STATE RESTRICTIONS ON VISION CARE PROVIDERS: THE EFFECTS ON CONSUMERS ("EYEGLASSES II")

Report of the Staff

to the Federal Trade Commission

BUREAU OF CONSUMER PROTECTION

JULY 1980

STATE RESTRICTIONS ON VISION CARE PROVIDERS
THE EFFECTS ON CONSUMERS
("EYEGLASSES II")

Report of the Staff
to the Federal Trade Commission

by

Gary Hailey
Christine Latsey
Scott P. Klurfeld
Elizabeth R. Hilder
Erica L. Summers
Renate Kinscheck
Terry S. Latanich

ACKNOWLEDGEMENTS

The staff wishes to acknowledge the valuable assistance provided to it by the following individuals:

Dianne Dusman, Jill Siegel, Gail Jensen, and Mark Baribeau performed a variety of tasks, including research, editing and proofreading, with speed and diligence.

Duane Fink, Bonnie Linn, and Elaine Lucas typed the report, patiently accepting the thousands of changes and revisions requested by the staff between first draft and final product.

Finally, several members of the Bureau of Economics (particularly Ronald Bond and John Phelan) answered in terms that lawyers could understand many questions on economic and statistical topics.

PREFACE

In this Staff Report to the Federal Trade Commission, the Bureau of Consumer Protection recommends that the Commission publish for comment an Advance Notice of Proposed Rulemaking concerning private and public restrictions which affect providers and consumers of ophthalmic goods and services.

By making this Staff Report public at this time, the Commission hopes to provide information about those restrictions to the public and to focus current debate about their effects. However, nothing in the Report is intended to limit the form or substance of public comment on the proposed rule.

The Commission has not adopted any of the findings or conclusions presented in this Report.

Table of Contents

July 3, 1980

Division of Professional Services
Bureau of Consumer Protection

Eyeglasses II Investigation -- Staff Recommendation
that Commission Propose a Trade Regulation Rule

Commission

INTRODUCTION

In this report, we recommend that the Commission propose amendments to the Eyeglasses I Rule and new trade regulation rule provisions under the authority of Section 18 of the FTC Act to subject to scrutiny some, but not all, of the issues raised in our Eyeglasses II investigation.

The restrictions at issue in Eyeglasses II fall into two distinct categories: (1) form of practice restrictions, and (2) scope of practice restrictions. In the first category, we are examining restrictions imposed primarily on optometrists and opticians which limit the ability of those professionals to work for "for-profit" corporations, restrict the number of offices which they may operate, limit the locations at which they may practice (e.g., proscribe the location of an optometric practice in a mercantile establishment or a shopping center), or prohibit the use of a trade name. This first category of restrictions, which we will term restrictions on "commercial practice," are intended primarily to restrict the growth of high-volume, "chain" vision care outlets. For the reasons discussed in this report, we recommend that the Commission propose a trade regulation rule which would remove total bans on commercial

ophthalmic practice.

In the second category, scope of practice limitations, we have focused on two restrictions. First, we have conducted an inquiry into the effect on consumers of state laws which restrict the fitting of contact lenses to ophthalmologists and optometrists, excluding opticians from that market. We have worked closely with representatives of those three groups to design and administer a study of patients to arrive at comparative measures of cost and quality of care delivered by members of those groups.

For the reasons discussed later in our report, we do not recommend that the Commission propose a trade regulation rule preempting state laws on the fitting of contact lenses. Our study data show that existing entry requirements for contact lens fitters may exclude many competent providers and force consumers to spend more than necessary to obtain quality contact lens care. Our recommendation not to include this issue within the rulemaking is founded in our concern that effective Commission action would raise serious questions of federal-state relations, and would encounter severe remedial difficulties. It is our recommendation that the Commission continue its work in this area with the goal of developing a report and model law for submission to the states for their consideration.

The second group of scope of practice restrictions we have investigated are state-imposed restrictions on the duplication of lenses by opticians. A number of states make it illegal for an optician to duplicate an existing pair of eyeglasses

without having a signed prescription from an optometrist or ophthalmologist. If a consumer cannot have a broken lens replaced or a duplicate pair of eyeglasses prepared from an existing pair, he or she may be forced to undergo a potentially unnecessary eye examination.

We have conducted a survey to measure the adequacy of duplication by opticians in states where they are permitted to perform that task. We recommend that the Commission include this issue within the proposed rulemaking. Although this issue involves a state scope of practice determination, the course we recommend to the Commission would not involve a preemption of state laws. Rather, our recommendation would simply modify the current prescription release requirement of the Eyeglasses I Rule so that consumers could obtain replacement eyeglass lenses by presenting their original lens specifications. Such a rule would effectively eliminate the possibility of duplication error, yet would allow the states to place an expiration date on the prescription to control the length of time during which duplications may be obtained. Our recommendation would mitigate the current consumer loss without preempting state laws and would elevate the level of eyeglass quality currently received by consumers who desire duplicate or replacement eyeglasses which contain the visual correction present in their existing eyeglasses.

The Eyeglasses II investigation was authorized by the Commission on January 19, 1975. The original Commission authorization grew out of the Eyeglasses I investigation, which culminated

when the Commission adopted the first final Magnuson-Moss Trade Regulation Rule on The Advertising of Ophthalmic Goods and Services (16 C.F.R. Part 456). When we recommended that the Commission propose the Eyeglasses I Rule, we recommended that other restrictions in the ophthalmic market which appeared to increase consumer costs for vision care and to decrease consumption of those goods and services, but which did not offer consumers commensurate benefits in terms of increased quality or protection, be investigated. The Eyeglasses II investigation did not begin in earnest until the conclusion of the Eyeglasses I proceeding, because the staff members assigned to Eyeglasses II were also responsible for conducting that proceeding.

The Eyeglasses II investigation is best described as one of the Commission's "second-generation" rulemaking proceedings. In the months following adoption of the Magnuson-Moss Act, the Commission proposed numerous trade regulation rules. In the years which followed, the Bureau of Consumer Protection underwent a transition from being primarily litigation-oriented to being primarily rulemaking-oriented. As evidenced by the report of the Administrative Conference of the United States, as well as the Commission's response to that report, we have learned a considerable amount about how to conduct a rulemaking proceeding.

The Eyeglasses II investigation has made extensive use of market studies not only to measure the prevalence and economic impact of the practices under investigation, but also to test and measure the efficacy of the remedial alternatives being considered. In the sections of this report which follow, we will

detail the survey research which we conducted. It is important to note that in our efforts to conduct good research we have enjoyed the support and cooperation of the professional groups whose members would be most affected by Commission action. The American Academy of Ophthalmology, the American Association of Ophthalmology, the American Optometric Association, the Opticians Association of America, the National Association of Optometrists and Opticians, and other groups have provided us with expert advice and technical support in designing and administering our studies and surveys. Without this cooperation, it would have been much more difficult to conduct these studies. Even more importantly, the dialogue which occurred between the Commission's staff and these professional groups has, we hope, demonstrated the objective nature of our inquiry and mitigated the adversarial atmosphere which inevitably surrounds investigations of this importance.

Quality of Care -- The Commission's Role

In each of the sections of this report detailing the specific questions under investigation, we respond in detail to the so-called "quality of care" defense. We believe that it is necessary to provide the Commission with a broader perspective on this issue because it is a potentially volatile issue which will be present in virtually all of the Commission's activities affecting the delivery of health care.

In the Occupational Deregulation Program and other health care matters currently being considered within the Bureau of Consumer Protection, it is invariably asserted by defenders

of the status quo that prevailing restrictions are necessary to maintain and protect the quality of care delivered. In some instances, restrictive regulations may maintain or elevate the quality of care. In other cases, the quality defense is little more than a public relations technique employed by a profession to fend off governmental or public scrutiny of anticompetitive or anti-consumer conduct which results in consumer injury. We believe that the Commission must be willing to give the staff the time and resources necessary to study and assess the quality of care defense to determine whether restrictive private conduct or state laws which seemingly cause economic injury to consumers are actually necessary to protect the public health, safety and welfare.

In considering the quality of care issue, we believe that the Commission (or any other decisionmaking body) must be careful to examine all aspects of the quality issue, not only the level of care received by those who can afford it. The critical inquiry is that of "aggregate" quality, not "delivered" quality. In examining restrictions on how and by whom professional services are delivered, we must be careful not to focus solely on those members of society who actually obtain care. The effects of unnecessarily restrictive regulations may be to make care less accessible, or less frequently accessible to some segments of our society. Thus, it is imperative that we also consider the "no-care" component of quality. Difficult questions will inevitably arise as to whether the level of care available should be maintained at a specified level through restrictive regulation

even if the result is to deny any care at all to some members of society because of the costs imposed by that regulation. It is our belief that before a decision of that magnitude can be made, we must provide the Commission with the best available evidence addressing the extent and magnitude of the cost/quality trade-off. We have tried to produce such evidence in this proceeding.

The difficulty, however, is that the evidence produced on the cost and quality issues will seldom, if ever, result in a clear-cut outcome. The decisions will be difficult ones because they may involve trade-offs between cost and quality. We recognize that while the Commission may at some point be faced with a situation where the removal of restrictions on how and by whom professional services are delivered could result in such a trade-off (i.e., removal would alleviate the "no care" problem but would also lower the overall quality of care delivered), the evidence shows that this is not an issue in Eyeglasses II.

We believe that the validity of a quality defense often cannot be determined without conducting a thorough investigation. In some cases we may find that the conduct being investigated is justified to protect the public health and welfare. Should our investigation demonstrate that particular forms of regulation are indeed appropriate and protect the public with a minimum of economic costs being imposed, we will have accomplished an important objective. By gathering reliable data with respect to alternative providers and forms of practice, we will have made a significant contribution to health care decisionmaking.

The Staff Report

In the past, there has been criticism of staff reports recommending proposed Magnuson-Moss trade regulation rules. Within the Commission there has been concern that the Staff Reports were unnecessarily lengthy, and may have become too advocative. Outside the Commission, staff reports have been criticized as conclusory and have been put forth as proof that the staff had prejudged the issues under consideration. Cognizant of these criticisms, we have attempted to present the results of our investigation concisely, and to present the facts in a balanced fashion.

In addition, we have made a deliberate effort to minimize the length of our report. We were able to shorten our report to some extent because we chose not to repeat information contained in the final Eyeglasses I Staff Report. Thus, we have not included within this report detailed background on the industry and the consumer market, except to the extent that it is necessary to understand the market and how it varies with respect to the restrictive state laws under investigation.

Access to the Record

Brief mention should be made of how members of the public may review the evidence cited in the staff report. First, references to documents contained in the Eyeglasses I record include the author, title, publication information, public record exhibit number (e.g., "Exhibit III-1") and the record page number within the exhibit which supports the text (e.g., "at R.12345"). Citations to the Eyeglasses I Final Staff Report and Presiding

Officer's Report also have the actual page numbers from the report noted in parentheses (e.g., "(p.120)"). Citations to witness' testimony at the public hearings in the Eyeglasses I proceeding include the name and affiliation of the witness, the transcript page at which his or her testimony begins, and the specific transcript page which supports the text (e.g., "Tr. 2000 at 2020"). References to hearing exhibits from the Eyeglasses I proceeding are identified as HX ___; record page numbers are not included because the hearing exhibits are not paginated.

Documents cited in this report which are not on the record include all of the relevant bibliographical information, and citation to the document page number. Copies of the Bureau of Consumer Protection's study on the duplication of lenses without a prescription (entitled "A Comparison of a Random Sample of Eyeglasses"), the Eyeglasses I Staff Report (entitled "Staff Report on Advertising of Ophthalmic Goods and Services and Proposed Trade Regulation Rule (16 CFR Part 456)"), and the Bureau of Economics study on commercial practice (entitled "Staff Report on Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry") which are discussed in this report may be obtained from: Public Reference Room (Room 130), Federal Trade Commission, 6th and Pennsylvania Ave., N.W., Washington, DC 20580, telephone (202) 523-3467.

Rulemaking Procedures

Several Magnuson-Moss rules proposed by the Commission in

the recent past (namely, Children's Advertising,[1] R-Value,[2] and Standards and Certification[3] have employed modified versions of the rulemaking procedures specified in Section 1.13 of the Commission's Rules of Practice. We believe that the procedures to be followed in this proceeding, should the Commission choose to follow our recommendation and propose a rule, are of critical importance.

We do not favor the use of the bifurcated hearing procedure employed in the Children's Advertising Rule for this proceeding. In the Eyeglasses II proceeding, the critical evidence consists of market studies measuring the cost and quality of care provided in differing modes of practice and from different kinds of health care providers. Consistent with our investigatory efforts, we believe that it is critical that both consumer and industry representatives be given the opportunity to cross-examine in detail the studies which are the foundation of our investigation. Industry groups bring to a rulemaking proceeding considerable sophistication in the operation of their industries, in this case both on economic and quality of care issues. We believe the quality of the record ultimately presented to the Commission

---

1 Children's Advertising, Proposed Trade Regulation Rulemaking and Public Hearing, 43 Fed. Reg. 17,967 (1978).

2 Trade Regulation Rule on Labeling and Advertising of Home Insulation, 16 C.F.R. Part 460; Statement of Basis and Purpose, 44 Fed. Reg. 50,218 (1979); Home Insulation, Proposed Trade Regulation Rule, 42 Fed. Reg. 59,678 (1977).

3 Standards and Certification, Proposed Trade Regulation Rule, 43 Fed. Reg. 57,269 (1978).

would suffer if the industry groups were not permitted to conduct their own cross-examination.

Similarly, we believe that the staff must be able to cross-examine surveys and studies submitted by other groups during the course of the rulemaking proceeding. During the course of our investigation we have gained substantial experience in conducting survey research on the issues in this matter, which a presiding officer cannot bring to the proceeding. We cannot overemphasize our belief that limiting the ability of the industry and the staff to cross-examine studies which form the foundation of a good rulemaking record will ultimately weaken the record presented to the Commission and lessen the credibility of the proceeding.

Based on the experience of the staff assigned to this proceeding in conducting the first two final Magnuson-Moss Rules (Vocational Schools and Eyeglasses I), we believe that the delay factor attributed to cross-examination is grossly overstated. In Eyeglasses I, for example, the entire public hearing phase of the proceeding was completed in three months, notwithstanding the fact that we held hearings in five different cities. In the Advance Notice of Proposed Rulemaking we have described the different hearing procedures which could be used if the Commission proposes a rule in Eyeglasses II and have asked for comment on which format should be followed in this proceeding.

We recommend that the Commission convene only two public hearings: the first in Washington, D.C., to permit us to present

our studies and subject our consultants and survey designers to cross-examination, and the second in a western city, either Los Angeles or Denver. This geographic split will facilitate public involvement in the hearing process, while minimizing the unnecessarily repetitive aspect of numerous public hearing sites. We project three weeks of public hearings in each site, with the entire public hearing process being completed in two months; that is, three weeks of hearings, three weeks off between sites, and then the final three weeks of public hearings.

Finally, we recommend that the Commission employ a one-notice concept in this proceeding. The Commission has developed some expertise in the ophthalmic market through its involvement in Eyeglasses I. Through the extensive dialogue which has taken place between the staff and industry groups, the process of issue identification has been essentially completed. Thus, we recommend that the Commission issue a single notice of proposed rulemaking, designating the issues which will serve as the focus of the proceeding, setting forth the hearing sites and times, as well as the procedures for submitting materials to the rule-making record.

With the exception of the aforementioned modifications, we recommend that the Commission adhere to the basic 1.13 procedures for Magnuson-Moss rulemaking.

APPROVED:

Michael C. McCarey, Assistant
Director for Professional Services
Bureau of Consumer Protection

RESPECTFULLY SUBMITTED:

Gary D. Hailey

Christine Latsey

Scott P. Klurfeld

Elizabeth R. Hilder

Erica L. Summers

Renate Kinscheck

Terry S. Latanich

I. Commercial Practice

A. Introduction

As part of the Eyeglasses II investigation, we examined restrictions on the practice of optometry and opticianry in commercial settings. This aspect of our investigation deals with structural restraints in the retail ophthalmic industry which restrict the permissible modes of commercial practice. We have focused on four major restrictions which limit the form and location of practice within the ophthalmic professions: (1) restrictions on the employment of a licensed professional by an unlicensed person or non-professional corporation; (2) restrictions on the location of a practice in a mercantile or commercial setting; (3) restrictions on the number of branch offices which an individual practitioner or firm may operate; and (4) restrictions on the right of a practitioner or corporation to practice under a trade name.

In the Eyeglasses I rulemaking proceeding, we found that advertising prohibitions were only part of a comprehensive network of public and private restrictions regulating the form and mode of practice in the ophthalmic professions. Evidence from that proceeding led both the staff and the presiding officer to conclude that restrictions on the permissible form and location of practice may limit competition, increase the cost and decrease the availability of vision care.[1] Some witnesses testified

---

[1] Bureau of Consumer Protection, Federal Trade Commission Staff Report on Advertising of Ophthalmic Goods and Ser- (Footnote Continued)

that consumers would not receive the full benefits from the removal of restrictions on advertising unless these business practice restraints were removed as well.[2]

States have argued that restrictions on commercial practice are necessary to protect the public health and safety by ensuring the quality of vision care. The principal questions we will address in our discussion, therefore, are how these restrictions affect the price, quality and accessibility of vision care. In our investigation we sought to determine not only whether higher prices and lower accessibility are attri-

---

1 (Footnote Continued)

vices and Proposed Trade Regulation Rule, Exhibit XIII-2 at R. 24492 (p. 120) (May 1977) [hereinafter cited as Staff Report]; Report of the Presiding Officer on Proposed Trade Regulation Rule Regarding Advertising of Ophthalmic Goods and Services, XIII-1 atR. 24235-36 (pp. 61-62) (December 10, 1976) [hereinafter cited as Presiding Officer's Report].

2 It has been argued that high-volume practices which are limited or entirely prohibited by commercial practice restrictions are the ones most likely to take advantage of the opportunity to advertise. High-volume retail optical firms, capitalizing on economies of scale in both purchasing and distribution of ophthalmic goods, may be able to pass these savings on to the consumer in the form of lower prices. Thus, if advertising is permitted but the restrictions on form and location of practices exist, then these economies of scale may be lost. See, e.g., Testimony of R. Burr Porter, Ph.D., on behalf of National Association of Optometrists and Opticians [hereinafter cited NAOO], Tr. 6264(e) and (v); Testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr 6207; Comment of J.A. Miller, Executive Director of Opticians Association of America, R. 17377 [hereinafter cited as OAA]; Presiding Officer's Report supra note 1, at R. 24224 (p. 50) (lower prices may not come about in the face of these other serious limiting factors).

butable to these restraints, but also whether there are any offsetting consumer benefits which result from these restrictions, with special attention being given to assessing their impact on the quality of care.[3]

B. Industry Background

The Eyeglasses I Staff Report provided the Commission with a thorough general description of the retail optical industry.[4] We will not repeat the discussion in this report, except to update the relevant statistics on sales and market shares of the competing segments of the market. In addition, we will discuss the market trends in the area of commercial practice.

Commercial practice in the retail optical industry is generally understood to refer to large-scale, high-volume practitioners who make heavy use of advertising and locate in easily accessible high consumer-traffic locations. While commercialists have long existed in the vision care market, the application of modern marketing concepts to this field has resulted in a rapidly growing group of competitors.

---

3 Price and quality comparisons will be made between the "commercial" and the "professional" providers in the industry. Commercial practice refers to the high-volume practitioner who is often employed by a non-professional or "lay" corporation and usually located in a shopping center, department store or other type of commercial building. "Non-commercial" or "professional" optometrists or opticians are usually those who practice as solo practitioners or in small group practices. The term "professional" as used in this context in no way refers to the ethics, integrity or competency of the practitioner.

4 Staff Report, supra note 1, at R. 24195-24205 (pp. 11-31).

There are two basic types of commercial optical centers. Some, known as "full service" outlets, employ one or more optometrists to provide eye examinations, and one or more dispensing opticians to fit and sell eyeglasses. Customers can thereby have their eyes examined and their prescriptions filled at the same location. Some stores, because of state law limitations, may employ only opticians, who fill prescriptions which have been brought from ophthalmologists or optometrists who practice elsewhere.

A variety of forms of commercial optometric practice have evolved in response to state law restrictions. One is the straight optical chain in which a retailer, often a corporation, employs optometrists at a number of stores. A second type is the leased department. Where corporate employment of optometrists is prohibited, optical retailers may lease space to optometrists, thus enhancing the convenience of an optical dispensary at the same location. Some states ban both corporate employment and lease arrangements, and this produces a third type of practice, the side-by-side operation. In this form, an optometric practice is located next to an optical dispensary, thus permitting referrals from one office to another.

In 1977, there were approximately 20,000 optometrists[5] and

---

5 Bureau of Health Manpower, U.S. Dep't of Health, Education and Welfare, Supply of Optometrists in the United States at Table 3 (1978) [hereinafter cited as DHEW, Supply of Optometrists].

