists and nonoptometrists. However, we realized that this language would leave some uncertainty in the minds of lawmakers and practitioners as to the scope of the rule.¹⁶⁰ We have narrowed the language of § 456.4(a)(1) to make it an unfair act or practice for states to prohibit those specific types of associations that the record demonstrates are critical to the development of commercial practice: (1) The employment of optometrists by lay persons or corporations to provide optometric services; (2) partnership agreements, joint-ownership or equity-participation agreements, profit-sharing agreements, or franchise agreements¹⁶¹ between optometrists and nonoptometrists (including those that involve the sharing of revenues between optometrists and nonoptometrists) for the purpose of providing optometric services or ophthalmic goods or services; or (3) the leasing of office space by optometrists from nonoptometrists, including the payment of rentals on such leases based on a percentage of the optometrist's revenues.

The record also demonstrates that lay control over the business aspects of an optometric practice is an integral element of commercial practice. Subsection (v) invalidates those state regulations that prevent lay persons or corporations from controlling those business aspects of a practice that the record demonstrates have no effect on

¹⁶⁰ For example, some commenters argued that the original language was broad enough to encompass regulations banning "capping and steering" and referral arrangements. While in some instances such regulations may be unconstitutional restraints on commercial speech, the rule language makes clear that the rule does not cover such prohibitions.

¹⁶¹ Typically, under an optometric franchising arrangement, the optometrist pays the franchiser for a specified set of goods or services, which might include the use of the franchiser's trade name and trademarks, the benefits of its goodwill, proven method of doing business, volume discounts on equipment and inventory, financing available through the franchiser, and participation in the franchiser's advertising program. The franchiser retains control over many aspects of the franchisee's business organization, such as office design, items stocked, and minimum quality standards. J. Solish, Attorney, R.H. Teagle Corp., Tr. 1366-72; cf. P. Zeidman, Attorney, National Franchise Association, Tr. 591 (describing attributes of franchising agreements generally).

quality of care—e.g., setting of fees, salaries, or minimum office hours; location of the practice; choice of suppliers of material, equipment, services, and laboratory work; establishing minimum quantities of materials in stock and minimum equipment;¹⁶² advertising, promotion, and marketing practices; accounting and financial practices; office design, decor, and maintenance; and other activities that involve business judgments to a similar degree.¹⁶³ As discussed more completely herein, this provision of the rule does not prevent states from passing regulations concerning these business aspects of optometry. It simply prevents the states from mandating that optometrists alone, and not lay persons or corporations, must make these decisions.

Finally, the language of this provision makes clear that the only affiliations covered by § 456.4(a)(1) are affiliations for the purpose of "providing optometric services" or "forming entities whose business, in whole or part, is providing optometric services or ophthalmic goods and services to the public." The inclusion of this language makes clear that affiliations for anything other than this stated purpose are not covered by the rule.¹⁶⁴

¹⁶² Obviously, these minimum standards would have to accord with any state-imposed standards for optometric practice. Furthermore, under the rule, states could require that optometrists be permitted to have equipment and inventory above the minimum level established by the lay person or corporation.

¹⁶³ The record establishes that corporations which associate with optometrists—for example, by employing optometrists or entering into franchise agreements—where currently permitted, commonly control these aspects of the business. See, e.g., NAOO, H-78a, at 38-40 and Appendices J, K, L, and M. Other evidence on the record, see supra section H.C., demonstrates that associations between optometrists and lay persons have no adverse impact on the quality of care available in the market.

¹⁶⁴ For example, the rule was never 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 this provision, ophthalmologists also may enter into affiliations with optometrists for the purpose of providing optometric services or ophthalmic goods and services to the public.

The term "sellers" also appeared in the proposed language of § 456.4(a)(1). Sellers was defined to include opticians. As a result, the rule as originally proposed would have prohibited state restraints on lay persons employing (or otherwise affiliating with) "sellers." The record shows that the law of only one state prohibits such affiliations, and no evidence or comments were submitted about this restriction. Consequently we decline to extend the rule to such a restriction.