12,000 opticians[6] in active practice. No estimates are available on how many of those might be classified as commercial practitioners. It is clear that the vast majority of optometrists are "non-commercial" or professional practitioners. Most are solo practitioners, although increasing numbers are turning to partnership or group practice.[7]

Although most optometrists are self-employed, there has been an increase in the proportion of optometrists under salaried employment.[8] Many of those are employed either by other optometrists or in the military.[9] 1975 figures indicate that about 3% of the full-time optometrists in active practice in 1975 were employed by large optical chains, department stores, or independent opticians.[10] However, there is strong reason to believe that this figure understates the actual number of commercially employed optometrists.[11]

---

6 U.S. Dep't of Health, Education and Welfare, Health, United States, 1976-1977 Table 112 (1977).

7 DHEW, Supply of Optometrists, supra note 5 at 2.

8 U.S. Dep't of Health, Education and Welfare, A Report to the President and Congress on the Status of Health Professions Personnel in the United States, VI-3 (1978).

9 Id. Generally, newly graduated optometrists are more likely to be salaried employees than longer practicing optometrists. Id.

10 Gordon R. Trapnell Consulting Actuaries, The Impact of National Health Insurance on the Use and Spending for Sight Correction Services, (January 1976), Exhibit II-68 at R.1967.

11 The Trapnell report, supra note 10, used manpower data gathered by the American Optometric Association in 1973.

(Footnote Continued)

About 70% of opticians active in 1969 were employed in "independent" retail optical establishments.[12] At that time, approximately 9% of all active opticians were employed by optometrists, ophthalmologists or other physicians, and between 3% and 4% were employed in department store optical departments.[13] In view of the dramatic growth during the past ten years in drug and department store optical establishments, the current distribution of opticians may be very different from the 1969 figures.

Industry observers estimate that consumers spent approximately three billion dollars on ophthalmic goods in 1978, and an additional one billion dollars for eye examinations.[14] Chain

---

11 (Footnote Continued)

In arriving at estimates for 1975, Trapnell used a straight growth rate of 2% per year. However, it is likely that the proportion of commercially employed optometrists has grown since 1973, since there has been a tremendous expansion in commercial practice in the past few years. Searle, the largest commercial retailer, did not enter the market until 1974. Thus, we doubt that Trapnell's estimates reflect the current situation.

12 U.S. Dep't of Health, Education and Welfare, Health Resources Statistics, Table 126 at p. 190 (1976-1977).

13 Id.

14 Telephone interview with Edward A. Porter, Group Counsel, Opticks, Inc., by Gary D. Hailey, FTC Staff (April 3, 1979), [hereinafter cited as Porter Interview]. These are generally the amounts that are quoted in discussions of the retail ophthalmic market. See, e.g., "G.D. Searle Trying Once Again for the Right Acquisition Mix," Business Week, Mar. 19, 1979, at 150 (2.7 billion dollars for eyeglasses and contact lenses); "Drugstores See Boom in Eyeglasses," Business Week, Feb. 13, 1978, at 116 (3 billion). Statistics on the retail ophthalmic market are not readily avail-
(Footnote Continued)

optical stores held 12-15% of the market for retail eyewear; drug chain and department stores accounted for about 3%.[15]

The largest retailer of ophthalmic goods is G.D. Searle & Company. Searle entered the market in 1974 and, by the end of 1978, had over 400 outlets in 28 states. Operating under the trade name of Pearle Vision Centers in most areas, and Hillman Kohan Vision Centers in New York and New Jersey, these stores had sales of 91 million dollars in 1978.[16] Searle is currently experimenting with specialized contact lens outlets.

The second largest optical retailer is Cole National Corporation which entered the market in the mid-1960's. Cole National operates optical departments in leased space in Sears, Roebuck & Company and Montgomery Ward stores. In 1977, Cole operated 373 optical departments and had over 54 million dollars in total sales.[17] Cole National currently operates over 420 retail outlets

---

14 (Footnote Continued)

able. Published government data are not very useful because ophthalmic goods are included within the broader category of "Eyeglasses and Other Appliances." In our Staff Report on Eyeglasses I we quoted figures cited in Gordon Trapnell's report, supra note 10, which estimated, based on adjustments to U.S. government statistics, that expenditures for eye examinations in 1975 were 1.1 billion dollars. Because of uncertainty about the government statistics, we have chosen in this report to use industry figures.

15 Porter Interview, supra note 14.

16 G.D. Searle & Co., 1978 Annual Report at 16.

17 Cole National Corporation, 1977 Annual Report at 9.

in department stores in 36 states.[18]

Drug chains began to become a significant factor in the retail optical market in 1973. By 1977, there were over 200 outlets operated by about 20 drug chains.[19] A 1979 report on drug chain dispensing indicated there are at least 30 drug chains with some form of optical department.[20] These optical centers employ one or more dispensing opticians, but at this time generally do not offer eye examination services.[21]

The growth of commercial chains in optical retailing has affected other segments of the industry as well. Many of the large retailers have opened their own wholesale optical laboratories. In 1977, Cole National operated seven labs which processed only prescriptions from Cole optical departments.[22] At least 20 of the 30 dispensing drug chains report using their own labs.[23]

While there has been dramatic growth during the last 10 years in optical retailing, the impact of these changes on

---

18 "OMA Spotlights Stiff Challenges Ahead for Industry and Dispensing Professions" 20/20, Jan./Feb. 1980, at 72.

19 "Optical Departments Facing Some Problems," American Druggist, Aug. 1977, at 38.

20 "Update on Chain Optical Dispensing, Part 2" Optometric Monthly, Feb. 1979, at 44 [hereinafter cited as Optometric Monthly].

21 Id. at 45.

22 Cole National Coporation, 1977 Annual Report at 9.

23 Optometric Monthly, supra note 20, at 44.

independent dispensers and solo practicing optometrists is not precisely known. One industry observer estimated that among dispensing opticians, the market share of the so-called "independent" optician dropped from 86% in 1973 to 60% in 1978.[24] A 1979 industry survey of 2,000 consumers indicated that, in 1978, local optometrists lost in sales of eyeglasses to chain optical shops, but that local independent opticians held their sales level.[25]

C. Analysis of State Laws

The goal of restraints on commercial practice generally is the elimination of the chain or volume practice.[26] The primary justification offered for these restraints is that volume practice and the intervention of unlicensed personnel into the delivery process lower the quality of care.[27]

There are various means of achieving this goal, and each is discussed separately below. However, all of these restrictions are simply different routes to the same end. Although the imposition of one type of commercial practice restriction may in some instances be enough to achieve the desired effect

---

24 "Drugstores See a Boom in Eyeglasses," Business Week, Feb. 13, 1978, at 116.

25 Ettore, Fashion Fuels in the Eyeglass Business, New York Times, July 25, 1979, § D, at 1, col. 4.

26 See Summary of Comments by State and Local Governmental Officials on Notice of Staff Intent to Recommended Rulemaking, Appendix A, notes 10 and 11 [hereinafter cited as Summary of Comments].

27 Id. at notes 12-17 and notes 20-22.

of eliminating commercial practice, our analysis of state laws indicates that if one type of form of practice restriction is imposed, others usually also exist.

In our discussion of state laws, we focus on those restrictions affecting optometrists and opticians. No data are given about restrictions affecting ophthalmologists. The practice of ophthalmology, a medical specialty, involves functions and activities beyond the scope of the Eyeglasses II investigation. However, to the extent that an ophthalmologist limits his or her activities to those which are the subject of this investigation, (i.e., diagnostic eye examinations), the Commission may wish to cover them in the proposed rule.

1. Restrictions on the Employment of Optometrists and Opticians by Commercial Firms and Lay Individuals.

Our analysis of state laws indicates that there are generally two categories of laws restricting the ability of optometrists and opticians to work for an unlicensed person or corporation. A substantial number of states make it illegal for an optometrist to work for either a "lay" individual[28] or corporation[29] or for an optician. A smaller group of states restrict the ability of opticians to work for non-opticians or lay corporations in dispensing eyewear.

---

28 A "lay individual" as it is used here means a person who is not licensed to practice optometry.

29 A "lay corporation" as it is used here (and throughout this report) means a nonprofessional or business corporation.

Lay employment restrictions prevent a non-licensed person or firm from owning a share of an optometric or optical firm.[30] This type of restriction limits the availability of equity or venture capital for optometric and optical practices.[31] Outside capital, which is often necessary to finance the expansion of a business,[32] can come from two different sources: investors,

---

30 "No corporation shall engage in the practice of optometry under any lease, contract or other arrangement whereby any person not duly authorized to practice optometry, shares directly or indirectly, in any fees received in connection with said practice of optometry."

N.H. Rev. Stat. Ann § 327:27. See also Mass. Gen. Laws Ann. ch 112 § 72 (West); N.C. Gen. Stat. § 90-125.

"It shall be unlawful for any person to practice or offer to practice as a dispensing optician as an employee of any person not engaged primarily in the practice as dispensing optician as a licensee under this chapter, or of any firm or corporation not engaged primarily in the practice of dispensing opticians under the actual and personal supervision of partners, officer, manager or stockholders who possess valid unrevoked licenses as dispensing opticians entitled to practice within the state of Tennessee in accordance with the provisions of this chapter."

Tenn. Code Ann. § 63-1403 (d).

31 Equity or venture capital means that the investor owns a share of the business. While a lender is often more concerned with repayment of his or her loan, an investor is primarily concerned with the business' potential for future returns as a result of capital appreciation. Hence, the investor may be more willing to take a risk and invest a larger sum of money than a lender would be willing to lend. See, e.g., J. Weston & E. Brigham, Essentials of Managerial Finance (4th ed. 1977).

32 As mentioned earlier, it is often desirable to expand one's business in order to achieve the necessary volume of busi-
(Footnote Continued)

who, by investing in the business, become part owners; and lenders. If equity capital is not available to optometric and optical practices because of state restrictions outlined above, the alternative is debt financing which usually occurs through bank loans. This is usually a more costly method of financing expansion because it involves a loan and may also mean that lesser sums will be available for financing than could be obtained through equity capital. If it becomes too costly to obtain capital because of these restrictions on the use of outside capital, the expansion of optometric and optical practices to their most efficient volumes may be discouraged.

a. Employment of Optometrists

Restrictions on the employment of optometrists by anyone other than licensed optometrists or professional corporations controlled by optometrists are imposed in a variety of ways. In twenty-four states, these restrictions are explicitly imposed by statute.[33] Generally, these statutes provide that it is unprofessional conduct or an illegal practice for an optometrist to accept employment directly

---

32 (Footnote Continued)

ness to receive discount purchases of supplies and otherwise to reduce costs of production and distribution. Such efficiencies may then be passed on to the consumer in the form of lower prices.

33 Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Maine, Massachusetts, Montana, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Oklahoma, Rhode Island, South Dakota, Tennessee, Virginia, and West Virginia.

or indirectly from either a lay individual or non-professional corporation, or that it is unlawful for a lay individual or non-professional corporation to engage the services of an optometrist upon a salary or commission basis.[34]

---

34 "No optometrists shall engage in the practice of optometry with any organization, corporation, group or lay individual. This provision shall not prohibit optometrists from employing or from forming partnerships or professional associations with optometrists licensed in this state." Fla. Stat. Ann. § 463.014 (c) (West) (1979 Supp).

"The practice of optometry in a corporate capacity is prohibited, but this prohibition shall not apply to a professional corporation formed pursuant to this article . . ." Col. Rev. Stat. § 12-40-122.

In enacting these statutory restrictions some states also have enacted a "grandfather clause" which exempts from the restrictions those optometrists who are engaged in the "unlawful practice" as of the effective date of the statute. For example, the state of Virginia has enacted a grandfather clause which provides:

> No registered optometrists shall practice optometry as an employee, directly or indirectly, of any commercial or mercantile establishment nor shall he so advertise himself or through such commercial or mercantile establishment, unless such commercial or mercantile establishment was employing a full-time registered optometrist in its established place of business on June twenty-first, nineteen hundred thirty-eight. Va. Code § 54-388(2)(k).

Interestingly, a circuit court in Virginia (S. Galeski Optical Co. v. Virginia State Board of Examiners in Optometry, et al., Chancery No. G-3602-1) on February 6, 1980, ruled that the above grandfather clause does not apply to entities but rather only to business locations. Thus, the clause applies only to those established locations of a firm which employed full-time optometrists as of June 21, 1938, and not to branches of the same company opened subsequent to the effective date of the statute.

In addition to prohibiting employment of optometrists by lay persons or firms, some of these statutes appear to preclude any type of financial association between optometrists and lay persons. For example, one type of statute provides that an optometrist shall not associate himself or herself in any way with a person who is not a licensed or registered optometrist.[35] Another type of statute provides that an unlicensed individual or firm shall not engage the services of an optometrist upon a lease arrangement as well as upon a salary or commission basis.[36]

In addition to the twenty-four states with express statutory employment restrictions, there are eight additional states with statutory provisions making it illegal "to split or divide a fee with an unlicensed person" or "to aid or abet an unlicensed

---

35 "Association for the joint practice of optometry with any person, corporation or partnership not licensed to practice optometry or another of the healing arts [shall be deemed unauthorized]." Me. Rev. Stat. Tit. 32, § 2435.

An equally broad provision is found in Connecticut's optometry act. It provides that "no unlicensed person shall engage indirectly in such practice by utilizing for commercial benefit or pecuniary gain the profesional services of any licensed optometrist." Conn. Gen. Stat. Ann. § 20-133a.

36 "It is likewise unlawful for any corporation, lay body, organization, group, or lay individual to engage or undertake to engage in, the practice of optometry through means of engaging the services upon a salary, commission or lease basis, or by other means or inducement, any person licensed to practice optometry in this state." Fla. Stat. Ann. § 463.11(3). See e.g., N.H. Rev. Stat. Ann. § 327:27; R.I. Gen. Laws § 5-35-20(1).

person in the practice of optometry."[37] These statutes may be interpreted to prohibit lay employment of optometrists and therefore indirectly achieve the same result as explicit restrictions on lay employment.[38]

Another means of restricting lay employment is through state board of optometry rules or regulations defining unethical, unprofessional or illegal practices.[39] There are six states in which the optometry practice acts are silent on the question of lay employment but in which lay employment is proscribed through board of optometry regulations.[40] Finally, employment restrictions have also been effectively imposed even by court decisions[41]

---

37 Alabama, Maryland, Michigan, Minnesota, New Mexico, Texas, Wisconsin, and Wyoming. In 4 of these states, the statutes proscribe splitting or dividing a fee with any person. See Ala. Code tit. 34 § 34-22-23(16); Mich. Stat. Ann. § 338.254(2)(a); Minn. Stat. Ann § 148.57(3); and Wyo. Stat. § 33-300(1)(2a).

38 For example, the Alabama statute provides that an optometrist's license may be revoked or suspended "[f]or practicing optometry as the employee of any person, group, association or corporation on the basis of any fee splitting or on any basis which has the effect of such agreement. Ala. Code tit. 34, §34-22-23(16).

39 In such cases the optometry board is given the power, through the optometric practice act, to adopt rules or regulations defining unethical, unprofessional or illegal practices. Available information indicates that a total of 13 boards of optometry restrict lay employment (in six of these states, the statutes regulating the practice of optometry are silent on the question of lay employment). See chart on page 28, infra.

40 Alaska, Arizona, Kentucky, Mississippi, Ohio and Pennsylvania.

41 See, e.g., New York State Optical Association v. Whelan, 380 N.Y.S. 2d 973 (1976); Golding v. Schuback Optical Co., 93 Utah 32, 70 P. 2d 871 (1937).

and attorney general opinion.[42]

b. Employment of Opticians

Restrictions on lay employment of opticians are only an issue in those twenty states which currently license opticians.[43] Of these states, two impose specific employment restrictions on opticians.[44] In some states which license opticians, the state legislature has taken the opposite tack and has specifically allowed opticians to work for non-opticians and non-professional corporations.[45]

---

42 See Op. Atty. Gen. of Vt. No. 19 at p. 191 (Jan. 16, 1967).

43 Alaska, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Kentucky, Massachusetts, Nevada, New Jersey, New York, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Washington.

44 The two states are Arizona and Tennessee. The Tennessee statute provides that it is unlawful for any person to practice as a dispensing optician as an employee of any person who is not a licensed dispensing optician or for any firm or corporation which is not engaged primarily in the practice of a dispensing opticianry under the actual and personal supervision of partners, officer, manager, or stockholders who possess licenses as dispensing opticians. Tenn. Code Ann. § 63-1403(d). The Arizona statute, on the other hand, provides that the corporate form of practice is permissible so long as the person "actively in charge of the establishment" is a licensed dispensing optician. Ariz. Rev. Stat. § 32-1696(1). This may mean that non-opticians can be shareholders or officers so long as the manager or person in charge of the day-to-day operations of the firm is a licensed optician.

45 See, e.g., Fla. Stat. Ann. § 484.014(4) (West); Ohio Rev. Code Ann. §4725.59(B) (Page); Vt. Stat. Ann. tit.26, § 2653(3). It would appear that the concern about commercialism or growth of "non-traditional delivery systems" does not evoke the same concerns as it does for the field of optometry. As the chart on page 28, infra, shows, there are few commercial practice restraints specifically applying to opticians. Rather, opticians are generally restricted by scope
(Footnote Continued)

Besides those restrictions directly affecting the development of commercial optical practice outlined above, limitations on opticians in the capacity of an employer of optometrists also have the effect of restraining commercial optical practice. A substantial number of states prohibit opticians from furnishing the services of, or employing optometrists.[46] By preventing opticians from employing optometrists (and similarly by preventing optometrists from working for opticians) the ability of the optician's practice to "generate" prescriptions is limited. If optical firms are allowed to employ optometrists for the purpose of offering eye examinations, optical firms would be able to offer the one-stop service available from dispensing optometrists and ophthalmologists. To some extent,the prescription release requirement of the Commission's Eyeglasses I Rule has reduced this competitive disadvantage but the reality of the situation is that the ability of a practice (solo or commercial) to combine the examination and dispensing functions provides the practice with a steady flow of prescriptions to

---

45 (Footnote Continued)

of practice restraints, that is, duplication of lenses and contact lens fitting restrictions.

46 Arizona, California, Connecticut, Hawaii, Kansas, Maine, Massachusetts, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, and Pennsylvania. (Four of these states -- Kansas, Maine, North Dakota, and Pennsylvania -- do not license opticians. Thus, in those states, this restriction is contained in the optometry practice acts.)

be filled. Thus, as a practical matter, even where commercial optical practice is permitted, the inability of a retail ophthalmic seller to employ an optometrist may serve to deter potential volume sellers from entering a market.

2. Restrictions on the Permissible Location of Optometric and Optician Practices

Some people assert that large retail optical firms rely on convenient locations to attract customers and obtain a substantial portion of their business from walk-in customers. If these assertions are true, the ability of an optical firm to operate in a high traffic area (such as a shopping center or department store) may ultimately determine whether it is possible to develop a high-volume practice.

Location restrictions are imposed in a number of ways. Thirteen states restrict by statute the ability of optometrists to locate in mercantile establishments.[47] In fifteen other states, location of optometric practice is restricted through board of optometry regulations.[48] Generally, these provisions state that an optometrist's license to practice may be revoked or suspended for practicing in an office not devoted exclusively to the practice of optometry or other health care profession, or where material or merchandise is displayed pertaining to a commercial undertaking not bearing any relation to the practice

---

47 Connecticut, Delaware, Hawaii, Maine, Nevada, New Jersey, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, and West Virginia.

48 See chart on page 28, infra.

of optometry or other health care profession.[49] The practical consequence of restrictions of this type is to eliminate the possibility of locating an optometric practice in a department or drug store.

Another category of location restrictions seeks to prevent optometrists from locating near retail opticians.[50] While the proffered rationale for restraints on "side-by-side" operations is to prevent any patronage system from developing, this type of restriction may also prevent the growth of a high-volume practice.[51] Indeed, side-by-side practices appear to have

---

49 The Delaware statute provides that an optometrist's certificate of registration may be revoked or suspended for "practicing in an office not exclusively devoted to the practice of optometry or other health care profession, where material or merchandise is displayed pertaining to a business or commercial undertaking not bearing any relation to the practice of optometry or other health care profession; or practicing in a store or office which does not conform to that used by the majority of professional men in the area." Del. Code tit. 24, § 2113(a)(7)(d). See, e.g., Nev. Rev. Stat. § 636.300(11); N.J. Rev. Stat. § 45: 12-11(1)(2)(j) (West).

In addition, the Maine statute provides that sanctions may be imposed "if such person practices in or on premises where any materials other than those necessary to render his services are dispensed to the public." Me. Rev. Stat. tit. 32, § 2432(1).

50 See, e.g., Okla. Stat. Ann. tit. 59, § 594 (West) which provides: "No optometrist . . . shall practice his profession adjacent to or in such geographical proximity to a retail optical outlet store, optical dispensery or any establishment where optical goods and materials are purveyed to the public so as to induce patronage for himself thereby."

51 If side-by-side operations were permitted, non-dispensing optometrists might be able to compete for patients who prefer one-stop shopping and, therefore, ordinarily select

(Footnote Continued)

developed to provide the functional equivalent to mercantile location and corporate employment in areas where those practices are banned.

Several courts have held that statutory provisions or board of optometry or opticianry regulations prohibiting mercantile location are constitutional and within the state's police power.[52] In general, courts have applied a rational relation test and have been unwilling to delve into the merits of the quality justification offered in support of location restrictions.

There are no statutory location restrictions affecting where an optician may operate his or her business.[53] Two states which license opticians, have, in fact, enacted statutory provisions which provide that opticians may locate in a mercantile

---

51 (Footnote Continued)

the services of a dispensing optometrist or ophthalmologist.

52 See, e.g., Williamson v. Lee Optical of Oklahoma, Inc., 348 U.S. 483 (1955), reversing Lee Optical of Oklahoma, Inc. v. Williamson, D.C., 120 F. Supp. 128 (W.D. Okla. 1954); Wall v. American Optometric Association, 379 F. Supp. 175 (N.D. Ga. 1974), aff'd 419 U.S. 99 (1974); Silverman v. Board of Registration in Optometry, 181 N.E. 2d 540 (Mass. 1962).

53 However, restrictions on an optometrist's ability to locate near an optician, to locate in a mercantile location, and on the ability of opticians to employ optometrists may have an impact on opticians despite the fact that there may be no location restrictions directly applying to opticians.

or other "commercial" area.[54]

3. State Restrictions on the Number of Branch Offices an Eye Care Practitioner May Operate

A number of states restrict the number of offices an optometrist or optician may legally operate. The laws vary considerably in the type of restriction imposed. For example, some provisions set a maximum number of branch offices a practitioner may operate.[55] Other states require that a practitioner must apply to the licensing board for a permit to open a branch office.[56] Some laws further restrict practitioners by providing that the branch office must be closed when the practitioner is not in personal attendance.[57] Another provision provides that a practitioner may operate branch offices so long as he or she is in personal attendance at each office 50% of the time the office is open to the public.[58] Thus, such a restriction

---

54 See, e.g., Fla. Stat. Ann. § 484.014(5)(West); Va. Code § 54-398.23(7).

55 The maximum number of branch offices permitted is generally one. See, e.g., Ky. Rev. Stat. Ann. § 320.310(3) (Baldwin); Me. Rev. Stat. tit. 32, § 2432 (11).

56 A permit is usually granted only if the board determines that the branch office would be in the public interest or if the practitioner satisfies certain criteria such as being physically present in the branch office a certain number of hours per week. See, e.g., Pa. Stat. Ann. tit. 63, § 234 (Purdon).

57 See, e.g., Tex. [Health & Safety] Code Ann. tit. 71, § 4552-5.13(e) (Vernon).

58 See, e.g., Cal. [Bus. & Prof.] Code § 3007(i) (Deering) which provides:

> Nothing in this chapter shall prevent an

(Footnote Continued)

limits the practitioner to only one branch office, to the extent that such a practitioner seeks to have the branch office open normal business hours.

Nine states restrict by statute the number of branch offices optometrists may operate.[59] There appears to be only one state which imposes any kind of branching restriction on opticians.[60] In addition to the nine states which statutorily impose branch office restrictions on optometrists, eleven other states impose branching restrictions through board of optometry regulation.[61] In Ohio, branching restrictions are imposed through attorney general opinion.[62]

The courts have held that a state, through its police power, may restrict the number of branch offices an eye care

---

58 (Footnote Continued)

> optometrist from owning, maintaining or operating more than one branch office if he is in personal attendance at each of his offices fifty percent (50%) of the time during which such office is open for the practice of optometry.

59 Alabama, Alaska, California, Kentucky, Maine, Massachusetts, Pennsylvania, Tennessee, Texas, and Vermont.

60 See N.C. Admin. Code Title 21, Chap. 40, § .0203. Florida, in fact, has enacted a provision specifically providing that opticians shall not be restricted in the number of offices they may wish to operate. See Fla. Stat. Ann. § 484.014(5) (West).

61 Arizona, Connecticut, Florida, Georgia, Idaho, Massachusetts, Mississippi, North Carolina, Oklahoma, Oregon, and South Carolina.

62 See Op. Atty. Gen. Ohio No. 4263 (1932).

practitioner may operate.[63] In these decisions, the courts have applied the rational relation test to determine whether there is a basis for the restriction and have not scrutinized the merits of the proffered justifications.

4. Restrictions on the Ability of Optometrists or Opticians to Practice Under a Trade Name

Another state-imposed restriction which serves to impede the growth of commercial practice is a ban on the use of trade names. Trade name restrictions generally prohibit an optometrist from practicing under any name other than the one shown on his or her license or certificate of registration.[64] However, these restrictions generally do not prevent an optometrist from working for another optometrist and holding him or herself out under the name of the professional corporation. Thus, these restrictions have a distinct discriminatory impact on non-professional corporations. (The discriminatory impact here is not that a professional corporation is able to use a traditional trade name but rather that an individual optometrist can hold him or herself out under a firm name which does not contain his or her individual name so long as that firm is a professional corporation or the name of a licensed optometrist who employs

---

63 See, e.g., Wall v. American Optometric Association, Inc., 379 F. Supp. 175 (N.D. Ga.), aff'd, 419 U.S. 888 (1974); Abelson's Inc. v. New Jersey State Board of Optometry, 75 A.2d 867 (N.J. 1950).

64 For example, a trade name ban would prohibit an optometrist or optician from using a name such as "Discount Optical" or "The Contact Lens Clinic."

that individual optometrist.)

The trade name ban issue arose during the Eyeglasses I proceeding. The Eyegasses I Rule[65] preempted state laws which prohibit, limit, or burden the advertising of ophthalmic goods and services. Although the United States Court of Appeals for the District of Columbia Circuit has remanded for further consideration the entire advertising portion of the Eyeglasses Rule (thereby suspending operation of that portion of the Rule), at the time the Rule was promulgated, the question arose whether a practitioner could be prohibited from using a trade name in advertising. We concluded that trade name bans were not preempted by the trade regulation rule because they do not refer to whether one can advertise but rather to the form in which one can do business. The intent of the Rule was to eliminate burdens on the dissemination of information and not to alter state regulations regarding permissible forms of business practice.

It has been argued that trade name bans indirectly restrict corporate practice and the development of large commercial chains.[66] Bans on the use of trade names may prevent providers from operating multiple store operations and developing goodwill based on the name and reputation of the firm generally.

Trade name bans may also inhibit effective mass-media

---

65 16 C.F.R. Part 456 (1980).

66 See, e.g., Birenbaum and Kamarck, Freedom of Commercial Speech Threatened by Friedman Decision, The Natl. L.J. 20, 21 (Ap. 23, 1979).

advertising by large firms and, thus, indirectly restrict commercial practice even in those states where the commercial practice of optometry is otherwise permitted. It has been asserted that over time a trade name can provide consumers with important information concerning the type, price and quality of goods and services offered for sale in that practice and that, therefore, trade name bans, like advertising bans, restrict the free flow of commercial information.[67] If the use of trade names does facilitate advertising which is often important to the success of large-scale commercial practices with numerous branch operations,[68] these bans may have the indirect effect of precluding commercial practice. (In fact, some people have asserted that the real purpose of optometric trade name bans is to stifle commercial practice.) Thus, our position is that trade name bans are appropriately considered in an investigation of commercial practice restraints.

A prohibition on the use of trade names was recently upheld

---

67 See Friedman v. Rogers, 440 U.S. 1, 22-23 (1975) (dissenting opinion, J. Blackman) (quoting deposition of Prof. Lee Benham).

> Trade names such as Sears or Bloomingdales convey to most people totally different ideas and expectations as to the price, reliability and quality of merchandise sold at the different named stores. In addition, trade name bans make it difficult for a firm offering a degree of uniformity in goods and services at all their outlets to tell consumers that the firm exists. By conveying such information, trade names may reduce search costs for consumers.

68 Trade names may also help consumers distinguish commercial providers from non-commercial providers.

by the United States Supreme Court against a First Amendment challenge in Friedman v. Rogers.[69] Later in this report we discuss the justifications offered in support of trade name bans and the impact of the Supreme Court's decision on the ability of the Commission to act.

Trade name bans are imposed in a variety of ways. Twenty-one states prohibit by statute the use of trade names by optometrists.[70] These statutes provide that practicing optometry "under a name other than one's own name" shall constitute grounds for revocation or suspension of one's license to practice.[71] In eight other states, the statutes do not refer explicitly to trade names[72] but provide that the practice of optometry under a "false or assumed name" shall be grounds for suspension or revocation of one's license to practice optometry.[73] An additional twelve states prohibit the use of trade names by optometrists through state board of optometry regulations.[74]

---

69 440 U.S. 1 (1979).

70 Alabama, Florida, Hawaii, Illinois, Kansas, Kentucky, Maine, Massachusetts, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Washington.

71 See, e.g., Ala. Code tit. 34 § 22-23(11); N.M. Stat. Ann. § 67-1-11(D); Tenn. Code Ann. § 63-822(f).

72 Arizona, California, Idaho, Iowa, Montana, Oregon, Vermont, and West Virginia.

73 See, e.g., Ariz. Rev. Stat. § 32-1755(11); Idaho Code § 54-1510(2); Or. Rev. Stat. § 683.180(5).

74 See chart on page 28, infra.

Thus, only nine states and the District of Columbia permit or are silent on the use of optometric trade names.[75]

---

75 See chart on page 28, infra.

Chart of State Laws (Commercial Practice Restraints)

State	Employment Restrictions O.D.	Employment Restrictions Optician	Location Restrictions O.D.	Location Restrictions Optician	Branch Restrictions O.D.	Branch Restrictions Optician	Trade Name Bans O.D.	Trade Name Bans Optician
Alabama	S*		E		S		S,E	
Alaska	R		R		S,R		R	
Arizona	R	S			R		S*,R,E	
Arkansas	S		E				E	
California	S				S		S*,R,E	
Colorado	S		R,E				R	
Connecticut	S,E		S,E		R		E	
Delaware	S,R		S,R				R	
District of Columbia								
Florida	S,R		R,E		R		S,R,E	
Georgia			R,E		R,C		R,E	
Hawaii	S		S				S	
Idaho	S,R		R		R		S*,R	
Illinois			E				S,E	
Indiana	S						R	
Iowa	C		E				S*,E	
Kansas	S,R,C						S,R	
Kentucky	R,C				S,R		S	
Louisiana	C						E	
Maine	S,E		S,E		S		S,E	
Maryland	S*							
Massachusetts	S		R,E		R,E,A		S,R	
Michigan	S*		E				R,E	
Minnesota	S*,E,A		E				E	
Mississippi	R,C,A		R		R		R	
Missouri			R,E				S,E	
Montana	S		R,E				S*,R,E	
Nebraska								
Nevada	S		S,R				R	
New Hampshire	S		R					
New Jersey	S,R		S,E		C		S,E	
New Mexico	S*						S,E	
New York	C						R,E	
North Carolina	S		R		R	R	S	
North Dakota	S						R	
Ohio	R,C				A		R	
Oklahoma	S		S,R,E		R,E		S,E	
Oregon					R		S*,E	
Pennsylvania	R		R		S*,R		R,E	
Rhode Island	S		S				S,R	
South Carolina			S,R		R		S,R	
South Dakota	S,S*		R				S,R	
Tennessee	S	S	S		S		S	
Texas	S*		S,E		S,E		S,E	
Utah	C		R				S	
Vermont	A,				S		R,S*	
Virginia	S,R		S				S,R	
Washington	C,E		E,R				S*,E	
West Virginia	R,S		E,S				S,E,R	
Wisconsin	S*							
Wyoming	S*							

Key: S - Statutory restriction (revocation, suspension, refusal to renew license)
S* - ambiguous statute
R - State Board or Administrative Regulation
E - State Optometric Association rule of practice or code of ethics prohibition
C - Court decision
A - Attorney General Opinion

D. Proffered Justifications for Commercial Practice Restraints

1. Introduction

Proponents of commercial practice restraints argue that these restrictions are necessary to protect the public health, safety and welfare. The most serious claim is that these restrictions are necessary to protect the public from low quality vision care. In addition, one particular category of commercial practice restriction, bans on the use of trade names, has been justified on the ground that such laws are necessary to prevent consumer deception.

With the exception of whether trade name bans are necessary to prevent deception, our discussion of these justifications which follows treats the four commercial practice restrictions together, rather than considering separately each of the arguments offered in favor of prohibitions on corporate employment, limitations on operation of branch offices, restrictions on mercantile location, and trade name bans. Each of these restrictions is, in essence, aimed at inhibiting large volume, chain retail operations, and, therefore, many of the same arguments are made to justify each of the individual restrictions. To the extent that there are arguments which apply specifically to a particular restriction, these will be noted.

2. Restrictions on Commercial Practice Are Necessary to Maintain the Quality of Vision Care

The primary argument made against commercial firms in the ophthalmic market is that they provide low quality vision care. Those who seek to eradicate commercialism from the market argue

that commercial practice restrictions are necessary to protect the public health, safety and welfare. High-volume commercialists, it is maintained, will place their interest in profits above their responsibilities to consumers. As a result, argue opponents of commercial practice, the quality of goods and services provided by optometrists who work in a commercial setting is lower than that provided by "professionals."[76] Furthermore, they assert that if professional practitioners are forced to compete with commercialists, the overall level of quality for all categories of practitioners will decline.[77]

The quality-based arguments against commercial practice fall into two general categories. The first include those which focus on the evils alleged to be associated with high-volume practice: practicing in a commercial environment may cause the practitioner to employ a variety of cost-cutting and revenue-generating techniques in order to increase his or her profits. The second stresses the dangers of lay-owned optometric practices: lay interference in the traditional doctor-patient relationship and with professional judgments concerning patient welfare.

One of the most common charges made by those opposing commercial practice is that the high-volume practice which characterizes the commercial firm results in brief and inadequate

---

76 See Summary of Comments, supra note 26 at 2-4.

77 See note 95, infra.

eye examinations for consumers.[78] This is the so-called "quickie exam" argument. Some speak of eye examinations lasting 5 to 7 minutes.[79] Examples are cited of commercial optometrists performing 45 examinations in a day.[80] Others suggest that the length of the exam may vary, depending on the time available and the number of persons in the waiting room.[81] Thus, on a busy Saturday, one may see the examining optometrist only 3 to 5 minutes.[82]

Those making these charges cite two major dangers resulting from the quickie exam. First, commercial optometrists may fail to detect eye pathology and refer the patient to a physician for further care. A five minute examination leaves no time for such tests as the retinoscopy, ophthalmoscopy, or tonometry,

---

78 See, e.g., Letter from Joseph W. Jenkins, Executive Director, South Carolina Optometric Association, to FTC (Oct. 22, 1975), Exhibit IV-60, at R. 3189; Letter from Carl Jagolinzer, O.D., to FTC (Oct. 29, 1979), Exhibit IV-39, at R. 3048; Comment of Maryland Optometric Association, Exhibit VIII-177 at R. 14865; Letter from James W. Elless, O.D., to FTC (Oct. 28, 1975), Exhibit VIII-196, at R. 15002.

79 See Comment of Maryland Optometric Association, supra note 78, at R. 14865; Letter from Karl D. Morrision, Executive Director, Florida Optometric Association, to FTC (Oct. 28, 1975), Exhibit IV-60, at R. 3088.

80 See Letter from James W. Elless, O.D., supra note 78.

81 See Hearings on H.R. 2388 before Subcomm. No. 4 of the House Comm. on the District of Columbia, 91st Cong., 1st Sess. (1969) (Statement of Charles M. Babb, Esq., on behalf of the Texas Optometric Association), Exhibit VI-29, at R. 12343; Testimony of Edward F. Stein, O.D., Tr. 926 at 929, 930; Testimony of Herman Gould, O.D., Tr. 4749 at 4754.

82 See Letter from Karl D. Morrison, supra note 79, at R. 3088.

and, as a result, symptoms of eye disease may go undetected.[83]

Second, "quickie" exams may lead to inaccurate prescriptions. Opponents of commercial practice have contended that the exams performed by commercial optometrists do not permit enough time for a thorough refraction, and that errors in prescriptions result from the rushed procedures.[84]

Similarly, objections to high-volume practice have been founded in the contention that adequate quality control is lacking. A justification proffered for branch office restrictions is the assertion that the owner of an optometric practice should be physically present in order to insure the adequate performance of his or her employees.

The other major argument against commercialism is that lay-owned firms interfere with professional judgments concerning consumer welfare and ignore the traditional doctor-patient relationship. It is argued that the managements of commercial firms pressure their employees to perform low quality examinations and to sell as many pairs of eyeglasses as possible by establishing systems of remuneration which reward high

---

83 See Hearings on H.R. 2388 before Subcomm. No. 4 of the House Comm. on the District of Columbia, 91st Cong., 1st Sess. (1960) (Statement of Eugene V. McCrary, O.D., Director of National Affairs, AOA), Exhibit VI-29, at R. 12474-75; Letter from Gary Wilson, M.D., to FTC (May 24, 1976), Exhibit VIII-199, at R. 15010; Letter from Joseph W. Jenkins, supra note 78.

84 See Report to the Public by the New Jersey Optometric Association concerning Highway Eyeglass Centers, Exhibit IV-141, at R. 6115.

volume.[85] Several witnesses testified that commercial firms utilize a variety of incentives to increase sales, such as paying employees on a "per head" basis for examinations performed,[86] offering sales commissions,[87] and giving bonuses for selling a second pair of eyeglasses.[88] It is frequently charged that as a result of these financial incentives, commercial optometrists write many unnecessary prescriptions. Professionals claim that commercial optometrists prescribe eyeglasses and contact lenses more frequently than other practitioners.[89]

A variety of other types of interference have been cited to illustrate the ways in which pressures to maintain profits lead to low quality vision care. One former employee of a large commercial chain has alleged that opticians were instructed by management to use lenses from in-store stock to fill prescriptions even though that meant that, in some cases, a prescription was not filled according to the prescriber's speci-

---

85 See, e.g., Testimony of Edward F. Stein, supra note 81 at 935, 937; California Attorney General's Fight Inflation Committee Hearing (1975), (Statement of Robert Oliver, Assistant Attorney General of Texas), Exhibit IV-141 at R. 6038-39.

86 See Testimony of Edward F. Stein, supra note 81 at 929.

87 See California Attorney General's Fight Inflation Commmittee Hearing, supra note 85 at R. 6038-39.

88 Id.

89 See Testimony of Herman Gould, supra note 81, at 4754-55; Letter from Brian Klinger, President, New Hampshire Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60 at R. 3144.

fications.[90] Such a policy would cut costs by avoiding the expense of ordering out-of-stock lenses from laboratories. Other critics of commercial practice suggest that large firms control costs by eliminating the routine verification of lenses when they return from the lab.[91] Rather, verification is only performed if a customer notices a problem and complains.

It is often suggested that commercial firms use inferior quality goods to keep their costs down.[92] Another common charge is that commercial optometrists have only minimal equipment for conducting eye examinations.[93]

Critics also argue that other less obvious, but equally serious, problems arise when commercial firms enter the market. Some claim that the doctor-patient relationship is endangered in a high-volume commercial practice because of the rushed and

---

90 See "FTC Probes Pearle Vision Centers," Optometric Management, March 1979, at 43-51; transcript of interview of Russel Smith by Michael Milgrom, FTC staff attorney, concerning FTC investigation of G.D. Searle, Inc. at 14-18 (Dec. 6, 1978).

91 See Letter from Alan Wasserman, President, Georgia State Board of Examiners in Optometry, to Rachel Shao, Attorney, FTC, (Oct. 15, 1975), Exhibit IV-59, at R. 2970; California Attorney General's Fight Inflation Committee Hearing (1975), (Exhibit appended to Statement of Gerald Easton, President, California Optometric Association), Exhibit IV-141, at R. 5959.

92 See California Attorney General's Fight Inflation Committee Hearing, supra note 85, at R. 6039.

93 See, e.g., "History of Optometry in Rhode Island," Attachment to Letter from Mary Ellen McCabe, for the Rhode Island State Board of Examiners in Optometry, to FTC (Dec. 9, 1975), Exhibit IV-59, at R. 3042.

impersonal nature of such practice. Even if one assumes there is no interference by corporate management or local store managers, professional practitioners have argued that optometrists in corporate practice tend to become indifferent and feel less responsibility to their patients. Their individual identities shielded by a trade name, corporate practitioners have a lesser need to maintain a personal reputation for high quality service. Thus, some charge, this lack of personal accountability in commercial practice leads to a decline in the quality of vision care.[94]

Finally, opponents of commercial practice argue that the overall quality of vision care will decline if commercial firms enter the market. They claim that if professional practitioners are forced to compete with the commercial chains, they will have to lower the quality of their services in order to meet the low prices of their competitors.[95]

---

94 See, e.g., Jurisdictional Statement of Appellent Texas Optometric Association, Inc. at 12-17, Friedman v. Rogers, 440 U.S. 1 (1979).