The rule does not interfere with a state's ability to adopt or enforce any law or regulation that addresses specific harmful practices arising from lay association. For example, the rule does not interfere with a state's ability to prohibit improper lay control of the practice of optometry or the professional judgment of an optometrist, where the terms "practice of optometry" or "professional judgment" do not encompass those business aspects of a practice described in subsection (v).

The rule does not affect the ability of the states to prohibit the use of certain compensation schemes. For example, states could, if they were so inclined, prohibit employers of optometrists from setting quotas for the number of examinations that optometrists must perform. States could also choose to ban the payment of commission based on the number of examinations given or prescriptions written by optometrists. The evidence in this record does not establish that commission payments provide clear consumer benefits or that they result in no consumer injury.¹⁶⁵

States may also establish minimum standards of competence or honesty and discipline those optometrists, commercial or not, who fail to meet those standards. In short, under the rule, states retain broad authority to regulate the commercial and traditional practice of optometry in order to protect the health and safety of their citizens and to prevent abuse of consumers.

Paragraph (a)(2): Branch Offices. The rule allows 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 rule also prohibits states from requiring optometrists to remain in personal attendance at each branch office for a specific percentage of the time the branch is open. Such a requirement effectively limits the number of branch offices that an optometrist may own and therefore is prohibited by the rule.

However, as § 456.5(a) makes clear, the states retain broad authority to regulate health and safety and to

¹⁶⁵ In contrast to sa franchise or leasing arrangement, for example, where an optometrist pays a percentage of his gross revenue to the franchiser or lessor, commission payments entail a payment to an optometrist which varies depending upon the number of eyeglasses sold or revenue generated by the optometrist. The former creates no incentive for the optometrist to overprescribe while the latter arguably does.

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prevent consumer abuses. For example, states could require that optometric services or ophthalmic goods or services provided at each office be supplied only 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 office equipment, or a specific level of sanitation.

Paragraph (a)(3): Mercantile locations. This provision allows optometrists to locate their practices inside retail optical stores, department stores, or other mercantile establishments. Optometrists can also locate in shopping malls or adjacent to optical retailers. Under the rule corporations and other entities that offer optometric services by employing optometrists or otherwise affiliating with optometrists, pursuant to § 456.4(a)(1) of the rule, can also locate in mercantile locations.

Consequently, the rule also eliminates so-called "two-door" or "side-by-side" requirements, which are frequently used to prohibit optometrists from locating directly inside mercantile establishments. These requirements mandate separate offices for the optometrist and the optician, including, in some instances, separate doors and duplicate facilities and partitions between the two offices. Under the rule, states could not require separate offices, separate entrances, duplicate facilities, or partitions.

Finally, as § 456.5(a) makes clear, 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 an optometric practice in an area which would create a public health or safety hazard.

Paragraph (a)(4): Trade Names.¹⁶⁵ The rule invalidates state prohibitions on optometrists' practicing under any nondeceptive trade name. Thus, for example, optometrists employed by a chain firm could practice under the name of the chain firm as long as the name was not deceptive. Optometrists working for other optometrists could practice under the name used by 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

¹⁶⁵ Section 456.1(f) of the rule as originally proposed defined the term "trade name ban." The rule incorporates the substance of this definition in this section, which bars states from prohibiting the use of trade names. Thus, a separate definition is unnecessary.

with optometrists, pursuant to § 456.4(a)(1) of the rule, could also practice under any nondeceptive trade name.

Some states, for example, require that any trade name include the name of one or more of the optometrists practicing under the trade name.¹⁶⁷ Such requirements would violate the rule since they prohibit use of a wide variety of nondeceptive trade names, including some that are well-established in other states. Other states require that all trade names used by optometrists include the word "optometric" or "optometrist."¹⁶⁸ Trade names which do not include these terms, such as "Smith Optical Center," are not in general, deceptive. Such a requirement would also be prohibited under the rule, since it would prohibit the use of all other nondeceptive trade names.¹⁶⁹

The rule also allows optometrists to advertise under a trade name in a nondeceptive manner. For example, optometrists could display their trade names on signs and use the trade name in media advertising. Similarly, chain firms offering eye exams could advertise optometric services under the trade name.