95 A major argument in the Eyeglasses I proceeding was that practitioners would be forced to lower prices and quality in order to survive in the more competitive marketplace that advertising would engender. See, e.g, Testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1003; Testimony of Ron G. Fair, O.D., President, American Optometric Association, Tr. 4638 at 4694; Testimony of David C. Hendershot, Executive Director, Ohio Optometric Association, to FTC (Oct. 22, 1975), Exhibit IV-60, at R. 3192; Letter from Robert R. Kimbro, Executive Director, New Mexico Optometric Association, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3148; Letter from William S. Eisner, Administrative Director, Maryland Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3134. The
(Footnote Continued)

Advocates of commercial practice dispute the claim that commercial firms provide lower quality service than professional practitioners. Commercial practitioners, they argue, rely on customer goodwill and repeat business in order to survive. Thus, they continue, commercialists have a strong incentive to maintain high standards of quality in order to insure consumer satisfaction.[96]

In particular, they take issue with the charge that the practice of commercial optometry is controlled primarily by economic incentives. They argue that, in fact, the financial pressures on self-employed practitioners are far greater than those on their salaried counterparts.[97] An independent optometrist has a strong motivation to sell an additional pair of eyeglasses when he or she receives all the profits from that sale.

A few commercial firms testified that their employees work

---

95 (Footnote Continued)

Bureau of Economics study findings contradict the assertion that commercial practice will lower overall quality. See pp. 66-80, infra.

96 See Testimony of William A. Schwartz, Vice President, Wall & Ochs, Inc., Tr. 346 at 369; Testimony of Edward Crittenden, President, Eyear Optical, Tr. 6015 at 6019; Testimony of Donald Juhl, President, Jack Eckerd Corp., Tr. 379 at 381-83; Rebuttal submission of Stanley C. Pearle, Chairman, Opticks, Inc., Exhibit IX-161, at R. 16378-79; Comment of Cole National Corporation, Exhibit VIII-154, at 14639-40.

97 See, e.g., Hearings on H.R. 2388, supra note 81 (Statement of Richard A. Wienman, for United Optical Workers) at R. 12383-84; Testimony of Gordon S. Black, Ph.D., Tr. 4518 at 4544.

on a fixed salary and receive no commissions from the sale of eyeglasses.[98] However, we subpoenaed a number of large ophthalmic firms, and the returns show that some firms do offer bonuses or other incentives to increase sales.[99]

Supporters of commercial practice have also argued that corporate employment permits a practitioner to function more effectively.[100] In a corporate setting, the practitioner can concentrate on providing vision care, while the independent optometrist or optician must be concerned with inventories, accounts, and a variety of other business considerations.

Commercial firms also state that they employ a variety of quality control procedures, such as using independent shoppers to obtain eye examinations, in order to maintain quality standards.[101]

Several representatives of state and local consumer pro-

---

98 See, Hearings on H.R. 2388, supra note 81 (Statement of Alvin M. Stein, representing Sterling Optical Company) at R. 12494.

99 Reply to Subpoena Duces Tecum served on Acrylic Optics Corporation (May 2, 1977); Reply to Subpoena Duces Tecum served on Coffman Optical Company (May 18, 1977); Reply to Subpoena Duces Tecum served on King Optical Corporation (May 10, 1977); Reply to Subpoena Duces Tecum served on Royal International Corporation (June 27, 1977); Reply to Subpoena Duces Tecum served on The House of Vision, Inc. (June 10, 1977); Reply to Subpoena Duces Tecum served on Wall & Ochs, Inc. (Sept. 15, 1977).

100 See Comment of the NAOO, Exhibit VIII-187 at R. 14938-39; Letter from Franklin D. Rozak, Vice President, Cole National Corporation, to FTC (November 26, 1975), Exhibit V-42, at R. 9993.

101 See, e.g., Letter from Franklin D. Rozak, supra note 100, at R. 9993.

tection agencies who testified in the Eyeglasses I proceeding challenged the arguments that commercial practice restraints ensure high quality.[102] For example, one argued that there appeared to be no basis for the restrictions other than to restrict competition and preserve an existing economic advantage.[103]

Much of the testimony in the Eyeglasses I proceeding on the differences in quality between commercial and professional practitioners is based on anecdotes and personal opinion. Several optometrists who testified referred to their own experiences with low quality commercial work while practicing as employees of commercial firms.[104] Yet little was offered to show that there are systematic differences in the quality of vision care

---

102 See, e.g., Testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1854-58; Testimony of Elinor Guggenheimer, New York City Department of Consumer Affairs, Tr. 1963 at 1965-67.

103 See, e.g., Testimony of Virginia Long, supra note 102, at Tr. 1856:

> There is not the slightest reason why an optometrist should not be allowed to locate wherever he pleases. The only basis for the prohibition is the possible economic advantage which could accrue to one optometrist over his colleagues if he located in connection with a commercial optician. This proposed economic problem may be a real one for the private practitioner of optometry, but in my estimation it is utterly irrelevant to the question of the public welfare and health.

104 See Testimony of James Elless, supra note 78 at Tr. 5363-71; Testimony of Herman Gould, supra note 81 at Tr. 4750, 4755-56; Testimony of Edward F. Stein, supra note 81 at TR. 929.

provided by commercial and professional firms.[105] Thus, notwithstanding the assertion that commercial practice restrictions ensure high quality vision care, there is little or no systematic evidence to prove or disprove this assertion. As we discuss below in Section E, the studies done by the Bureau of Economics and James Begun provide reliable evidence on this claim and draw into question its validity.

3. Trade Name Bans Are Necessary to Prevent Deception

One of the four commercial practice restraints, the prohibition on practicing under a trade name, warrants separate consideration in this section. In addition to the quality arguments discussed above, trade name bans have been justified on the ground that they are necessary to prevent deception. It has been argued that any optometric practice under a trade name is "false and misleading to the public."[106] The United States Supreme Court recently held in Friedman v. Rogers that a Texas law prohibiting optometrists from practicing under a trade name did not violate the First Amendment.[107] In so holding,

---

105 A number of opponents of commercial practice who testified or submitted comments in the Eyeglasses I proceeding cited studies to support their views. See, e.g., Report to the Public by the New Jersey Optometric Association concerning Highway Eyeglass Centers, supra note 84. These studies, however, surveyed only commercial practitioners, and do not contain comparative data on professional practitioners.

106 Testimony of Alden N. Haffner, Ph.D., Dean of the State College of Optometry, State University of New York, Tr. 2035 at 2081.

107 Friedman v. Rogers, 440 U.S. 1 (1979).

the Court concluded that "there is a significant possibility that trade names will be used to mislead the public."[108]

The Supreme Court identified three ways in which use of a trade name can be deceptive or misleading. First, it noted that there may be a turnover of optometrists within a firm employing a trade name while the trade name remains the same. As a result, the reputation of a firm using a trade name may be based on the skills of optometrists who no longer practice with that firm. Second, an optometric practice can simply assume a new trade name if the old one becomes associated with negligent practice or misconduct. Third, trade names may be used to give a false impression of competition among shops under common ownership. In addition, some have suggested that use of a trade name is inherently deceptive because it conceals the identity of the licensed optometrist.[109]

It is our opinion, based on the evidence available, that these arguments do not justify a flat prohibition on trade names, and that there are less restrictive means of preventing the potential dangers of optometric trade names. The state's interest in preventing deceptive commercial speech can be protected by controlling the way in which trade names are used, rather than the trade name itself.

---

108 Id. at 13.

109 See, e.g., Jurisdictional Statement of Appellant at 13, Friedman v. Rogers, supra, note 107 and testimony of Alden N. Haffner, supra note 106, at Tr. 2081.

One of the arguments against trade names is that they conceal the identity of the individual optometrist. However, the individual optometrist's identity is no more concealed than when he or she practices as an employee of another optometrist or as a member of a professional corporation. Yet most states permit an optometrist to work for another licensed optometrist and to be a member of a professional corporation, the name of which does not contain the individual optometrist's name. If a state were concerned that the name of a practicing optometrist was concealed from the public, the legislature could require that the names of optometrists be prominently posted at each office at which they practice.[110] Similarly, to the extent that a state is concerned about the manipulation of trade names to create a false impression of competition, it could more narrowly regulate by banning the use of different trade names for shops under common ownership.

In addition, there are federal, state, and local consumer protection laws which may be used to combat deceptive or misleading trade practices.[111] In instances where deception occurs

---

110 It is difficult, however, to accept the contention that the mere use of trade name results in deception. The identity of the practicing optometrist is "concealed" only in the sense that it might not appear in advertising or other places where a firm's trade name may be encountered. There is no reason to suppose that consumers cannot obtain information about the identities of practitioners employed under a trade name, patronize those whom they wish, and avoid those whom they find unsatisfactory.

111 In addition to the Federal Trade Commission Act, 49 states and the District of Columbia have enacted "Little FTC Acts"
(Footnote Continued)

through the use of trade names, these laws may be invoked.

Notwithstanding the decision of the Supreme Court in Friedman, we know of no systematic evidence indicating that professionals engaged in "trade name practice" are deceiving the public. Indeed, carried to its logical conclusion, the Supreme Court's decision would hold that virtually all lawyers practicing in traditional law firm practice are engaged in deception, insofar as they are practicing under the name of the law firm, not their own name.

Careful scrutiny of the Texas law sustained in Friedman

---

111 (Footnote Continued)

to prevent deceptive and unfair trade practices. Alabama, which does not have such a law, has a statute which makes false advertising a misdemeanor, and a consumer complaint clearinghouse designed to facilitate enforcement of existing laws and recommend new legislation. In fact, the Texas Optometry Act requires each optometrist to display his or her license in a conspicuous place and to sign each prescription they write:

> "Every person practicing optometry in this state shall display his license or certificate in a conspicuous place in the principal office where he practices optometry and whenever required, exhibit such license or certificate to said board, or its authorized representative, and whenever practicing said profession of optometry outside of, or away from said office or place of business, he shall deliver to each person fitted with glasses a bill, which shall contain his signature, post-office address, and number of his license or certificate, together with a specification of the lenses and material furnished and the prices charged for the same respectively." Tex. Health and Safety] Code Ann. tit. 71 § 4552-5.01 (Vernon).

belies the contention that it was designed to promote professional identification of the professional delivering the optometric service to the public. The Texas trade name statute,[112] while prohibiting an optometrist from practicing under the name of a lay corporation, would permit that same optometrist to practice under the name of a professional corporation composed of himself or herself and other optometrists, or the name of another optometrist who is his or her employer.[113] Thus, the dissent in Friedman concluded that one primary basis for the Texas regulation was to stifle the otherwise legal practice of commercial optometry in Texas,[114] a conclusion we share.

Therefore, it is necessary to include trade name restrictions within the scope of our rulemaking recommendation to obtain public comment on less restrictive alternatives to ensure meaningful "professional identification" without the adverse economic injury attending trade name bans. The question whether the Friedman decision is a bar to Commission action is discussed later in this report.

E. The Effects of Commercial Practice Restraints on Consumers

---

112 Tex. [Health and Safety] Code Ann.§ 4552-5.13 (Vernon).

113 In pertinent part § 5.13(d) states:

> "[o]ptometrists who are employed by other optometrists shall practice in their own names, but may practice in an office listed under the name of the individual optometrist or partnership of optometrists by whom they are employed."

114 440 U.S. at 24.

1. Introduction

In this section we discuss whether the commercial practice restraints outlined above have a sufficiently serious impact on consumers to warrant federal attention.

In measuring consumer injury, one issue is how these restrictions affect the price of vision care. Opponents of commercial practice restrictions contend that they limit competition and significantly increase the cost of eye care.[115] Testimony was introduced in the Eyeglasses I hearings that commercial optometric firms generally charge less than other optometrists[116] because they are able to employ cost-saving techniques in purchasing and distribution which may then be passed on to the consumer.[117]

---

115 Staff Report, supra note 1, at R. 24492 (p. 120); Presiding Officer's Report, supra note 1, at R. 24235-36 (pp. 61-62). See, e.g., Testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1981; Testimony of William B. Haley, Acting Director, Department of Public Affairs, Community Service Society, New York, New York, Tr. 2129 at 2138.

116 See, e.g., Testimony of James J. Ryan, NAOO, Tr. 2360 at 2376; Testimony of R. Ted Bottiger, Counsel, Washington Optometric Association, Tr. 4047 at 4048; Testimony of Delia Schletter, San Francisco Consumer Union, Tr. 6297 at 6309.

117 See, A Look Into the Price of Eyeglasses, An Investigative Study by the Community Service Society, HX 183 at 18859. The study concluded that in these outlets, wholesalers generally charge high-volume outlets less per unit and that this saving is passed on to the consumer in the form of lower retail prices. HX 183 at 18859.

In addition to the availability of volume discounts on eyeglass purchases at wholesale, it is argued that commercial firms may have management skills and access to capital which solo practitioners and small group practitioners lack.

A second issue is the effect of commercial practice restrictions on the quality of vision care. States have justified these restrictions as necessary to protect public health and safety by maintaining the quality of vision care.[118] Thus, even if prices are found to be lower in states where commercial practice is permitted, we must determine whether there are offsetting consumer benefits in the form of higher quality which result from these restrictions.

A third issue is the impact of these restrictions on the accessibility of vision care and the frequency with which eyeglasses and eye examinations are purchased. In the Eyeglasses I proceeding witnesses testified that restrictions on the permissible form and location of practice make eye care less available.[119] It is asserted that restrictions on branch offices and mercantile location make it more inconvenient for consumers to obtain vision care. Such proponents maintain that some consumers, especially the elderly who are often less mobile, may be deterred from seeking eye care because it is not available

---

118 See Summary of Comments, supra note 26, at notes 10-16.

119 See, e.g., Testimony of Kenneth Boyer, Ph.D., Assistant Professor of Economics, Michigan State University, Tr. 1281 at 1289; Testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1854; Testimony of James J. Ryan, supra note 116, at 2367; Testimony of Dr. Simon Rottenberg, Professor of Economics, University of Massachusetts, Tr. 2404 at 2434; Testimony of Michael Magura, Ph.D., Professor of Economics, University of Toledo, Tr. 1261 at 1263.

at readily accessible locations.[120] These same people argue that the ability to locate one's practice in a department store or other high traffic area, where the office is visible to consumers upon entering the area, may also make vision care more accessible to consumers. In addition, some people may not receive any care at all or may receive care with decreased frequency because of higher prices which may be attributed to commercial practice restraints. In assessing consumer impact, it is important to take into account this "no-care" factor.

2. The Preliminary Evidence

A number of studies were submitted in the Eyeglasses I rulemaking proceeding or made available to us during the course of this investigation which consistently showed that commercial practice restrictions have the effect of increasing the costs of vision care products and services. However, in each case there were shortcomings in the study methodologies employed which were sufficiently serious to question whether these studies were adequate to support Commission action to remove commercial practice restrictions.

Studies by Professor Lee Benham of Washington University[121] and the National Association of Optometrists and Opticians

---

120 Testimony of Ralph J. Rubinoff, Executive Director, Massachusetts Association of Registered Dispensing Opticians, Tr. 2532 at 2543.

121 Benham and Benham, Regulating Through the Professions: A Perspective on Information Control. 18 J.L. & Econ. 421, Exhibit V-2 (1975) [hereinafter cited as Benham & Benham].

(NAOO)[122] sought to assess the economic impact of commercial practice restrictions. In both studies, the authors concluded that restrictions on commercial practice significantly increased costs to consumers.

A third study was conducted in 1976 by Professor James W. Begun, of the University of North Carolina at Chapel Hill.[123] This study was the first study to address the quality issue.

Begun conducted a national survey of optometrists in order to gather data on the price and quality of eye examinations.[124] His objective was to determine whether the alleged benefits

---

122 NAOO, The Price of Ophthalmic Goods and Services, HX 390, R. 23607 [hereinafter cited as NAOO Study].

123 Begun, James W., Ph.D., "Professionalism and the Public Interest: Price and Quality in Optometry." (Ph.D. dissertation, University of North Carolina, June 1977) [hereinafter cited as Begun].

124 Questionnaires were mailed to a ten percent sample (2,238) of optometrists practicing in the United States. 1,195 usable responses were received from this sample after three mailings. The questionnaire was designed to elicit information about practice characteristics, attitude about professionalism, price of materials and services, and possible indicators of practice quality. The reliability of the data received was checked against prior surveys of optometrists. Three questions relating to price were included in the questionnaire: one about prices for bifocal lenses, a second about the price for a specific frame, and the third about the charge to conduct and eye examination of a presbyope. Begun attempted to measure quality of optometric service by asking questions about equipment available in the refractionist's office, procedures performed in an examination of a presbyope, and length of an examination of a presbyope. Begun, supra note 123 at 43-46. See note 154, infra for a definition of "presbyope." In addition, a copy of the actual questionnaire mailed out may be found in Appendix C of the Begun study, supra note 123, at 114-125.

of professionalism [125] outweighed the costs in terms of the higher prices which earlier studies had shown to be associated with restrictions on commercial practice. The questionnaire was designed to elicit information about practice characteristics, attitudes about professionalism, price of materials and services, and possible indicators of practice quality.

While Begun's study is important in view of the failure of past studies to measure quality, it does not offer conclusive evidence on the quality issue. Although the data indicated that professional optometrists performed longer, more technical examinations, the study offered no information in terms of patient outcome.[126] One of the major arguments against

---

125 To measure "professionalism," Begun considered such factors as a practitioner's involvement in the AOA, his or her advertising behavior, whether the practitioner was involved in a voluntary continuing education program, and how many trade journals the practitioner received. Begun, supra note 123, at 50. A more detailed analysis of the methodology is found in the next section. In the majority of the comparisons Begun made, the quality measures were higher for the more "professional" optometrists.

126 "Patient outcome" may involve more than length of examination and tests performed during that examination. The key issues are the accuracy of the prescription written by the refractionist and discernment of any medical problems.

Begun agrees that the quality of the practitioner is not necessarily measured by the length or complexity of the examination or equipment available for use. Rather, these three factors relate to quality of service. Begun, supra note 123 at 62. A study conducted in New York, however, did show a correlation between the number of components in an examination and the eventual accuracy of the examination. There was also a high correlation between the thoroughness of the examination and the accuracy of the prescription.
(Footnote Continued)

commercial providers is that they perform "quickie" examinations. However, measurements of patient outcome include such things as the number of unnecessary prescriptions written, the accuracy of the prescriptions, whether the eyeglasses match the prescriptions, quality of eyeglasses dispensed, and whether existing medical problems are uncovered during the refraction. None of these was examined by the Begun study.

The Bureau of Economics (BE) recently conducted a study to determine the effects of advertising and commercial practice on the price and quality of vision care. In the pages that follow, we discuss the findings of that study. Studies from the Eyeglasses I proceeding are discussed to the extent that they confirm, corroborate or dispute BE's findings.

3. The Bureau of Economics Study

The most comprehensive study of the effects of commercial practice restraints on consumers is a study by the Commission's Bureau of Economics in 1978.[127] BE conducted an

---

126 (Footnote Continued)

Testimony of Elinor Guggenheimer, supra note 115 at 1980-1981. Begun, in his study, argued that at least two measures of professionalism -- trade journals and continuing education hours -- may be measures of the quality of practitioners. The data showed both of these as being positively related to examination price. Begun, supra note 123 at 76. He found that continuing education raises examination prices approximately $2.67 in those states with a requirement for continuing education. Begun, supra note 123, at 76.

127 Bureau of Economics, Federal Trade Commission, Economic Report -- Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (September 1980) [hereinafter cited as "BE Study"].

extensive shopper survey of optometric services by purchasing eye examinations and eyeglasses in typical market settings. The BE study provides comparative data on the price and quality of eyeglasses and eye examinations provided by commercial and professional practitioners. The following is a general discussion of its methodology and results.

The BE study was designed to determine whether differences in the price and quality of optometric services are related to advertising and commercial practice. In order to compare the cost and quality of vision care provided by optometrists in different competitive environments, BE purchased over 400 eye examinations in twelve cities throughout the United States, some of which were in states where both commercial and professional optometrists practice and others which were in states where commercial practice is banned.[128]

---

128 BE defined the relevant geographical market as Standard Metropolitan Statistical Areas (SMSA's), rather than cities. The 12 SMSA's in the survey were:

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

BE Study, supra note 127 at 41.

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

BE sent trained survey subjects into the field to purchase eye examinations and eyeglasses after each subject had received two thorough eye examinations, one by optometrists from the School of Optometry of the State University of New York (SUNY), and a second by staff at the Pennsylvania College of Optometry (PCO). Subjects with different types of refractive conditions were chosen,[129] and those with any eye pathology were excluded.[130]

---

129 Subjects fell into 3 categories:

(1) "blurred" - myopic individuals aged 43-51 who went to their eye appointments without their eyeglasses;

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

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

Be Study supra note 127 at 51-52.

130 The BE study is a process study which measures completeness of inputs or procedures performed and is not a patient outcome study designed to measure the ability of the optometrist to discover all relevant facts about the patient's eye condition. While a study designed to assess a practitioner's performance in detecting eye disease and referring such patients for appropriate treatment might be the most ideal, no actual pathologies were found in any of the candidates examined by optometrists at SUNY and PCO. In addition, we were told by our consultants that it would have been inadvisable to use people with eye disease as survey subjects. A survey subject with an eye pathology would not have been able to receive treatment until completion of the field eye examinations. To permit such a survey subject to delay treatment, even if he or she consents, would have raised a serious ethical question.

The optometry staff at SUNY trained survey subjects to recognize the procedures and equipment used in a complete eye examination. After four days of training at the SUNY campus, subjects spent one day at PCO in Philadelphia where they were tested on their ability to observe and record accurately various visual tests. Before the survey subjects were sent into the field to obtain eye examinations, they were debriefed by BE staff members.[131]

Nineteen subjects then obtained 434 eye examinations and corrective lens prescriptions from randomly selected optometrists in the twelve survey cities. In 231 cases, subjects bought a pair of eyeglasses.[132]

In analyzing the data, BE compared the price and quality of vision care in cities with neither advertising[133] nor commer-

---

131 The issue of possible bias was introduced at this time and subjects were instructed to disregard any such bias. The BE staff has assured us that the ability of the survey subjects to record accurately what happened in the field was not affected by any bias.

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

133 Data was collected during late 1977 and early 1978, at which time state and private restrictions on advertising of ophthalmic goods and services were still in effect.
(Footnote Continued)

cial practice, to that in cities where commercial practice and advertising by optometrists were permitted. Within the latter category, the so-called "non-restrictive" markets,[134] BE identified three types of optometric practice:

(1) non-advertising, non-commercial optometrists;

(2) advertisers[135] not associated with large chain firms; and

---

133 (Footnote Continued)

The Eyeglasses I TRR, 16 CFR Part 456, which eliminated those restrictions, until remanded by the United States Court of Appeals, took effect July 13, 1978.

134 "Non-restrictive" markets were those cities in which there was (1) nonprice advertising of eyeglassees only and large chain firms present; (2) nonprice advertising of both eyeglasses and eye examinations and large chain firms present; and (3) price advertising of eyeglasses and nonprice advertising of eye examinations and large chain firms present. (The limitation to nonprice forms of advertising of eye examinations was more the result of actual practice than experimental design since in the entire study, in any city, at any time, only one advertisement containing an advertised price for an eye examination was found.)

"Restrictive" markets on the other hand, were those cities where there was (1) no mass media advertising of either eyeglasses or eye examinations and no large chain firms present; and (2) nonprice advertising of eyeglasses only and no large chain firms present.

135 Advertisers were defined as optometric practices that advertised in the yellow pages or the newspapers. Optometrists who listed in the yellow pages only such information as name, address, and telephone number, were classified as nonadvertisers. Certain additional information in yellow pages listings, such as the location of the office relative to major thoroughfares, or use of the words "eye examinations," was not considered advertising; however, anyone using boldface type were considered advertisers. Non-advertisers who were found to use window displays and other sorts of on-site advertising were reclassified as "on-site advertisers."

(3) optometrists associated with large chain optical firms.[136]

Those in category (1) are what might be termed "traditional" professionals: non-advertising optometrists in either solo practice or standard group practice. Category (2) includes professionals who engage in limited forms of advertising as well as small firm advertisers. Category (3) is made up of commercial practitioners. These optometrists practice in mercantile locations, and may either be employed by a lay corporation or lease space from one. (BE did not determine whether optometrists associated with large commercial chains were actually employed by these firms or whether they merely leased space from the firms.)

In the discussion of BE's findings which follows, we will compare categories (1) and (3) only. The former clearly represents the traditional professional optometrists, the latter the high-volume optical chains which commercial practice restrictions serve to inhibit. Category (2), the "small advertisers," cannot be classified as either clearly professional or commercial. It includes optometrists who, aside from using advertising to some extent, may be indistinguishable from those classified as professionals. Category (2) also includes firms that may conduct a relatively high-volume practice similar to the large

---

136 BE identified large chain firms by using a list of major retail optical firms supplied to BE by the OAA. All the large chain firms engaged in advertising.

chains in category (3), but who do not fall into that group because it was limited by definition to the large interstate optical chains. Some smaller, local firms may well represent commercial practitioners.

We intend to obtain from BE the names of the optometrists and firms in category (2) and eventually to classify them as professional or commercial. But in this report we have excluded the category (2) observations from our discussion.

In order to assess the impact of advertising and commercial practice restraints on price, BE compared the average price paid in restrictive cities (those with no advertising or large commercial firms) with the average prices charged by commercial and non-commercial optometrists in non-restrictive cities. Price comparisons were based on the total package price for the eye examination and eyeglasses.[137] This amount includes any dispensing fees, as well as charges for glaucoma tests or any other examination procedures which were priced separately.

In order to permit meaningful price comparisons, a number of adjustments were made to the price data to control for factors

---

137 Prices were determined from receipts obtained by subjects. Although subjects were instructed to request an itemized receipt, price comparisons were based on the total package price, because allocation of charges to specific items may have been quite arbitrary. Because not all subjects purchased eyeglasses, it was possible to compare examination prices for those cases in which only an exam was obtained. Although there was a limited number of observations in this category, the overall pattern of price differences is the same as that found for the total price data. See BE Study, supra note 127, at 55.

other than the presence of advertising and commercial practice which might affect prices. Variations among subjects' refractive conditions were accounted for, since those with more complex vision problems might be expected to incur higher costs. Other controls included variations in per capita income by city (to account for different demand conditions) and city to city differences in the number of optometrists per capita and income-per-capita (the less the density of optometrists and the higher the average income, the higher is the market-wide price). Finally, adjustments to price data were made in order to reflect differences in the cost of living in the twelve cities which were included in the survey sample.[138]

The chart which follows present BE's findings on price.

Estimates of Average Price for Eye Examinations and Eyeglasses[139]

	Restrictive Cities	Non-restrictive Cities[140]

---

138 See BE Study, supra note 127, at pp. 48-55 for a more detailed discussion of the price adjustments made.

139 It should be noted that the average prices shown in the table are estimates, based on the adjustments described in the text above.

140 In this chart only, "restrictive cities" are those where there was no mass media advertising of either eyeglasses or eye examinations and no large chain firms present, and "non-restrictive cities" are those where BE observed price advertising of eyeglasses and at least non-price advertising of eye examinations (as well as the presence of large chain firms). Data was also collected in cities with intermediate levels of restrictions, but BE found that the price differences were less significant.

Since price advertising of eyeglasses and eye examinations may now be legal in all states (see Court of Appeals decision

(Footnote Continued)

Non-advertising Non-commercial Optometrists	$94.63	$73.43
Large Chain Firms	none	$61.36

Source: Bureau of Economics

The BE data show that, on the average, commercial firms charge less than professional optometrists, and that prices are lower for all types of practitioners when commercial firms are present in the market.

BE found that the price of optometric services in restrictive cities was significantly higher than in markets where advertising and commercial practice were permitted. Both categories of optometrists in non-restrictive markets charged less than practitioners in restrictive markets. The difference is statistically significant.[141]

The largest price differential ($33) was between large com-

---

140 (Footnote Continued)

in American Optometric Ass'n. v. FTC, CCH 1980-1 Trade Cas. ¶ 63,165 (D.C. Cir. 1980), BE's findings concerning price differentials in cities with only non-price forms of advertising are not relevant to our current inquiry. It is interesting to note, however, the importance of advertising to commercial practice. BE found that the presence of chains had an impact on the prices charged by professionals in the same market only in cities where there was price advertising.

141 The "significance" statements made here and throughout this report are at the 95% confidence level.

mercial firms in nonrestrictive markets and professionals practicing in a restrictive environment. The difference is statistically significant.

Professionals in nonrestrictive cities were found to charge significantly less ($21) than professionals in restrictive cities, but more than their commercial competitors.

The Benham and Begun studies corroborate BE's findings of substantial price differentials as a function of mode of practice. In 1975, Lee and Alexandra Benham conducted a study to determine the effect of professional control -- including restraints on commercial practice -- upon prices.[142] In a study conducted in 1972,[143] Benham had compared prices paid for eyeglasses in states which had complete advertising prohibitions with prices paid in states which had no restrictions

---

142 Data concerning prices paid for eyeglasses, source of eyeglasses, quantities purchased and other demographic variables are from a 1970 health interview survey conducted by Ronald Anderson in conjunction with the National Opinion Research Center and the Center of Health Administration Studies of the University of Chicago. Benham & Benham, supra note 121, at 428. The data file includes 10,000 individuals. Out of a total of 1625 individuals, 929 reported price paid for eyeglasses separately, 422 reported combination prices for eyeglasses and eye examination, and 274 provided no information. When combination prices were given, the cost of eyeglasses was calculated as 67% of the total cost if a physician was listed as the source of care, and 70% otherwise.The 1351 individuals who provided price information are used as the basic sample to obtain price estimates. The 274 who did not report price information were used in estimates in determining the frequency of purchases only. Benham & Benham, supra note 121, at 428, n. 18.

143 Benham, Lee, "The Effect of Advertising on the Price of Eyeglasses," 15 J.L. & Econ. 337, Exhibit V-1 (1972).

and found prices were lower in states that permitted advertising. Benham's 1975 study was spurred by the recognition in his first study that there were factors, in addition to advertising bans, which restrict commercial information in the retail ophthalmic industry and which could, therefore, result in higher prices.

The Benham study compared eyeglasses prices in different states and, like the BE study, found that consumers paid a substantially higher price for eyeglasses in states where there was greater control by the professional associations and where advertising and commercial practice were less prevalent. The Benham study, however, did not control for the variation in eyeglass frames and lenses and did not purport to measure the comparative quality of the eyeglasses purchased.[144]

The Benhams felt that information flow would be weaker

---

144 The Benhams' study was strongly criticized in a study financed by the AOA and conducted by the Southern Research Institute (SRI). Testimony of John Burdeshaw, Southern Research Institute, The Advertising of Ophthalmic Goods and Services: An Economic and Statistical Review of Selected FTC and Related Documents, Report to the AOA, Project 3692 (June 25, 1979), HX 356. As to the argument that the heterogeneous nature of eyeglasses purchases was not considered, the Benhams countered that the issue is not whether some eyeglasses are more expensive than others, but whether consumers in less restrictive states systematically obtain eyeglasses which were less elaborate or of lower quality. A wide variety of individual characteristics were examined and were not found to be systematically associated with price differences across states.

The BE study attempted to control for the heterogeneity of eyeglasses by instructing survey subjects to purchase a particular unisex metal frame and to request glass, as opposed to plastic, lenses. See BE Study, supra note 127, at 46.

in those states where commercial firms did not exist or had a small share of the market and where professional associations exerted more control. Three measures of "professional control" were used in the 1975 study:

(1) the proportion of licensed optometrists who were members of the American Optometric Association (AOA) through its state affiliates;[145]

(2) how difficult it was for commercial firms to enter the eyeglasses market in a given state;[146] and

(3) the number of individuals who obtained their eyeglasses from commercial sources.[147]

Taking into account various factors which influence the

---

145 Although the AOA no longer prevents "commercial" optometrists from becoming members, many of the state-affiliated associations do impose such a restriction or at least discourage advertising, and membership in the AOA is predicated upon membership in a state-affiliated association. Hence, the Benhams assumed that the larger the percentage of optometrists who are members of the AOA in a given state, the smaller the number of optometrists who engage in advertising in that state, and therefore, the fewer commercial practitioners there will be.

146 The Benhams categorized states as "restrictive" or "non-restrictive." Restrictive states were defined as those states in which large commercial firms had difficulty entering and operating (for reasons other than competition from existing commercial firms). In those states classified as restrictive, a variety of rules and regulations existed to discourage or eliminate commercial practice. The restraints included express and implicit prohibitions on advertising and restrictions on the employment of optometrists by lay corporations. Benham & Benham supra note 121, at R. 6237-6238 (pp. 426-27).

147 Benham & Benham, supra note 121, at R. 6237-6238 (pp. 426-27). Commercial sources were those sources of eyeglasses not listed in the Directory of the American Medical Association, Directory of the American Osteopathic Association and the Bluebook of Optometrists. Id. at R. 6238 (p. 427), n. 16.

price of eyeglasses,[148] the Benhams concluded that all three indices used to measure "professional control" were strongly associated with higher prices paid for eyeglasses.[149] Prices

---

148 For discussion of the model used and other variables included in the estimates, see id. at R. 6241-6245 (pp. 430-34). The model is based, in part, on economic literature which indicates that purchase price is affected by time costs associated with search and purchase. Id. at R. 6241 (p. 430). Thus, other associated factors were considered: family size, location of residence, age, sex and race. Id. at R. 6234 (p. 423). A number of other variables were also included in their estimates: years of schooling, marital status, employment income, other income, car ownership, number of pairs of eyeglasses purchased, per capita optometrists in state, insurance coverage of eye related expenses, cost of eye examination, and free eye care received. Id. at R. 6246 (p. 435).

149 The Benhams specifically found that:

1. Prices increase at nearly one-half the rate which membership in the AOA increases. As the proportion of optometrists who are members of the AOA increases from 43% to 91%, eyeglasses prices increase approximately $12.18;

2. Individuals living in states with greater professional control pay 25% to 40% more for eyeglasses;

3. The mean price of eyeglasses increases substantially as the proportion of eyeglasses purchased from commercial firms declines from 79% to 0%; and

4. The mean price paid for eyeglasses increased for each category of supplier (physician, optometrist or commercial outlet) as the level of professional control increased. (This finding refutes the assertion that price differentials across states are due to the fact that in the more professional states a larger proportion of the output is supplied by ophthalmologists and optometrists, whose services are of higher quality and therefore more costly.) Comparisons of states with low and high AOA membership levels show that mean prices paid for eyeglasses obtained from physicians are 20% higher, while optometrists' prices are 42% higher and commercial firms' prices are 41% higher than in states with low levels of professional control. Id. at R. 6241-6251 (pp. 430-41).

were higher in states in which a greater proportion of the licensed optometrists belonged to the AOA, states in which commercial firms had difficulty entering, and states in which a greater proportion of eyeglasses purchases were from non-commercial sources.[150] Thus, the Benhams concluded that restrictions on the permissible form and location of business practice which limit commercial practice may be instrumental in increasing the cost of vision care and may affect the frequency with which consumers obtain vision care.[151]

The NAOO study results also support the proposition that form and location of practice restraints reduce competition and cause prices to be higher than they would be in the absence of these restraints.[152]

---

150 In those states classified as "restrictive," eyeglasses prices were on the average $8.46 higher. In addition, as the proportion of purchases from commercial sources declined from 79% to 0%, (the range observed in the survey) the mean price increased $11.71. Id. at R. 6244-46 (pp.433-35).

151 Id. at R. 6256 (p. 446).

152 This study compared eyeglass prices in New York and Mississippi. Mississippi was selected because it permitted advertising but prohibited corporate employment of optometrists, optometrists from practicing in "mercantile" locations or leasing space owned by opticians, and the operation of more than one branch office by an optometrist. Conversely, New York permitted these so-called "commercial activities" but imposed certain restrictions on advertising. Thus, if the results of the study showed that prices were higher in Mississippi than those in New York, the findings would indicate that restraints other than advertising cause or contribute to prices that are higher than prices in areas with no such restrictions. NAOO Study, supra note 122, at 23611.

NACO study controlled for the heterogeneity of the eyeglasses.
(Footnote Continued)

The Begun study measured the effects of advertising and commercial practice restrictions on price.[153] The study measured

---

152 (Footnote Continued)

Shoppers were instructed to request a specific frame (Corsair (Pilot) by Universal for single-vision lenses and Leading Lady by Artcraft for executive trifocal lenses). NAOO Study, supra note 122, at 23611.

The average price of single vision prescription eyeglasses in Mississippi, where commercial practice was prohibited, was $51.88, 25% higher than the mean price in New York which was $41.38. The average price of trifocal eyeglasses in Mississippi was $68.90, 16% higher than the average price of $59.45 in New York. NAOO Study, supra note 122, at 23619-20.

The NAOO recognized that other factors such as costs of production could have caused prices in Mississippi to be higher. However, NAOO stated that one would expect costs of production to be lower in Mississippi than in New York in view of the lower cost of living, lower cost of medical services and lower per capita income. Adjustments for differences in per capita income were made by dividing the 1975 per capita income of Mississippi ($4,041) and that of New York ($6,603) into the mean price for eyeglasses in those states respectively. The result showed that on the average the price of eyeglasses in Mississippi has twice as much impact on the family budget as it has in New York. The study concluded, therefore, that the higher prices in Mississippi probably resulted from the commercial practice restraints. NAOO Study, supra note 122, at 23624-27.

Although the cost of living is generally higher in New York, NAOO did not make a study of whether it costs more to produce prescription eyeglasses in Mississippi than in New York. Testimony of R. Burr Porter, Ph.D., Associate Professor of Finance, Southern Methodist University, on behalf of NAOO, Tr. 6264 at 6285-86.

153 It should be noted that the data was collected before the FTC trade regulation rule which lifted advertising bans took effect. In states where advertising was prohibited, little commercial practice could be expected to exist. In other words, the ability to obtain the volume of business which makes commercial practice viable appears to be dependent on the ability to engage in mass media advertising.
(Footnote Continued)

prices for optometric services, comparing fees for the eye examination of a presbyope.[154] Although the questionnaire mailed to optometrists asked one question concerning prices for bifocal lenses and a second question concerning the price of a specific frame, Begun did not use the responses to those questions in his study but instead focused on comparing examination prices.[155]

Begun's data indicated that examination prices were substantially higher in states where advertising was restricted and among optometrists considered more "professional."[156] Mean

---

153 (Footnote Continued)

Thus, in states which statutorily prohibited advertising, there was little inducement for a commercial firm to enter the market.

154 Presbyopia is the deterioration in the ability to focus for near vision and is associated with aging.

155 Begun felt the responses to these questions were unreliable due to misinterpretation of the questions by the optometrists who responded. Moreover, there appeared to be little systematic variation among optometrists in frames and lens prices. Begun, supra note 123 at 60.

156 The professionalism measures used by Begun were of two types. One he termed "individual" professionalism which included such factors as a practitioner's involvement in the AOA, his or her advertising behavior and attitude about commercial optometry, whether the practitioner was involved in a voluntary continuing education program, and how many trade journals the practitioner received. The other Begun termed as "structural" or "legislated" professionalism. Five measures of structural professionalism were used:

(1) Continuing education required for relicensing;
(2) Price advertising by optometrists prohibited by state law or board regulation;
(3) Price advertising by opticians prohibited by state law or board regulation;

(Footnote Continued)

examination prices were about 20% higher for optometrists who did not advertise or who were involved in the AOA.[157] Examination prices were also approximately 20% higher for optometrists in states which statutorily restricted commercial practice and in states requiring continuing education.[158]

The study results indicated that the price charged for an eye examination was correlated to the length of examination, equipment available for use and examination procedures actually performed.[159] However, after holding quality constant across states, Begun found that examination prices were still higher in states where commercial practice was restricted and where

---

156 (Footnote Continued)

(4) Employment, location or commercial practice of optometrists restricted by state law or board regulation; and
(5) Membership coverage of AOA-affiliated state optometric associations.

Begun, supra note 123, at 73-74.

157 As mentioned earlier, commercial practitioners generally are not members of the AOA, which is why the fifth measure listed above was included.

158 Begun, supra note 123, at 73-74. An increase of one unit in the legislated professionalism score raised the examination price by $1.29 and all five indicators of legislated professionalism were found to be positively related to examination price. Of the individual measures of professionalism, anti-commercial attitudes and AOA involvement were most significantly related to price. Id. at 79-82.

159 The three measures of quality used by Begun were positively related to price. An increase in the length of an examination by ten minutes increased examination prices by $1.20. One additional piece of equipment raised price $.58 and one additional examination procedure raised price $.34. Id. at 82.

individual anti-commercial attitudes were stronger.[160]

Because many have argued that lower prices reflect lower quality service,[161] the BE study was designed to evaluate and compare the quality of optometric services delivered by different types of practitioners. Four aspects of quality were addressed:

(1) the thoroughness of the eye examination;

(2) the accuracy of the ophthalmic prescription;

(3) the accuracy and workmanship of the eyeglasses prepared from that prescription; and

(4) the extent of unnecessary prescribing of eyeglasses.