The rule also prohibits states from mandating that any trade name advertisement disclose the names of all optometrists practicing at a given advertised location or practicing under the advertised trade name.

However, as § 456.5(a) (3) and (4) make clear, the rule does not infringe on the state's ability to enforce any law, rule, or regulation which requires that the identity of an optometrist be disclosed to a patient before, during, or after the time optometric services are provided or ophthalmic goods are dispensed or from enforcing any state law, rule, or regulation that is reasonably necessary to prevent the deceptive use of trade names in advertising. Also, the rule would not prevent states from imposing reasonable disclosure requirements on any trade name advertising.

Sections 456.4(b) and 456.5(b): Enforcement Policy

The Commission expects that the states will comply voluntarily with the

¹⁶⁷ See, e.g., La. Rev. Stat. Ann. section 1112 (West 1952); Mo. Admin. Code Tit. 4, CSR 210-2.060(4)(E) (1984); Or. Admin. R. section 852-300-010 (1984).

¹⁶⁸ See, e.g., Minn. R. 6300.0900, Subp. 3 (1987).

¹⁶⁹ In fact, use of the term "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.

rule. If, however, a state or local governmental agency or official attempts to enforce a state law or regulation that conflicts with the rule, § 456.5(b), while not creating a private right of action, recognizes that individuals can interpose the rule as a defense in any proceeding brought by the state. In such a situation, a person could correctly assert that the rule preempts the state law or regulation and therefore there is no basis on which any enforcement action could be brought. Because the Commission expects the states to comply voluntarily with the rule, it does not anticipate bringing any law enforcement actions against state or local governmental agencies or officials. Section 456.4(b) of the rule also provides that no state or local governmental agency or official is liable for civil penalties, consumer redress, or other monetary relief that would ordinarily be available under the FTC Act for violations of this rule.

Section 456.5: Declaration of Commission Intent

Paragraph (a): Section 456.5(a) is intended to make clear that the rule does not affect 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 does not interfere with a broad range of state regulation that safeguards the health and safety of eye care consumers, or prevents unfair or deceptive practices or anticompetitive conduct by eye care providers, including commercial practitioners. For example, many states specify that particular procedures must be performed each time an optometrist performs an eye examination or that every optometrist's office must have particular equipment. 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."¹⁷⁰ The rule does not interfere with a state's ability to regulate optometry, including commercial practice, through such regulations.

We also acknowledge that a state or local government can enact regulation that may have an incidental impact on the ability of optometrists to engage in the specific practices covered by the rule, as long as the regulation does not distinguish between commercial and

¹⁷⁰ See Final Staff Report, L-1, at 45-48.

noncommercial optometrists or optometric firms. Thus, the rule does not invalidate state labor laws, antitrust laws, zoning laws, or other state or local regulation that may have an incidental impact on the ability of optometrists to engage in the conduct protected by the rule.

Paragraph (b): See analysis of § 456.4(b) for a discussion of the Commission's views regarding the ways in which the Commission intends the rule to be enforced.

Paragraph (c): See analysis of waivers and disclaimers of liability in § 456.2(d).

VI. Alternatives Considered

During the course of this proceeding the Commission carefully considered alternative approaches to the promulgation of a rule. We also considered adopting a broader prohibition on commercial practice restraints—one that would reach indirect as well as direct bans—and considered various proposed modifications to the existing prescription release provisions. Each of these alternatives is discussed below.

A. Alternatives to Promulgation of a Rule

1. *Take no action; defer to the states.* The Commission could leave to the states the decision whether or not to eliminate these restrictions. The Commission could continue to make its staff studies and other evidence available to state legislatures and regulatory agencies, 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 are dim. The BE Study has been available since 1980, and staff has testified or submitted comments in support of deregulation of commercial practice in a significant number of states.¹⁷¹ Nevertheless, the record indicates that such restrictions are still widespread.¹⁷² Based on this record we have no reason to expect that more than a few states will voluntarily repeal commercial practice restrictions in the foreseeable future.