BE's findings on the comparative levels of quality are mixed. Analysis of the data revealed significant differences in the thoroughness of eye examinations performed by the various categories of optometrists, but no real differences in the other aspects of quality. There were no significant differences between commercial and non-commercial practitioners with respect to the accuracy of prescriptions written or the quality of eyeglasses sold. Nor was there any evidence to support the contention that commercial chains are more likely to promote sales through unnecessary prescribing.

---

160 Id. at 79.

161 See Section D, supra, for a discussion of the allegations concerning low quality vision care by commercial firms. See also Staff Report, supra note 1, at R. 24555-24561 (pp. 183-89) for a discussion of arguments on the price-quality relationship.

The BE study did find, however, that there were significant differences in the thoroughness of eye examinations. In the sense that quality was defined in the BE study, commercial firms provided examinations of lower quality than professional firms.

In measuring the quality of eye examinations, BE considered such things as the number and types of tests performed and questions asked of patients in taking a case history. Survey subjects had been trained to observe and identify a variety of tests and procedures commonly performed in a complete routine eye examination. Upon leaving an examination, they completed a debriefing questionnaire which included a checklist of the procedures performed in the examination. BE staff evaluated the results using a scoring system developed by study consultants to reflect the relative importance of the various elements of an eye examination to overall quality. Each test or procedure on the debriefing sheet was assigned a value which reflected its relative importance in the eye examination in the judgment of the consultants.[162] The result was a single quality index with 100 as the maximum possible score. Thus, each practitioner received a single summary score, ranging

---

162 See BE Study, supra note 127, at 94-166 (copy of debriefing sheet attached).

A second system of weights was developed by the NAOO. (Three other optometric groups declined the opportunity to suggest a scoring system.) Although there was some difference between the scoring system developed by our consultants and NAOO's system, the two measures were highly correlated. See BE study, supra note 127 at 6-7.

from zero to 100. The numbers show differences between practitioners in terms of thoroughness of examination.

Estimates of Eye Examination Quality[163]

(t-value in Parentheses)[164]

	Restrictive[165] Cities	Non-Restrictive[166] Cities
Non-advertising Non-commercial Practitioners	58.8 N = 104	70.0 N = 89 (4.17)
Large Chain Firms	None	51.6 N = 50 (2.28)

N = number of observations

Source: Bureau of Economics

163 The estimates are based on multivariate analysis of all regulatory environments, and they are net of variation due to differences in subjects, state optometrists per capita, and change in SMSA population. These control variables were used in computing all of the quality estimates which follow.

164 The t-value may be used to assess the significance of the difference between the class for which the t-value is presented and non-advertising optometrists in cities without chain firms. In a one tail test, values greater than about 1.65 are significant at the 5% level; values greater than about 1.29 are significant at the 10% level. For example, the average score on examination quality is higher for professionals in non-restrictive cities, and it is statistically significant, compared to professionals in restrictive cities.

165 In this chart and in the charts which follow, "restrictive cities" are those where there were no large chain firms present.

166 In this chart, and in the charts which follow, "non-restrictive cities" are those where large chain firms were present which sold both eyeglasses and eye examinations.

As the chart above indicates, BE found that there were quality differences among the different categories of optometrists:

1. Examinations by large chain firms were less thorough than those given by optometrists in cities where commercial practice is restricted.
2. Non-commercial practitioners in non-restrictive markets scored significantly higher on the quality index than their counterparts in restrictive cities.
3. Both groups of non-commercial optometrists scored higher than large chain firms.

In order to determine the source of differences in the quality of eye examinations, BE computed quality index scores for the three parts of the eye examination: (1) the case history; (2) the eye health exam; and (3) the vision test. In addition, BE focused on five procedures generally recognized as important to a thorough eye examination:[167]

(1) ophthalmoscopy (examination of the eye with an instrument that illuminates the interior of the eye);

(2) slit lamp exam or biomicroscopy (examination of the cornea under high magnification);

(3) tonometry (a means of detecting glaucoma by measuring the fluid pressure within the eye);

(4) retinoscopy or objective refraction (measurement of the refractive power of the eye by projecting light into the pupil and analyzing the motion of the lights

---

167 These were the most important procedures according to both the FTC and NAOO quality scoring systems. See also "How to Buy Eyeglasses," Consumer Reports, Nov. 1977, at 645.

and shadows on the retina) sometimes called an "objective refraction";

(5) subjective refraction (measurement of the refractive power of the eye based on the patient's response to different lenses the examiner places before the patient's eyes during a reading of an eye chart).[168]

In the table below, BE presents the estimated average quality index score for the three parts of the eye examination. For the eye health or medical portion of the examination, BE shows the estimated average number of seconds spent examining the eye with an ophthalmoscope and the percent of optometrists using the slit lamp and the tonometer. For the vision testing portion of the exam, the percent of optometrists using a retinoscope and the percent performing a subjective refraction are given.

Estimated Values of
Important Components of the Eye Examination[169]

---

168 The definitions are based on Herbert Solomon, O.D., and Walden J. Zinn, O.D., The Complete Guide to Eye Care, Eyeglasses and Contact Lenses 55-59, 235-43 (1977).

169 The estimated quality index scores for the three parts of the eye exam and the estimated number of seconds spent using the ophthalmoscope are based on multivariate regression analysis. The estimates of the percent of optometrists performing critical tests are based on a statistical method known as "probit analysis."

Probit analysis is used when the dependent variable in an equation is qualitative rather than linear. For example, in analyzing whether or not an optometrist performed a slit lamp examination there are only two possible outcomes: either the test was performed or it was not. The quality measures considered previously were linear, that is, observations consisted of points on a continuum ranging from 0 to 100. The quality measures used in the BE study which remain to be discussed are all qualitatively dichotomous variables, and thus the estimated values presented in the balance of this discussion are all based on probit analysis.
(Footnote Continued)

(t-values in Parentheses)

	Restrictive Cities	Non-Restrictive Cities	
	Non-Advertising Non-Commercial Optometrists	Non-Advertising Non-Commercial Optometrists	Large Chain Firms
1. Average Score (%) Case History	44.4	55.4 (2.07)	39.6 (.83)
2. Average Score (%) Eye Health	52.3	69.5 (3.18)	47.9 (.73)
a. Percent close to eye with ophthalmoloscope	82.7	91.3	76.6
b. Number of Seconds Examining Each Eye with Ophthalmoscope	25.2	33.9 (1.91)	22.9 (.45)
c. Percent Using Slit Lamp	19.0	39.0 (1.88)	9.0 (1.18)
d. Percent Using Tonometer	55.0	61.0 (.57)	64.0 (.80)
3. Average Score (%) Vision Testing	55.1	70.9 (4.90)	55.6 (.15)
a. Percent Using Retinoscope	77.3	90.4 (2.83)	83.6 (1.78)
b. Percent Giving Subjective Refraction	100.0	100.0	100.0

169 (Footnote Continued)

For further explanation of probit analysis, see H. Theil, Principles of Econometrics 628-31 (1971).

	N = 104	N = 89	N = 50

Source: Bureau of Economics

As the chart above indicates, analysis of the components of the eye examination reveals a pattern similar to that observed in the overall quality index scores, with some exceptions:

(1) Chain firms used the retinoscope more frequently than did non-commercial optometrists in restrictive cities. This difference is statistically significant.[170]

(2) The data on use of the tonometer and the average vision testing scores run counter to the general pattern; however, the differences between chain firms and optometrists in cities without chain firms are not statistically significant.

(3) All optometrists performed a subjective refraction.

Perhaps the most interesting of BE's findings on eye examination quality is the striking difference in performance between non-commercial practitioners in different environments. As stated above, the BE results show that non-commercial practitioners in non-restrictive markets performed examinations of better quality than their counterparts in restrictive cities when quality is measured in terms of thoroughness of examination.

---

170 We have extracted this finding from the BE study data. See BE Study, supra note 127 at 12. This is a result, however, which BE did not report or attempt to explain in its study.

The average scores of non-commercial optometrists on the major portions of the examination (case history, eye health exam, vision exam) was also significantly higher than the average scores of non-commercial optometrists in the restrictive cities.

From these results BE has suggested that there may be two markets for vision care where advertising and commercial practice is permitted (that is, some consumers may not always desire a complete medical examination of the eye, but may just want to have a "vision" or acuity test). The presence of commercial practice and advertising does not lower the overall quality of examinations offered by all optometrists, but rather enables optometrists to differentiate among themselves and to signal the quality of examinations they offer. Because of competition from less expensive and more accessible commercial providers, non-commercial optometrists justify their higher prices and attract certain consumers by offering more thorough examinations.[171]

(While it may be true that less thorough examinations in non-restrictive cities tended to be concentrated in the small advertisers and chain firm cells, there were just as many less thorough examinations in restrictive cities and, in all markets, the results showed a wide range in the level of thoroughness of eye examination within each type of optometrist.)[172]

Given that overall quality in restrictive and non-restrictive

---

171 BE Study, supra note 127, at 61-63.

172 See BE study, supra note 127, at 9-11.

markets was found to be about the same, a complementary explanation suggested by BE is that in restrictive markets where advertising and commercial practice are not permitted, there is no clear signal which enables consumers to differentiate among providers. Therefore, there is no incentive to provide more thorough examinations in order to attract consumers.[173] Optometrists who are so inclined are able to give less thorough examinations but at higher prices than the same quality offered by non-advertisers in commercial markets.

The second aspect of quality, the accuracy of the prescriptions, was judged independently by the two consulting schools of optometry. Each school used the prescription derived from the pre-survey eye examination as a benchmark, against which the prescriptions obtained in the field were evaluated. Because an ophthalmic prescription is not a totally objective measure,[174] two sets of clinical evaluations were obtained to assess the accuracy of prescriptions.[175]

BE established four measurements of accuracy, based upon approval of the prescription by (1) PCO, (2) SUNY, (3) either school, and (4) both schools. The results were as follows:

Estimates of

---

173 BE Study, supra note 127, at 89.

174 There is no single "accurate" prescription for an individual. See discussion on pp. 123-131, infra.

175 Each school made a subjective judgment on the adequacy of the prescriptions for the subjects' visual needs. The schools disagreed in 36 out of 401 cases.

Percent of Prescriptions Judged Accurate

(t-values in Parentheses)

	Restrictive Cities	Non-restrictive cities	
	Non-advertising Non-commercial Practitioners	Non-advertising Non-commercial Practitioners	Large Chain Firms
Approved by PCO	76%	84% (1.43)	86% (1.43)
Aproved by SUNY	76%	84% (1.50)	82% (.87)
Approved by Either School	82%	88% (1.17)	86% (.52)
Approved by Both Schools	70%	80% (1.69)	82% (1.66)
	N = 138	N = 103	N = 61

Source: Bureau of Economics

Under any standard chosen, commercial practitioners performed as well as non-commercial practitioners in restrictive cities. BE attaches greatest significance to "approved by either school" on the theory that approval by at least one of the schools is a reliable yet flexible standard.[176] We agree that this is probably the most appropriate standard to use. It is interesting to note, however, that under the most restrictive standard,

---

176 Telephone conversation with Jack Phelan, Bureau of Economics, June 16, 1978.

"approved by both schools," large chains scored significantly higher than optometrists in cities where commercial practice is restricted, and that this difference is statistically significant.[177]

The third measure of quality was based upon an assessment of the eyeglasses which subjects purchased. The accuracy of the lenses purchased was evaluated against the written prescription. Lenses were compared to the prescriptions written by the examining optometrists even if the prescription itself was judged not to meet the subject's visual needs, because the quality issue under scrutiny in this phase of the study is the likelihood that an optometrist will produce a pair of eyeglasses in accordance with the prescription specifications.

Consultants used an automatic optical focimeter (a device which measures the optical characteristic of corrective lenses)[178] and lenses were judged accurate if they met the 1972 ANSI Z80.1 standards for ophthalmic lenses. The ANSI standards establish tolerances, i.e., acceptable margins of error, for spherical power, cylinder power, axis, and pupillary distance.[179]

In addition to the evaluation of lens accuracy based on

---

177 We have extracted this finding from the BE Study data. This is a result, however, which BE did not report or attempt to explain in its study.

178 For a more detailed description of an optical focimeter, see pp. 94-97, infra.

179 For a thorough discussion of the ANSI standards and the questions arising from their application, see pp. 113-115, infra.

the ANSI Standards, BE asked PCO and SUNY for a clinical evaluation of the adequacy of the lenses.[180] The results of both of these measures appear below:

Estimate of
Percent of Eyeglasses Judged Accurate

(t-value in Parentheses)

	Restrictive Cities	Non-restrictive cities	
	Non-advertising Non-commercial Practitioners	Non-advertising Non-commercial Practitioners	Large Chain Firms
Passed ANSI Standards	50%	64% (1.52)	52% (.13)
Approved by both PCO and SUNY	75%	82% (.89)	75% (.07)
Approved by either PCO or SUNY	84%	86% (.31)	81% (.35)

180 In judging the performance of the optometrists in terms of the accuracy of the eyeglasses, the schools each made a clinical evaluation of the eyeglasses rather than using the ANSI standards as the measure of performance. In evaluating the accuracy of the lenses, the schools considered sphere-cylinder-axis accuracy and decentration accuracy. In addition to lens accuracy, the workmanship of the eyeglasses was evaluated (that is, whether there were imperfections such as bubbles on scratches in the lenses, whether there were imperfections in the frames, and whether the lenses were well-edged and well-mounted in the frames). (While poor workmanship may be the result of laboratory preparation, it is generally agreed that it is the dispenser's responsibility to check all lenses and eyeglasses prepared by the laboratory and to reject eyeglasses with significant imperfections or inaccuracies.) See BE Study, supra note 127, at 79.

	N = 75	N = 47	N = 29

Source: Bureau of Economics

The most striking thing about the results presented in the chart above is the low pass rate under the ANSI standards.[181] The comparison between commercial and non-commercial optometrists, however, reveals no significant differences in performance. The results of the clinical evaluation of lens accuracy show a similar pattern.

In addition, lenses and frames were inspected for imperfections and checked to see that the lenses were properly edged and well mounted in the frames.[182] As with the evaluation of the prescriptions, both schools of optometry made a subjective judgment as to quality, thus producing four measures of workmanship, as indicated in the table below:

Estimates of
Percent of Eyeglasses Judged Adequate in Workmanship
(t-value in Parentheses)

Restrictive Cities		Non-restrictive cities	
Non-advertising Non-commercial Practitioners		Non-advertising Non-commercial Practitioners	Large Chain Firms

181 The debate over use of the ANSI tolerances performance standard for optical dispensers is discussed on pp. 113-115, infra.

182 Defects such as these may, in fact, be the fault of the optical wholesaler rather than the dispensing optometrist; however, the optometrist's responsibility was defined to include the responsibility for checking the quality of goods which he or she sells.

Approved by PCO	54%	74% (2.11)	53% (.13)
Aproved by SUNY	75%	83% (.91)	77% (.20)
Approved by Either School	81%	94% (2.05)	87% (.72)
Approved by Both Schools	48%	61% (1.37)	43% (.49)
	N = 76	N = 49	N = 30

Source: Bureau of Economics

Here again, the results contradict the contention that commercial practice bans assure higher quality. There were no significant differences between chain firms and professional optometrists in restrictive cities. Non-commercial optometrists in cities with large chain firms had the highest approval rates under any of the four standards, and rated significantly higher than professionals in restrictive cities under both the "approved by either" standard and the "approved by PCO" standard.

The final index of quality was the extent of unnecessary prescribing, sometimes referred to as "overprescription." This was defined as the percent of examinations which resulted in a recommendation of new eyeglasses for subjects who arrived at their examinations wearing a prescription judged adequate (the so-called "20/20" group) by the consulting schools of optometry. These subjects were instructed to inform the optometrists that they wanted new eyeglasses only if a new pair would "really make a difference" in their vision.

Two definitions of overprescription were used. The first includes all cases where a "20/20" subject was instructed by

the examining optometrist to buy a new pair. The second excludes those cases in which the examiner made an error in determining the patient's prescription. The latter definition is designed to capture only instances involving improper recommendations.

Estimates of
Frequency of Unnecessary Prescribing
(Percent of Cases Where New Eyeglasses Recommended)
(t-values in Parentheses)

	Restrictive Cities	Non-restrictive cities	
	Non-advertising Non-commercial Practitioners	Non-advertising Non-commercial Practitioners	Large Chain Firms
All 20/20s	32%	9% (1.24)	14% (.85)
	N = 37	N = 37	N = 24
Those with correct Rx	36%	7% (1.24)	10% (1.03)
	N = 25	N = 28	N = 20

Source: Bureau of Economics

Under either definition, chain firms showed no greater tendency to overprescribe, thus contradicting the allegation that commercial providers, because of their interest in profits, overprescribe with greater frequency than non-commercial providers.[183]

---

183 The differences in percentages which appear in the chart on p. 80 are not statistically significant. It should be noted that, because of relatively small sample sizes, only substantial differences among types of optometrists will be statistically significant. However, the direction of differences in these results runs counter to the hypothesis
(Footnote Continued)

Finally, BE sought to determine whether price is related to quality. Regression analysis revealed a significant positive relationship between thoroughness of examination and price.[184] Further analysis indicates that this price/quality relationship holds true for different types of practitioners, but that at a given level of exam quality, price is higher for professional optometrists than for large commercial firms. The other aspects of quality in the BE study did not correlate with price.

The Begun study also focused on the quality issue. Quality of optometric service was measured by optometrists' answers to survey questions concerning: (1) length of examination; (2) equipment available for use by the optometrist surveyed; and (3) examination procedures actually performed during an eye examination.[185] As discussed earlier, the results of the survey indicated that all three quality measures were positively related to increased prices, that is, the price charged for an eye examination correlated with the length of examination,

---

183 (Footnote Continued)

that chain firms overprescribe more frequently. Hence, it is unlikely that large sample sizes would reverse this statistical finding.

184 The price use in the equation was the total price for the examination and eyeglasses.

185 These three measures of quality are "input" measures rather than "output" measures of quality. That is, they do not measure how well the practitioner performs his or her service in terms of accuracy of prescription and eyeglasses.

equipment available for use, and examination procedures performed.[186]

Begun next sought to determine the correlation between quality as defined above and commercial behavior. Opponents of commercial practice argue that professionalism improves the quality of optometric service and that the prices charged reflect only this improved quality.[187] To evaluate the relationship between quality and type of practitioner, Begun used a regression analysis which showed that all three of the quality measures were positively related to type of practitioner. For example, optometrists with high AOA involvement and those who did not advertise performed longer examinations with more individual

---

186 It should be noted that while Begun's results indicate that there might be some quality difference, there are several shortcomings in his study. One major criticism is that the study results are based on optometrists' responses to questionnaires mailed to them. Optometrists were asked questions about the prices they charge for an eye examination, the type of equipment they have available for use, the average length of examination, and what examination procedures are performed. While the responses given may be entirely accurate, the data used in the Begun study were not objectively obtained. An indication of the reliability of the price data was provided by a 1975 survey of optometrists which produced a mean price for eye examinations. In that survey, the mean price was $23. The mean price for an examination in Begun's study was $24.35. Begun, supra note 123, at 50. The data received concerning equipment and procedures performed during an examination, however, were not verified. A second criticism of the Begun study is that the study offered no information in terms of patient outcome.

187 As explained earlier, "professionalism" was measured by individual practitioner attitudes about advertising and commercial practice, involvement in the AOA, participation in continuing education programs, number of professional journals received and legislative restrictions on advertising and commercial practice. See notes 125 and 156, supra.

procedures and had more examining equipment available.[188] Similar differences were found to exist between optometrists in states where commercial practice was restricted and optometrists in states where commercial practice was permitted.[189]

Since the data show that both higher quality (as it is defined in the study) and higher price are associated with advertising and commercial practice restrictions and optometrists with anti-commercial attitudes, Begun sought to determine the effects of professionalism on price independent of quality differences. A regression analysis was conducted using a number of control variables which could be expected to have some effect on price such as year of graduation, patient income status and number of practitioners in the area.[190]

The results of the regression analysis showed that commercial practice and advertising restrictions and individual anti-commercial attitudes are positively related to price after accounting for the effects of the control and quality variables.[191] Begun concluded therefore, that professionalism does have an independent and positive impact on price. At the same time,

---

188 Begun, supra note 123, at 73.

189 Id. at 75.

190 Id. at 76-78.

191 A total of 45% of variance in price is explained by the regression model. 21% of the variance is due to the control variances, while quality measures explain 14%. The remaining 10% of variance is accounted for by measures of professionalism. Begun, supra note 123, at 79.

however, the data also indicate that consumers may be getting a different type of service, that is longer, more thorough, and more technically advanced service from non-commercial optometrists.[192]

4. Do Commercial Practice Restrictions Affect Accessibility of Vision Care?

One measure of the accessibility of vision care is the frequency with which eyeglasses are purchased in a given period of time. The Benhams examined this issue in their 1975 study, taking into account factors which might affect the frequency with which eyeglasses are purchased.[193] The Benhams found that the likelihood of obtaining eyeglasses in a given year is greater in states with lower prices and that consumers purchase eyeglasses with greater frequency in the states termed less restrictive or having less professional control.[194]

---

192 Commercial optometrists performed an average of 47.67 examinations per week compared to professional optometrists who averaged 33.58. The examination length was 24.17 minutes compared to 33.57 minutes for professionals; equipment available score was 2.83 compared to 4.09; and examination procedures score was 3.23 compared to 4.36 for professionals. Begun at 98-99. It is interesting to note, however, that the "no advertising" measuring of professionalism was not related to examination procedure. Begun, supra note 123, at 85.