2. *Case-by-case approach.* A second alternative would be to issue complaints and proceed on a case-by-case basis against particular states or state regulatory boards.¹⁷³ Rulemaking

appears to be the more appropriate vehicle for a number of reasons, especially since nearly all of the 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. In addition, promulgation of a rule would provide more complete protection for consumers. Even if an order were issued against a particular state or state regulatory board, that order would not extend to other states with similar restrictions. Thus, 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.

B. Alternative Rule Provisions

1. *Commercial Practice—Direct and Indirect Bans.* The rule as proposed at the start of this proceeding covered state restraints that directly or indirectly prohibited commercial practice.¹⁷⁴ Such a formulation would have given the Commission the greatest flexibility in reaching indirect attempts to prohibit commercial practice. At the same time, the Commission was mindful that such an approach arguably would invalidate many laws and regulations not specifically enumerated in the rule. We chose to promulgate a more limited rule that defines the invalidated restrictions very clearly in order to eliminate any uncertainty regarding which laws or regulations are affected by this rule. The rule sets out four types of state laws that act as direct restraints on the commercial practice of optometry: (1) Bans on lay association; (2) limitations on branch offices; (3) bans on mercantile locations; and (4) bans on trade names.

Additionally, we have clearly identified and incorporated into the rule four other types of restraints that interfere with activities essential to the functioning of commercial practice: (1) Bans on the sharing of profits (§ 456.4 (a)(1) (i)); (2) bans on lay control over the business aspects of a practice (§ 456.4 (a)(1) (v)); (3) requirements that specify that owners of branch offices remain in personal attendance at each

the state-imposed restraints at issue in this proceeding.

¹⁷⁴ See 50 FR 598 (1985). This intention was specifically stated in proposed §§ 456.5 (b) and (c).

branch for a specific percentage of the time that the branch is open (§ 456.4 (a)(2)); and (4) requirements that mandate the disclosure in advertising of the names of all optometrists practicing at a given advertised location or practicing under a trade name (§ 456.4 (a)(4)).

The rule is now much narrower. It proscribes only those specified types of state laws and regulations that the record demonstrates create serious barriers to the formation and operation of commercial optometric firms and thereby cause significant consumer injury.

2. *Prescription Release.* On June 2, 1978, the Commission promulgated the Eyeglasses Rule.¹⁷⁵ That rule, in pertinent part, requires optometrists and ophthalmologists to release to their patients copies of their eyeglass prescriptions immediately following eye examinations regardless of whether or not the patient requests the prescription.¹⁷⁶

The Commission found 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, or charged an additional fee for release of the prescription.¹⁷⁷ The Commission promulgated an automatic release 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 from the process of obtaining an eye exam.¹⁷⁸ The automatic release provision was thus imposed as a remedial measure.

In this proceeding the Commission considered whether or not the prescription release requirement should be modified or extended. The major modification considered was amendment of the rule to require that prescriptions be provided only upon request of the patient. In addition, the Commission asked for comment on five

¹⁷⁵ 43 FR 23,992 (1978) (codified at 16 CFR 456).

¹⁷⁶ The rule also prohibits optometrists and ophthalmologists from charging additional fees for the prescriptions, from conditioning the availability of eye examinations on the purchase of ophthalmic goods, or from including waivers of liability on the prescription. These provisions were upheld by the U.S. Court of Appeals in 1980. *American Optometric Assoc. v. FTC*, 626 F.2d 898 (DC Cir. 1980).

¹⁷⁷ In addition, some practitioners refused to conduct an examination unless the patient agreed to purchase eyeglasses from the practitioner or incurred potentially intimidating disclaimers of liability on the prescription itself. 43 FR 23992, 23998 (June 2, 1978).

¹⁷⁸ See Final Staff Report, L-1, at 251-52.