193 Individuals obtain eyeglasses periodically depending upon the rate of change in their vision, breakage or loss of eyeglasses and such other factors as income, price, age, sex, race and education. Benham & Benham, supra note 121, at R. 6243 (p. 432).

194 The proportion of individuals obtaining eyeglasses was directly related to the price of eyeglasses. A 30% increase in price resulted in a 28.5% to 34.2% decrease in the proportion of people buying glasses. The Benhams found that as
(Footnote Continued)

Another factor which could affect the accessibility or availability of vision care is the location or convenience of obtaining ophthalmic goods and services. A study commissioned by the California Optometric Association (COA)[195] sought to evaluate what factors influence where a consumer decides to purchase eyeglasses. The COA study involved a randomly selected sample of 500 consumers who were asked to state whether certain factors[196] were "very important," "somewhat important," "rather important," or "completely irrelevant" in their decision to purchase eyeglasses.[197] Locational convenience, one of the factors selected for study, was considered an important factor

---

194 (Footnote Continued)

the mean price increases in the restrictive states, the percentage of people buying eyeglasses in a specified time period declines as much as 35%. In states with a lower level of AOA membership, per capita expenditures are 3% lower, but the frequency of purchase is increased, with 36% more of the population obtaining eyeglasses during that time period. When multiple purchases of eyeglasses are taken into account, there is a 7% greater expenditure per capita for eyeglasses in non-restrictive states while 50% more eyeglasses are obtained. Benham & Benham, supra note 121, at R. 6249-6251 (pp. 438-441).

195 Statement of Dr. Harvey Adelman, HX 245.

196 The factors considered were:

1. reputation of doctor;
2. services provided by the doctor;
3. price for examination;
4. price of frames provided by the doctor, and
5. convenience of office location.

Id. at p. 1 Results.

197 Id. at p. 2 of Questionnaire.

by consumers.[198]

If location restrictions decrease the accessibility of vision care, these restrictions may decrease the frequency with which vision care is obtained. Some consumers may receive no care at all or may receive care less frequently than they otherwise might. This is particularly true with respect to the elderly, whose mobility problems are greater than those of the popultation as a whole.[199]

F. Conclusion

As we discussed above, the study conducted by the Commission's Bureau of Economics indicates that the quality differences between commercial and non-commercial optometrists may be far less significant than opponents of commercial practice have claimed. The BE study results indicate that commercial optometrists perform as well as non-commercial practitioners in determining the proper eyeglasses prescription and in the quality of the eyeglasses dispensed.[200]

The BE study results do not indicate that commercialists prescribe with any greater frequency than non-commercial opto-

---

198 The study results reveal that 23.4% of the consumers surveyed considered this factor "very important" and another 42.6% considered it somewhat important. Thus, overall, 66% of the sample thought location to be an important factor in their purchase decision. Copy of computer results used by Dr. Adelman, HX 247.

199 See notes 119 and 120, infra.

200 BE Study, supra note 127, at 14-20.

metrists.[201] It appears that the extent of unnecessary prescribing of eyeglasses is a product of the merged role of the optometrist as both prescriber and supplier rather than a product of commercial practice or lay interference with a professional's judgment.

The evidence in the BE study also contradicts the claim that the entry of commercial chains into the market brings about a lowering in the overall level of quality of vision care. BE found no evidence that professionals in restrictive cities delivered higher quality vision care than professionals who faced competition from commercial practitioners. In fact, BE found that, on the average, professionals in non-restrictive markets provided eye examinations of higher quality than their counterparts in restrictive cities.[202]

One other conclusion based on the BE data seems warranted. There does not appear to be any support for the assertion that commercial practice lowers the aggregate level of eye examination quality in non-restrictive states vis-a-vis restrictive states. BE found that the overall level of eye examination quality, including the thoroughness of the eye examinations, was the same in both states which permit, and those which prohibit commercial practice. Commercial firms may offer a less thorough eye examination, but so do some professionals in restrictive states.

---

201 Id. at 20.

202 Id. at 14.

The results showed a wide range in the level of thoroughness of eye examination within each type of optometrist.[203] The difference is that in restrictive states, where all providers look alike, the consumer has no way to ascertain who is providing the less thorough exam. What is clear, however, is that prices are substantially lower in states which permit commercial practice and that in restrictive markets, there is a statistical likelihood that a less thorough examination will be given by a commercial provider.

The results of the BE study suggest that commercial practice restraints do not, for the most part, protect consumers from lower quality care. Furthermore, BE found that prices were significantly higher in cities where commercial practice was restricted[204] and that for the same price, consumers received a higher quality eye examintion (as measured by the study) in non-restrictive cities than in restrictive markets.[205] While it is true that for higher prices consumers received a longer, more thorough eye examination from higher-priced optometrists, it is far from clear that the overall costs of commercial practice restrictions are offset by increases in quality. For some individuals the choice may be between a less thorough eye examination at a lower price or no examination at all. The higher

---

203 Id. at 9.

204 Id. at 4.

205 Id. at 25.

cost of a thorough eye examination may prevent some consumers from receiving any vision care at all.

The final staff report in the Eyeglasses I proceeding noted that high prices prevent many persons (particularly the elderly[206] or those who live on fixed incomes) from obtaining eyeglasses.[207] A recent survey of American families found that inflation had forced some to forego the purchase of new eyeglasses.[208]

As we noted in the introduction to this Staff Report, a true assessment of the quality of this nation's health care must take into account not only the level of quality for those that receive care, but also the number of persons who do not receive any care. Commercial practice restraints, which increase

---

206 In 1976, the House of Representatives Subcommittee on Health and Long-Term Care of the Select Committee on Aging conducted hearings on the needs and costs for the elderly. The AOA submitted a statement concerning the unmet vision needs of the elderly:

> "[W]e find too many elderly Americans who count up their remaining change at the end of a month and say to themselves that they cannot afford to have their eyes examined, they cannot afford to have spectacle frames repaired, they cannot afford new prescription lenses."

Medical Appliances for the Elderly: Needs and Costs, Hearings before the Subcomm. on Health and Long-Term Care of the Select Comm. on Aging, House of Representatives 94th Cong., 2d Sess. 156 (June 24, 1976) (statement of American Optometric Association).

207 Staff Report, supra note 1, at R. 24521-24524 (pp. 149-52.

208 Keran, U.S. Health Profile, Washington Post, Apr. 26, 1979, at. C1, col. 4.

the cost of vision care, may have a significant negative effect on the overall quality of care.

We believe that there may be a less restrictive and less costly (in terms of economic injury to consumers) means of protecting consumers from the dangers which may result from lower quality vision care than banning commercial practice. This less restrictive alternative would be a regulatory scheme which is aimed more directly at the quality of services consumers receive. For example, a more efficient way for states to insure standards of quality may be through direct regulation of examination procedures. To the extent that commercial firms are found to provide less thorough eye examinations, the states might establish minimum standards for office equipment and examination procedures. A number of states have already adopted this approach.[209]

Similarly, regulations could be designed to remedy perceived abuses which might arise from the nature of the commer-

---

209 See, e.g., N.J. Rev. Stat. § 45-12-11(v), and New Jersey State Board of Optometry Regulations, Exhibit IV-32. The New Jersey statute requires that:

> Prior to prescribing for or providing eyeglasses or spectacles a complete minimum examination shall be made of the patient to determine the corrective lenses necessary for such a patient. Id.

The New Jersey State Board of Optometry has enumerated 16 tests which constitute the minimum examination. See also Rules and Regulations of the Michigan State Board of Examiners in Optometry, Section 338.262, Exhibit IV-23 (specifies seven items of equipment which optometrists are required to "have and use").

cial setting. For example, one legislative proposal in the state of Ohio included the following provision (in a bill specifically permitting commercial optometric practice) to prevent employers from interfering in the doctor-patient relationship:

> The Board [of Optometry] shall not make any rule prohibiting, limiting, or restricting the location where the practice of optometry may be conducted or affecting the right of an optometrist to seek and obtain employment with any person, organization or association provided that licensed optometrist is the individual who performs the practice of optometry as defined . . . [elsewhere in Code of Optometry.] In the event that any person, organization, or association employing a licensed optometrist is found by a court of competent jurisdiction to be interfering with the proper exercise of the professional judgment of a licensed optometrist in the practice of optometry, the Board may forbid any licensed optometrist from seeking and accepting employment with such person, organization, or association for a specified and limited period of time to be determined by the board.[210]

In sum, many of the quality justifications raised by advocates of commercial practice restraints appear to be without merit. The evidence contained in the BE study (which is corroborated by the findings of the Begun study) indicates that the alleged quality differentials simply do not exist in most aspects of vision care services. The arguments concerning the thoroughness of eye examinations do raise a serious concern. However, there is reason to believe that a more appropriate solution may be found in more direct regulation of any perceived

---

210 H.B. 432, 111th Ohio General Assembly, Regular Session (1975-76), Exhibit IV-144 at R. 6204.

abuses, rather than broad restrictions aimed at banning commercial practice altogether. On the basis of these findings, we believe the proposing of a trade regulation rule is warranted, both to test the validity of our evidentiary findings and to provide a forum for discussion and debate on the implications of those findings.

II. Restrictions on the Duplication of Lenses by Opticians

A. Introduction

Many consumers who wear prescription eyeglasses will at some time wish to purchase a second pair of eyeglasses for fashion related reasons or as a spare pair. Other consumers will want to buy prescription sunglasses. Yet others will break or scratch their eyeglasses and need replacements. Consumers facing one of these situations have a number of options from which to choose:

1. They can undergo an eye examination, obtain a prescription and purchase new eyeglasses; or
2. They can return to the person who filled their original prescriptions for their new eyeglasses; or
3. They can go to a different provider and have their new eyeglasses prepared from their old lens prescription; or
4. They can go to a new provider (most likely an optician) and have their new eyeglasses duplicated from the original pair.

The option which the consumer chooses will cost varying amounts and will subject the consumer to varying problems. The first option, obtaining a new eye examination, will on the average cost $25 in addition to the cost of the new eyeglasses.[1]

Under the second option, the consumer would not incur the expense of the new eye examination, but would have to return to the provider from which he or she originally purchased eye-

---

1 James W. Begun, Ph.D., Professionalism and the Public Interest: Price and Quality in Optometry. (Ph.D. dissertation, University of North Carolina) (June 1977) [hereinafter cited as Begun]. Begun determined the average cost of an optometrist's exam to be $24.35. Id.at 50.

glasses. If the consumer has moved to a new city, this may be impossible. In other instances, the consumer may wish to shop around and seek out another provider who offers the desired cost and quality of service. Thus, although under this option consumers will not incur the expense of a new eye examination, they may not be able to capitalize on the increased competition and information in the optical market.

Under the third option, consumers can seek out the best buy only if they still have their prescriptions (or can obtain them from their original examiners or dispensers). As we discuss below, there is reason to believe that many dispensers of eyeglasses will not provide consumers' lens specifications to new providers.

The fourth option, lens duplication, is illegal in a number of states. In this section, we discuss the issues raised by state laws and regulations which prohibit opticians from replacing broken lenses, or duplicating an entirely new pair of eyeglasses from an existing pair, without having a signed prescription from an optometrist or ophthalmologist.[2]

B. What is Lens Duplication?

The process of duplicating lenses without a prescription is accomplished with a device called an "optical focimeter"[3]

---

2 In this section and throughout the staff report, the term "duplication" refers to the process of making a new lens or pair of eyeglasses by neutralizing an existing lens or pair of lenses.

3 Two widely-used manual optical focimeters are the "Lensometer" (Footnote Continued)

which measures the optical characteristics of spectacle lenses. Bausch and Lomb, which manufactures an optical focimeter under the trade name "Vertometer," describes the capabilities of its device, and generically the capabilities of manual optical focimeters, in the following manner:

> The Vertometer is an optical instrument used to determine the optical characteristics of ophthalmic lenses. It is used to check the power, axis, centering, etc., of lenses which have been surfaced and also to determine the optical characteristics of lenses which are to be duplicated.
>
> . . . The instrument consists of a light source, a movable target, a lens holder, and a telescope. By looking into the eyepiece, with the lens to be measured in the proper position, the target can be brought into focus by adjustment of the position of the target. This adjustment is accomplished by manipulation of the various dials of the instrument.[4]

The process of determining the power of an ophthalmic lens through the use of an optical focimeter is commonly termed "neutralization." The term derives from the fact that the technician "neutralizes" the refractive power of the lens being measured by bringing the "target" of the optical focimeter into focus. In essence, the technician has determined the power

---

3 (Footnote Continued)

manufactured by American Optical and the "Vertometer" manufactured by Bausch and Lomb. See Opticians Association of America, Technical Specifications and Operating Instructions for Selected Optical Focimeters (1978) for technical descriptions of these instruments.

4 Id. at Section B.

necessary to neutralize the lens being measured --that power being equal to the power of the lens itself.

It is important to note that the process of verification (by which an optician measures the accuracy with which the initial lenses were prepared by an optical laboratory) is functionally identical to the process of duplication.[5] That is, what an optician does to verify the accuracy of a lens prepared to fill an optometrist's or ophthalmologist's prescription is precisely what he or she does to duplicate eyeglasses. Indeed, it is the same process used by an optical laboratory to determine whether the correct prescription has been ground into the lenses being prepared.

There are two different kinds of optical focimeters: manual models (such as the Bausch and Lomb "Vertometer" described above), and automatic models which employ more sophisticated technology.[6]

---

5 Id.

6 See, e.g., technical description of the "Acuity Systems Auto-Lensmeter," id. at Section C. This automatic focimeter is described in the following terms by its manufacturer:

> The AUTO-LENSMETER is the first, fully-automated instrument for measuring the optical properties of ophthalmic lenses - including sphere, cylinder, axis, prism, optical center, and waves.
>
> Combining push-button ease with advanced laser technology and micro-computer precision, the AUTO-LENSMETER measures and computes optical prescriptions to 0.25, 0.12, or 0.01 diopter accuracy. These measurements are instantaneously displayed on a digital screen. An optical printer can docu-

(Footnote Continued)

Manufacturers of the automatic focimeters contend that these newer, more expensive devices can be used with a high level of accuracy by anyone with a minimal amount of training.[7]

C. Analysis of State Laws

It is often difficult to determine whether or not a state permits the duplication of lenses solely by examining the state statutes and regulations. In the clearest cases, the process of duplication is specifically prohibited or allowed. In other instances, bans on duplication are achieved through state legislation which defines the adaptation of eyeglasses to the face without a written prescription to be the practice of optometry

---

6 (Footnote Continued)

ment each measurement on paper tapes or lens envelopes.

7 . . . [T]he new Lens Analyzer makes split-second measurement of the sphere, cylinder, axis and prism and displays the results digitally in standard prescription notation. The instrument automatically computes the prism in each lens and calculates the relative prism in the spectacles as a pair.

. . . Experience by users of the instrument . . . has shown that persons without prior training can accurately operate the Lens Analyzer with less than one hour's instruction. The computer's speed and simplicity of operation allow greater office efficiency and increased lab productivity by eliminating several calculations previously done by hand. . . . A complete lens pair analysis . . . can be completed in two to four seconds.

Advertisement for describing Humphrey Instruments, Inc., "Lens Analyzer," in 20/20, at p. 56 (May - June 1978).

and prohibits opticians from practicing optometry.[8] Frequently, these state laws also include an exemption from the optometric practice act for providers such as medical doctors and opticians. However, it is often difficult to ascertain the scope of that exemption in actual practice (e.g., whether it would permit opticians to duplicate lenses).

States fall into three categories with respect to the legality of duplication by opticians. Ten states proscribe the duplication of lenses.[9] Approximately fifteen states specifically authorize opticians to duplicate lenses.[10] Twenty-five states and the District of Columbia have state laws which are either ambiguous or are silent on the question of duplication.[11] It appears that opticians are duplicating lenses in those states where the statutes are ambiguous or silent on this question.

---

8 See, e.g., Ark. Stat. Ann. Tit. 72, § 72-801 ("The profession and the practice of optometry is hereby defined to be. . . . [a]ny person . . . who prescribes, dispenses, . . . or duplicates lenses, . . . shall be deemed to be engaged in the practice of optometry.")

9 Arkansas, California, Idaho, Indiana, Kansas, Louisiana, Maine, Montana, Oklahoma, and Oregon.

10 Connecticut, Florida, Georgia, Hawaii, Kentucky, Minnesota, Montana, New Jersey, New Mexico, North Carolina, Rhode Island, Vermont, Virginia, Wisconsin and Wyoming.

11 Alabama, Alaska, Arizona, Colorado, Illinois, Iowa, Delaware, District of Columbia, Maryland, Montana, Nebraska, New Hampshire, New York, North Dakota, Ohio, Pennsylvania, South Carolina, Tennessee, South Dakota, Texas, Utah, Washington, and West Virginia.

In a landmark case, Williamson v. Lee Optical,[12] the Supreme Court considered the constitutionality of an Oklahoma law which prevented opticians from duplicating lenses by defining the process of duplication to be the practice of optometry. The District Court in Williamson had struck down the law on due process grounds, holding that the ban on duplication was "neither reasonably necessary nor reasonably related to the end sought to be achieved" by the state.[13]

In reversing the District Court decision, the Supreme Court capsulized the policy issues and state justifications which underlie restrictions on the duplication of lenses:

> The Oklahoma law may exact a needless, wasteful requirement in many cases. But it is for the legislature, not the courts, to balance the advantages and disadvantages of the . . . requirements. It appears that in many cases the optician can easily supply the new frames or new lenses without reference to the old written prescription. It also appears that many written prescriptions contain no directive data in regard to fitting spectacles to the face. But in some cases the directions contained in the prescription are essential, if the glasses are to be fitted so as to correct the eye condition. The legislature might have concluded that the frequency of occasions when a prescription is necessary was sufficient to justify this regulation of the fitting of eyeglasses. Likewise, when it is necessary to duplicate a lens, a written prescription may or may not be necessary. But the legislature might have concluded that one was needed often enough to require one in

---

12 348 U.S. 483 (1955).

13 Lee Optical v. Williamson, 120 F. Supp. 128, 137 (W.D. Okla. 1954).

> every case. Or the legislature may have concluded that eye examinations were so critical, not only for correction of vision but also for detection of latent ailments or diseases, that every change in frames should be accompanied by a prescription from a medical expert.[14]

The justifications advanced in support of state-imposed bans on duplication are, as stated in Williamson, twofold:

1. In some cases, opticians may not be able to duplicate eyeglasses accurately without reference to the written prescription, and

2. In some cases, duplication may be used by consumers (either intentionally or unintentionally) to bypass the examination process. This may result in eye diseases or other visual abnormalities remaining undetected.

Virtually no reliable data either supporting or refuting the proffered justifications exist. We have been unable to locate any research testing the validity of the first of these justifications and do not believe that any exists. The only evidence bearing on the ability of opticians to duplicate lenses accurately, consists of the reported experiences of individual opticians[15] (who uniformly testified that duplication can be,

---

14 348 U.S. 483, 487 (1955).

15 See, e.g., Testimony of Robert Troast, Tr. 2007 at 2029; testimony of Paul E. Alony, Tr. 2544 at 2548; testimony of Alfred P. Rosati, Tr. 27748 at 2784; testimony of Norman G. Michaud, Tr. 2789 at 2817; testimony of Doug Mathews, Tr. 4459 at 4483-84; testimony of Berry C. Lofland, Tr. 5510 at 5525; testimony of E. Logan Goar, Tr. 5550 at 5572-73; testimony of John H. Burns, Tr. 5582 at 5591-92; testimony of Stephen Lee Adams, Tr. 6035 at 6051; statement of Stanley C. Pearle, O.D., Exhibit V-5 at 500022.

and is done accurately) and optometrists[16] (some of whom contended that duplications were not being performed accurately in jurisdictions where duplication is permitted). As we discuss below, there are some limited data addressing the second justification.