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other possible changes in the rule.¹⁷⁹ The Commission considered the record evidence on each of these proposals and chose not to adopt any of them for the reasons outlined below.

a. Automatic Release. The Commission decided to retain the remedial aspect of the prescription release requirement after consideration of two surveys¹⁸⁰ placed on the rulemaking record, as well as numerous comments and testimony offered by optometrists, opticians, professional associations, state boards, and consumer groups.

Our reading of the record reveals that there is significant non-compliance with the automatic release requirement¹⁸¹ and that there continues to be a lack of consumer awareness about prescription rights. Given that the record does not contain sufficient evidence to conclude that the remedial aspects of the rule are no longer needed, we decline to modify or repeal the rule.¹⁸²

b. Contact Lens Prescription Release. The NPR requested comment on whether significant numbers of consumers were refused copies of their contact lens prescriptions, whether consumers could reasonably avoid these refusals, and what are the costs and benefits of extending the prescription release rule to contact lenses.¹⁸³ While

the record suggests that it is not uncommon for practitioners to refuse to give patients copies of their contact lens prescriptions,¹⁸⁴ and that the resulting costs to consumers could be significant,¹⁸⁵ we do not believe that the record contains sufficient reliable evidence to permit a conclusion that the practice is prevalent.

Moreover, even if the evidence on prevalence of refusal to release contact lens prescriptions and resulting injury to consumers were satisfactorily documented, we would have to consider if any countervailing benefits justified the refusal. Some commenters suggested that refusal to release is necessary to permit the fitter to verify the fit of the lens¹⁸⁶ on the eye because there is some danger that lenses may not conform to the eye as expected.¹⁸⁷ According to these commenters, 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 verify the fit.¹⁸⁸

Because the record evidence is insufficient to evaluate this claim fully, the Commission cannot conclude that a refusal to release a contact lens prescription is an unfair act or practice.

c. Other Prescription Release Matters. The Commission received no substantial evidence showing that practitioners refuse to release duplicate copies of prescriptions to patients who lose or misplace their original copies, or that eyeglass dispensers refuse to return prescriptions to patients after filling the prescription.¹⁸⁹ Because we do not have sufficient evidence to show that either of these practices is prevalent, rulemaking in these areas would be inappropriate.

VII. Other Matters

A. Cost-Benefit Analysis

Before the Commission determines that an act or practice is legally unfair, we analyze the act or practice in terms

of the scope and nature of the injury it causes and in light of any offsetting benefits it provides. In sections II. B. and C., we set out a detailed summary of the injury imposed by commercial practice restrictions and the absence of any countervailing benefits that might justify the restrictions. However, we also must consider the projected benefits and effects of the rule that we are promulgating.¹⁹⁰

1. Effect on Consumers. The primary benefit to consumers from the removal of commercial practice restrictions is that they will be able to purchase vision care goods and services at lower prices without any compromise in quality of care. The record evidence indicates that (1) Prices are significantly lower in markets where commercial practice is not restricted; (2) commercial optometrists charge lower prices than noncommercial optometrists; (3) noncommercial optometrists who operate in markets where commercial practice is permitted charge less than their counterparts in markets where commercial practice is prohibited; and (4) overall quality of care is no lower in nonrestrictive than in restrictive markets. As restrictions on commercial practice are removed, competition among optometrists should increase. Lower prices should then result from this increased competition and from economies of scale achieved by larger optometric providers. Lower prices will also increase the availability of ophthalmic goods and services to consumers who before could afford such services infrequently, or in some instances, not at all.

Implementation of the rule will have no adverse effect on consumers. They will be able to obtain the same overall quality of care, but at lower prices. Finally consumers will benefit from their ability to choose, if they wish, the convenience of one-stop service (eye examinations plus eyeglass or contact lens dispensing) from optometrists or retail optical firms who employ optometrists.

2. Effect on Industry Members. The rule will directly affect all ophthalmologists and optometrists who perform eye examinations and all optometrists, opticians, and others who desire to engage in commercial ophthalmic practice. In 1982, there were approximately 12,000 ophthalmologists, 22,000 optometrists, and 28,000 opticians in active practice in the United States. Most ophthalmologists and optometrists are self-employed. The majority of

¹⁷⁹ (1) Should the rule require optometrists and ophthalmologists only to offer, rather than give, eyeglass prescriptions to their patients? (2) Should the requirement be repealed altogether? (3) Should the rule be extended to require the release of contact lens prescriptions to patients? (4) Should the rule be extended to require optometrists and ophthalmologists to release duplicate copies of prescriptions to patients who lose or misplace their original copies? and (5) Should the rule require dispensers of eyeglasses to return the eyeglass prescription to patients after filling the prescription? 50 FR 802-03 (1985).

¹⁸⁰ The Market Facts Study, *supra* note 18, developed by 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 and experience with prescriptions. The American Association of Retired Persons also submitted a survey conducted in 1985. That survey polled older consumers to determine their familiarity with eyeglass prescriptions. AARP Survey, J-37(b) (Attachment to Statement of E. Eggen, Director, American Ass'n. of Retired Persons).

¹⁸¹ The Market Facts Study concludes that 44% of refractionists are not in compliance with the rule and that an additional 19% are only in partial compliance. See also Presiding Officer's Report, L-2, at 24-25, which concludes that noncompliance remains a problem and recommends that the rule not be modified.

¹⁸² Little evidence was presented in response to the Commission's question regarding an "offer" requirement. Comments from parties on opposing sides of the release upon request or repeal issues generally opposed the use of an offer in lieu of their favored position.

¹⁸³ 50 FR 803 (1985).

¹⁸⁴ See Final Staff Report, L-1, at 263-67.

¹⁸⁵ *Id.* at 282-89.

¹⁸⁶ This need varies somewhat between hard and soft contact lenses. Hard lenses are ordered according to the fitter's specifications and, in many cases, are then modified or finished by the fitter on a custom basis.

¹⁸⁷ E. McCrary, Vice President, Maryland Optometric Ass'n, Tr. 182; G. Easton, President-elect, American Optometric Ass'n, Tr. 154; H. Hanola, Pennsylvania Optometrist, Tr. 2316-18; T. Vail, Illinois Optometrist, H-116, at 9.

¹⁸⁸ 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 3-4; A. Gossan, Michigan Optometrist, H-1.

¹⁸⁹ See Final Staff Report, L-1, at 287-89.

¹⁹⁰ Federal Trade Commission, Rules of Practice, § 1.14(2)(iii).

opticians are self-employed or employed in "independent" retail optical establishments.

The rule will give members of the optometric industry greater freedom to provide goods and services in the most cost-effective manner. They will be able to enter into business affiliations with nonoptometrists, own and operate several branch offices, use a trade name for their practice, and locate their practices in retail or mercantile settings. In a less-restrictive regulatory environment, they will have greater opportunity to develop innovative ways of offering services and goods to consumers. Corporations or other business entities presently selling ophthalmic goods would be able to hire, lease space to, or associate with optometrists in order to offer one-stop shopping to consumers.

No direct costs would be imposed on optometrists, ophthalmologists, or opticians by the removal of state bans on commercial forms of practice. The rule would only permit, not require, providers to operate branch offices, maintain offices in mercantile locations, use trade names, or affiliate with lay corporations and individuals.

The only "costs" borne by industry members would be those created by doing business in a market where greater consumer choice stimulates more competition. The indirect effects of the rule on various industry members cannot be determined with any degree of precision, and will depend at least in part on how individual providers respond to the changing market conditions. For example, some noncommercial optometrists may be forced to adopt more cost-effective business practices or lower their prices in order to meet increased competition. In markets where commercial practice is now prohibited, it can be anticipated that commercial firms will enter.

3. Effect on Small Entities. The primary impact of the rule on small entities will stem from the increased competition in the vision care industry which can be anticipated as a result of the rule's deregulatory effects. The economic impact on individual small entities from increased competition in the vision care industry, although difficult to determine, could be substantial. However, the provisions of the rule that remove certain governmental restraints on commercial ophthalmic practice would permit small entities (i.e., optometrists and opticians) to engage in alternate modes of practice, including commercial practice, or to expand, should they desire to do so.

The rule could hurt some small entities and benefit others, depending on

how they respond to a more competitive market. In states that currently restrict commercial practice, for example, the market will become more flexible and capable of responding to consumer demand. Those small entities that have been denied the opportunity to engage in more efficient business practices will now be able to do so.

Data from studies of the ophthalmic market indicate that this market is price elastic: that is, as prices of eye examinations and eyeglasses decline, there is a proportionately greater increase in consumption. Thus, we anticipate an increase in total expenditures for vision care products and services. However, the market will be a more competitive one. Some less efficient providers will undoubtedly lose business.

4. Effect on Government Entities. The rule invalidates state statutes and regulations that ban commercial forms of practice. Thus, state and local regulatory agencies would not have to bear the costs of enforcing these bans. However, other indirect costs might arise should state or local officials decide to enact new regulations in areas not covered by the rule. In addition to the costs involved in enacting such regulations, the regulatory agencies might incur additional enforcement costs.

B. Final Regulatory Analysis

The final regulatory analysis¹⁹¹ of the rule has been integrated into the Statement of Basis and Purpose, as allowed by statute.¹⁹²

Accordingly, Title 16, Part 456 of the Code of Federal Regulations is revised to read as follows:

PART 456—OPHTHALMIC PRACTICE RULES

Sec.

- 456.1 Definitions.
- 456.2 Separation of examination and dispensing.
- 456.3 Federal or State employees.
- 456.4 State bans on commercial practice.
- 456.5 Declaration of Commission intent.

Authority: Section 18(a), 88 Stat. 2193, as amended 93 Stat. 95. (15 U.S.C. 57a); 80 Stat. 383; 81 Stat. 54; 88 Stat. 1561-1564; 93 Stat. 1247 (5 U.S.C. 552).

¹⁹¹ The statute requires that the analysis contain (1) A statement of the need for and objectives of the rule; (2) a summary of the issues raised by public comments, a summary of the agency's assessment of such issues, and a statement of changes made in the rule as a result of these comments; and (3) a description of the significant alternatives to the rule considered and reasons for rejecting each alternative. 5 U.S.C. 804.

¹⁹² 5 U.S.C. 605(a).

§ 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" are eyeglasses, or any component of eyeglasses, and contact lenses.

(d) "Ophthalmic services" are the measuring, fitting, and adjusting of ophthalmic goods 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" is any individual, partnership, corporation, association or other entity.

(h) A "prescription" is the written specifications for lenses for eyeglasses which are derived from an eye examination, including all of the information specified by state law, if any, necessary to obtain lenses for eyeglasses.

(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 to the patient one copy of the patient's prescription immediately after the eye examination is completed. Provided: An ophthalmologist 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 ophthalmologist's or optometrist's examination fee as a condition to releasing the prescription to the patient. Provided: 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 or require the patient to disclaim the accuracy of the ophthalmic goods and services seller.

§ 456.3 Federal

This rule d ophthalmolog employed by governmenta

§ 456.4 State practice.

(a) It is an any state or

(1) Prevent persons from entering into joint-owners

(i) Prohibit optometrists optometrists services to ti

(ii) Prohibit persons other entering into

agreements, agreements entities to p or ophthalm public;

(iii) Prohibit persons other entering into

(including th sharing of re forming enti services or services to

(iv) Prohibit leasing spat optometrist

services to optometrist for such sp under such percentage

(v) Prohibit business as practice or optometric and service

(2) Limit may be ow optometris

any of the § 456.4(a)(1 an owner c

personal a office for a

(3) Prohi

(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 ophthalmic goods and services dispensed by another seller.

§ 456.3 Federal or State employees.

This rule does not apply to ophthalmologists or optometrists employed by 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:

(1) Prevent or restrict optometrists from entering into associations with lay persons or corporations by:

(i) Prohibiting persons other than optometrists from employing optometrists to provide optometric services to the public;

(ii) Prohibiting optometrists and persons other than optometrists from entering into partnership agreements, joint-ownership or equity-participation agreements, or profit-sharing agreements for the purpose of forming entities to provide optometric services or ophthalmic goods and services to the public;

(iii) Prohibiting optometrists and persons other than optometrists from entering into franchise agreements (including those that provide for the sharing of revenues) for the purpose of forming entities to provide optometric services or ophthalmic goods and services to the public;

(iv) Prohibiting optometrists from leasing space from persons other than optometrists to provide optometric services to the public or prohibiting optometrists from entering into leases for such space where rental payments under such leases are based on a percentage of revenues; or

(v) Prohibiting lay control over the business aspects of an optometric practice or an entity formed to provide optometric services or ophthalmic goods and services to the public;

(2) Limit the number of offices that may be owned or operated by optometrists or by entities formed by any of the agreements covered by § 456.4(a)(1) of the rule; or require that an owner of branch offices remain in personal attendance at each branch office for a specific percentage of time;

(3) Prohibit optometrists, or any

entities formed by any of the agreements 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 any of the agreements 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 a name other than the name shown on their licenses or certificates of registration; or require the disclosure in advertising of the names of all optometrists practicing at a given advertised location or practicing under a trade name.

(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 other monetary liability under any section of the Federal Trade Commission Act.

§ 456.5 Declaration of Commission intent.

(a) The provisions of § 456.4(a)(1)-(4) are not intended to interfere with the exercise of state or local governmental authority to protect the health and welfare of the public. In exercising its authority to safeguard the health and safety of eye care consumers or to protect the public from unfair or deceptive practices or anticompetitive conduct, a state or local government can enact regulation that has the incidental effect of preventing an individual optometrist or optometric firm from engaging in a specific agreement or activity covered by § 456.4(a)(1)-(4), as long as such regulation does not distinguish between optometrists or optometric firms that engage in any of the agreements or activities enumerated in § 456.4(a)(1)-(4) and optometrists or optometric firms that do not engage in such agreements or activities. For example, the rule does not prevent states or local governments from prohibiting the location of an optometric practice in an area that could create a public health or safety hazard, or from enforcing a general zoning regulation, even though such prohibition or regulation had the incidental effect of preventing an optometrist from locating in some specific commercial location. While the rule affects state or local regulation of the business aspects of the practice of optometry, it is not intended to interfere with the authority of a state or local government to:

(1) Prohibit improper lay interference

in the ophthalmic care provided a patient by an optometrist;

(2) Require that the optometric services provided at a branch office be supplied by a person qualified to do so under state or local law;

(3) Require that the identity of an optometrist be disclosed to a patient before, after, or at the time optometric services are performed;

(4) Prevent the deceptive use of trade names or prevent trade name infringement; or

(5) Establish and maintain minimum quality standards for ophthalmic goods or services.

(b) The Commission intends that this rule may be used as a defense to any proceeding of any kind that may be brought against any optometrist, or any entity formed by any agreement covered by § 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.

(c) 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.

(d) The rule, each subpart, and the Declaration of Commission Intent and their application are separate and severable.

Separate Statement of Chairman Daniel Oliver, Ophthalmic Practice Rule Statement of Basis and Purpose

When the Commission voted to promulgate the Ophthalmic Practice Rule, I questioned the use of the Federal Trade Commission rulemaking authority to strike down state laws that restrict competition in the eye care market. Based on principles of federalism, I voted against the proposed rule.

The restraints at issue are clearly anticompetitive and adversely impact consumers. They illustrate what I have said a thousand times: it is government that is the primary source of restraints on competition.

Nevertheless, I continue to believe that this harmful effect on consumers does not allow us to strike down anticompetitive state activities that are protected by the "state action" doctrine. I reiterate my conclusion that the Commission lacks the authority to promulgate the Ophthalmic Practice Rule.

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