D. The Duplication Market -- Why Do Consumers Seek Out Duplication Services?

In the introduction to this section, we discussed the options which a consumer might have in seeking to purchase duplicate or replacement spectacle lenses. The viability of these options is critical to an understanding of why consumers seek out duplication services. We will discuss the economic considerations which attend those choices and other factors which may affect their viability.

The first option available to a consumer is to obtain a new eye examination and then purchase new eyeglasses, or the new form of eyeglasses (e.g., sunglasses, a second or "fashion" pair, etc.) they want. The primary consideration in exercising this choice is the cost. The most recent data show that the average cost of an eye examination by an optometrist is approxi-

---

16 In a study conducted by a group of optometrists called "Florida Gulf Coast Eye Care" a number of prescriptions were prepared into glasses, with the glasses subsequently being taken to opticians' establishments for duplication. The group concluded that the duplications were not being performed accurately, and the duplication should therefore not be permitted. Florida Gulf Coast Eye Care, Eyeglass Duplication Project (1977). Both the methodology and the ultimate results of this study have been seriously questioned by the Floria Board of Dispensing Opticians. Letter from Allen R. Smith, Jr. and Dale G. Bennett, Florida Board of Dispensing Opticians to the Division of Special Projects, Bureau of Consumer Protection, Federal Trade Commission (Nov. 16, 1977).

mately $25.[17] Thus, the consumer will have to pay for the eye examination and the new eyeglasses. In some situations, the eye examination expense is clearly unnecessary. For example, if a consumer obtains an eye examination and new eyeglasses, and shortly thereafter decides to purchase a pair of prescription sunglasses, a new eye examination would not be necessary. Yet, if the consumer chose this option, he or she would unnecessarily spend an extra $25. As we will discuss below, this may be the only option available to the consumer in a significant number of states.

If a consumer wishes to avoid the expense of undergoing a new eye examination (we will discuss later in this section the "quality" implications of facilitating the purchase of eyeglasses without undergoing a new eye examination), he or she can return to the person who filled his or her original prescription and obtain the new eyeglasses.

There are two fundamental problems with exercising this choice. If a consumer moves to another city, or even moves to a different location in part of the same city, he or she would incur substantial costs in returning to the original eyeglasses provider. And if a consumer scratches or breaks his or her eyeglasses while out of town, he or she cannot obtain an emergency replacement from the original provider.

Second, if forced to return to the original provider, con-

---

17 Begun, supra note 1, at 50.

sumers cannot shop for a better bargain. Consumers seeking a second pair of eyeglasses to serve as a spare might wish to take advantage of the increased advertising and the lower-cost alternatives now available.[18]

The second way a consumer might avoid the cost of new eye examinations is to select a new dispenser and have new eyeglasses prepared from his or her original prescription. Two problems are likely to be encountered in exercising this option. First, although under the terms of the Eyeglasses I Rule optometrists and ophthalmolgists are required to offer prescriptions to consumers upon completion of eye examinations,[19] the persons who fill those prescriptions (whether the eye doctor or an optician) may retain the prescriptions after filling them.[20] So if consumers select new providers they may not have their original lens specifications from which to obtain new eyeglasses.

Moreover, even when consumers ask for their prescriptions to be returned after they purchase eyeglasses, the documents which they receive frequently are not "fillable" prescriptions. In a study of optometrists conducted by the Bureau of Economics

---

18 Many providers offer complete eyeglasses for prices in the vicinity of $25, although usually with a limited selection of frames. See, e.g., Spring Optical, an Advertising Supplement to the Washington Post, March 20, 1980.

19 16 C.F.R. § 456.7.

20 For example, one large commercial chain provides patients with a carrying card (unsigned) with a notation that the original prescription is on file at the store where the original eyeglasses were purchased.

(BE study), survey subjects were instructed to ask that their prescriptions be returned to them after they had purchased eyeglasses.[21] Analysis of BE's data shows that in a small number of cases, the shoppers were refused their prescriptions.[22] In a higher percentage of cases, the document that was returned to the survey subjects was a laboratory work order or an unsigned copy of the prescription.[23] In all probability, these laboratory orders and unsigned prescriptions could not be legally filled by a subsequent provider.[24] Thus, notwith-

---

21 Bureau of Economics, Federal Trade Commission, Economic Report -- Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (September 1980) at Part III, Section 2, "Field Procedures." [hereinafter cited as BE study].

22 The number of actual refusals was small, approximately 7 of 280 total observations, or 2.5%. Since survey subjects asked that there prescriptions be returned to them, we do not know whether the dispensers would have returned the prescriptions absent the request.

23 The number of work orders or unsigned prescriptions was 58 out of 280, or approximately 21%. Copies of all the prescriptions received by the survey subjects in the Study are contained in the public record.

24 Most states do not define what constitutes a prescription. Rather, the state law simply states that an optician may fill a "valid written prescription" from an ophthalmologist or optometrist. In only a few states is the requirement that a prescription be signed by the examiner made explicit. See, e.g., Rules of the New York State Board of Regents Relating to Definitions of Unprofessional Conduct, Effective October 1, 1977, § 29.8; Proposed Rules of the Virginia State Board of Examiners in Optometry, Section I(C) ("A prescription for ophthalmic goods means an order written and signed. . ."). (emphasis added)

However, by analogy most states explicitly require medical prescriptions to be signed by the prescriber. See Mass. Gen. Laws. Ann. Ch. 112, § 12 D (Supp. 1979) (West); Conn.

(Footnote Continued)

standing specific requests for return of their prescriptions, consumers were not able to obtain "fillable" prescriptions.

There are three reasons for refusing to release the prescription after filling, two of which are express and one of which is implicit.

1. Many dispensers, particularly eye doctors, question the advisability of obtaining new eyeglasses from an "out-of-date" prescription. The validity of this reason for refusing to release the prescription is obviously contingent on the length of time which has elapsed since the original eye examination.

2. Many dispensers retain the original prescription for malpractice purposes. That is, they retain the prescription as proof that they filled the prescription correctly. By retaining the original prescription, they can compare their work against the original prescription. The provider may give the consumer a carrying card or other document containing the original lens specifications, but in states which preclude duplication without a prescription, such a document if prepared by an optician could not be filled.

3. The unstated reason for not releasing prescriptions, particularly upon the telephone request of a new provider, is the fear of losing the patient to a competitor. By

---

24 (Footnote Continued)

Gen. Stat. Ann. § 19-457 (West); Cal. [Bus. & Prof.] Code § 4036 (Supp. 1980) (Deering). (The analogy we are drawing here is the relationship between the physician and the pharmacy and the relationship between the ophthalmologist or optometrist and optician, not the relationship between the ophthalmologist or optometrist and optical laboratory.)

The reason most states are silent on whether an eyeglass prescription must be signed may be that most optometrists have traditionally filled their own prescriptions. Nevertheless, those states that are not silent on what constitutes a valid eyeglass prescription require a signature, and signatures are required for most medical prescriptions; therefore, we may infer that a prescription would not be valid unless it is signed. A further clarification of what constitutes a valid prescription will be elicited during rulemaking.

releasing the prescription, the original provider is giving the consumer the means needed to seek out another provider.

As we will discuss below, we believe that the failure of the original dispenser of eyeglasses to return a fillable prescription to the patient, at least upon request, is an unfair act or practice.

The final option available to consumers is to have their current eyeglasses lenses duplicated. However, at least ten states prohibit this option, and questions have been raised concerning the "quality" of eyeglasses produced by duplication. In addition, some people contend that consumers use the duplication process as a means of bypassing the eye examination process. We will discuss these issues at length in the sections which follow.

The market for lens duplication services is a substantial one. The most recent data show that opticians' sale of spectacle lenses account for approximately 920 million to one billion dollars annually.[25] In 1979, the Opticians Association of America (hereinafter "OAA") conducted a survey of member firms to elicit information about optical dispensing services offered to consumers (including the duplication of eyeglasses by neutralizing existing lenses) and a survey of consumers to determine, among other things, the reasons why they wanted to have their eyeglasses duplicated

---

25 Bureau of Consumer Protection, Federal Trade Commission Staff Report on Advertising of Ophthalmic Goods and Services and Proposed Trade Regulation Rule, Exhibit III-2 at R.24397 (p. 25), n.83 (May 1977) [hereinafter cited as Staff Report].

and the date of their most recent eye examination. The procedures employed by the OAA in gathering these data are discussed in the note below.[26]

The members of the OAA report approximately 10 to 11% of their total receipts were via duplication (as opposed to sales arising from the initial filling of a prescription).[27] A rough calculation would be that the market for duplication services is approximately $100 million dollars annually.

In the chart below, we show the percentage of OAA members' business attributable to duplication services.

CHART 2-1[28]

---

26 The study conducted by the OAA started with a sample of 921 member firms. Of these, 577 responded to the questionnaire with 444 indicating that they do duplicate lenses and 113 indicating that they do not.

The Opinion Research Corporation, who conducted the study for the OAA, also asked member firms in states which permit lens duplication by opticians to provide it with the names and addresses of customers for whom they had duplicated eyeglasses. The names of 1200 consumers who had purchased duplication services were submitted. The OAA then conducted a mail survey of those 1200 consumers. 408 consumers responded to the survey, and the analysis of consumer purchasing attitudes is based on this sample of 408. (An analysis of non-respondents, and the selection criteria for the original sample of 1200, will be supplied to the Commission for critical analysis.) Letter from J.V. O'Neill, Director, Government Relations, OAA, Terry S. Latanich, Attorney, Federal Trade Commission with results of both surveys attached (May 1, 1980) [hereinafter "OAA Submission"].

27 OAA Submission, at p. 1.

28 Id.

OAA member firms were asked,[29] "What percentage of the total number of pairs of prescription eyeglasses that your firm sold in the past three years were made up on the basis of prescription elements obtained by 'neutralizing' an existing lens or lenses rather than written or oral instructions from a refractionist?"

Their responses were:

Year	1%	2%	3-5%	6-10%	More Than 10%	Not Reported
1978	21%	11%	18%	12%	25%	13%
1977	20%	9%	17%	12%	22%	19%
1976	19%	9%	17%	13%	19%	22%

The typical or average respondent said that 11% of the pairs he or she sold in 1978 were attributable to "neutralization." Corresponding figures for 1977 and 1976 were 10% of total pairs sold.

The data show that the duplication market is a large one, both in terms of consumer expenditures and the number of transactions involved. On the question of why consumers obtain duplication services, the data show two primary reasons. First, in almost half the instances of duplication, consumers were obtaining replacements for broken lenses or frames. Other reasons cited for purchasing duplication services include the desire to obtain prescription sunglasses or a second pair of eyeglasses for fashion or other reasons. In interviews with over 400 consumers who had obtained duplication services, the OAA found the following reasons to be the most prevalent for

---

29 Although this question was asked of member firms in all states, only firms in states which permit opticians to duplicate eyeglasses responded to this question.

obtaining duplication services.

CHART 2-2[30]

Consumers were asked, "Why was the lens or pair of eyeglasses duplicated?" Their responses were:

Reasons:	Total Lens Duplication Consumers (Base: 408)	Total Male Lens Duplication Consumers (Base: 197)	Total Female Lens Duplication Consumers (Base: 211)
Wanted to replace a broken, cracked or scratched lens	25%	32%	18%
Wanted to replace a damaged frame	19	21	17
Wanted prescription sunglasses	24	22	26
Wanted a second, more fashionable, pair	23	16	29
Wanted a second pair for backup purposes	18	18	19
Other	17	19	15

Note: Many respondents gave more than one reason for having their eyeglasses duplicated.

While it is possible that the OAA data are not wholly precise in their ordering of reasons for obtaining duplication services, we believe they do corroborate the widely-held beliefs

30 Id. at p. 4.

within the industry concerning the reasons why consumers seek out duplication services.

Another issue involving duplication is the effect that obtaining duplication services has on the frequency with which consumers obtain eye examinations. As stated earlier, an assertion frequently offered in support of bans on duplication is that consumers use duplication as a means to bypass the eye examination process. The OAA attempted to address this issue in their survey. They asked a sample of 400 consumers who had obtained duplicate eyeglasses when they had last undergone an eye examination. The data show that 74% of the consumers surveyed had obtained an eye examination within the two years prior to the time they purchased the duplicate eyeglasses; over 84% had obtained an eye examination within three years of their purchase.[31]

These data raise a question concerning the validity of the assertion that duplication services are being used as a substitute for regular eye examination. They do not resolve the issue definitely, however, for the data fail to follow these persons to determine the period of time which elapsed after they purchased their duplicate lenses before they obtained another eye examination. Thus, we cannot tell with certainty whether the intervening duplication altered the frequency of eye examinations.

E. The Duplication Study

---

31 OAA Submission, supra note 26, at p. 5.

To address the "quality" variable, that is, the accuracy with which opticians duplicate lenses, we designed a shopper survey of optician establishments. Although the methodology and results of this study are contained in the final study report,[32] we will describe the basic survey methodology and the general results of the survey.

The survey was conducted in two states which permit opticians to duplicate eyeglass lenses: New York (which licenses opticians and has a proficiency examination as part of its licensing process) and Pennsylvania (which does not license opticians nor require any demonstration of proficiency as a condition of practice). A random sample of 390 opticians was drawn from the Yellow Pages of the New York and Philadelphia metropolitan areas.[33]

Three categories of lenses were used in the study: "lows" which are relatively low-power spherocylinders; "mediums" which are medium power spherocylinders; and "prisms," which are medium power spherocylinders with prisms.[34] These three categories were chosen to represent varying degrees of difficulty in the duplication process. The theory was that the more severe the prescription involved, i.e., the higher the diopter power of

---

32 A Comparison of a Random Sample of Eyeglasses, prepared by Resource Planning Corporation for the Bureau of Consumer Protection, Federal Trade Commission (July 1979) [hereinafter cited as Duplication Study].

33 Duplication Study at 2.

34 The optical characteristics of each of these categories are set forth contained in Appendix A of the Duplication Study.

the sphere and cylinder or whether a prism was present, the more difficult it might be to duplicate the lens correctly.

For the purposes of our study, we purchased complete pairs of eyeglasses, identical within each category with respect to prescriptive power and frame type. The Commission's consultant for technical issues on this study, the Chairman of the ANSI Z80.1 Subcommittee on Ophthalmic Lenses, measured the power of each lens using an Acuity Systems Auto-Lensmeter. One lens in each pair of eyeglasses was scratched to provide the "reason" for having the lens duplicated. After survey subjects posing as consumers obtained the duplication services, the eyeglasses were returned to our consultant and the power of both the control lens (the non-duplicated lens) and the duplicated lens were measured and recorded.

A questionnaire was then sent to each optician in our sample to determine the optical characteristics of the lenses as ordered by the optician.[35] Thus, for each purchase we have three measurements: (1) the amount of variation resulting from "measurement error" by the optician (i.e., the difference between the lens' actual strength and the strength of the lens ordered by the optician); (2) the amount of "fabrication error" (i.e., the difference between the optical characteristics of the lens as ordered by the optician and those of the lens produced by the laboratory); and (3) the "total error" (i.e., the combination of the measurement

---

35 A copy of the questionnaire is contained in Appendix C of the Duplication Study.

error and the fabrication error). In the charts which appear in the next section, unless otherwise noted, calculations are based on the "total error" figure.

The standards which we employed to determine whether the lenses were properly duplicated are the 1979 ANSI Z80.1 Standard for Ophthalmic Lenses.[36] We selected this standard because it appears to be the only generally accepted national standard for lens tolerances. The standard is designed as a benchmark for optical laboratories in the production of ophthalmic lenses from a prescription written by an optometrist or ophthalmologist. In the words of the Z80.1 Subcommittee on Ophthalmic Lenses, which drafted the standards, the ANSI standard

> . . . does not represent tolerances that describe the state-of-the-art of the ophthalmic laboratory, but provides goals for new or pristine lenses prepared to individual prescription. The individual performance parameters listed in this standard can be reliably achieved. However, it is difficult to meet all of the requirements simultaneously in any given lens or mounted pair. The fact that, under rigorous application of this standard, a significant number of spectacles (approximately 25% based on 1977 industry estimates) will not achieve all parameters simultaneously must be accepted as a reflection of the current state-of-the-art. As such, this standard expresses desirable technical concepts that provide a frame of reference for safety and effectiveness and is not designed as a regulatory instrument.[37]

---

36 American National Standards Institute, Recommendations for Prescription Ophthalmic Lenses, 1979.

37 Id. at Foreword.

Earlier versions of the ANSI standard, (the prior version of this ANSI standard was adopted in 1972), have been used as a measure in other studies of the quality of lens fabrication.[38] These studies differ from the Commission's study in that their purpose was to measure the accuracy with which optical laboratories produced spectacles which matched given lens specifications. Duplication, on the other hand, is a two-step process. First, the optician must determine the lens specifications by neutralizing the lens, and then the lens must be prepared to match that prescription.

In interpreting the results of our study, we caution the reader against equating the failure to achieve the ANSI tolerances with an adverse patient response. The optical literature is devoid of any reliable research assessing the amount of variation in a prescription which can be comfortably tolerated by a patient.[39] The ANSI standard expresses the state-of-the-art with respect to fabricating lenses, and is not designed to be

---

38 See, e.g., Chase & Lynch, An Examination of Ophthalmic Prescription Spectacle Quality Relative to American National Standard Z80.1-1972. (In this study, 300 glass prescriptions and 150 plastic lens prescriptions were processed by 30 laboratories around the country. 49% of the finished products failed to meet all of the 1972 tolerances simultaneously.) Augsburger, Evaluation of Ophthalmic Materials, Am. J. Opt. & Physiol Optics 700-705 (Oct. 1978).

39 See, e.g., King, Tolerance to Tolerances, 50 J. of the AOA (May 1979). In this article the author equates the deviation in two eye examinations conducted on the same patient as being "the limits of [patient] sensitivity. As our BE data demonstrate, this hypothesis is of questionable validity. See pp. 123-131, infra.

a standard reflecting the outer limits of patient acceptance or accommodation. We have assessed the performance of the opticians in our duplication study against the ANSI Z80.1 standard because it is the only available standard. We expect that industry groups will offer their viewpoints on the significance of the data during the course of the rulemaking proceeding.

Later in this report we also discuss the extent to which repeated examinations of the same patient by different eye doctors may result in different prescriptions.[40] The significance of the variations found in our duplication study must be assessed in relation to those data.[41]

F. Results of the Study

We measured the accuracy of the duplication process in three different ways. Irrespective of the standard used to measure opticians' performance, the results show no statistically significant difference between New York and Pennsylvania in terms of the accuracy with which the lenses were duplicated.[42] First, we measured how much the sphere, cylinder, axis, pupillary distance, and prism (if any) of each of the duplicated lenses

---

40 Infra section G.

41 As we will discuss in section G, in many cases the consumer's only viable alternative to duplication is a new eye exam. The extent to which variation in the prescription results from reexamination is relevant in assessing the significance of the error introduced via duplication.

42 For a more detailed discussion of the degree of confidence level used, see Duplication Study.

varied from each of the original lenses. Second, we determined what percentage of the duplicated lenses met the ANSI tolerances for each of the five parameters listed above. Finally, we calculated the percentage of the duplicated lenses which failed to meet the ANSI tolerances for all of those parameters.

The charts below list the mean amounts that the duplicated lenses varied from the originals, and the applicable ANSI tolerance for each parameter.

MEAN DEVIATIONS

1. Low-Power Lenses

Parameter	Mean N.Y. Deviation	Mean Pa. Deviation	ANSI Tolerance
Sphere (diopters)	.037 (n=50)	.056 (n=25)	.125
Cylinder (diopters)	.039 (n=50)	.073 (n=25)	.125
Axis (degrees)	5.58 (n=50)	4.84 (n=25)	7.00
Pupillary Distance (mm.)	1.90 (n=48)	1.98 (n=25)	8.67

2. Medium Power Lenses

Parameter	Mean N.Y. Deviation	Mean Pa. Deviation	ANSI Tolerance
Sphere (diopters)	.091 (n=41)	.146 (n=51)	.125
Cylinder (diopters)	.122 (n=41)	.160 (n=51)	.125
Axis (degrees)	3.12 (n=41)	4.55 (n=51)	3.00
Pupillary Distance (mm.)	1.60 (n=41)	1.27 (n=51)	2.50

3. Prism Lenses

Parameter	Mean N.Y. Deviation	Mean Pa. Deviation	ANSI Tolerance
Sphere (diopters)	.107 (n=37)	.113 (n=45)	.125
Cylinder (diopters)	.079 (n=37)	.059 (n=45)	.125
Axis (degrees)	2.78 (n=37)	6.13 (n=45)	5.00
Pupillary Distance (mm.)	1.13 (n=35)	1.54 (n=44)	2.50
Prism (diopters)	.98 (n=36)	.81 (n=45)	.33

As the first chart shows, the mean deviations (or mean errors) of the low-power lenses duplicated in both New York and Pennsylvania were less than the applicable ANSI tolerance for each of the four parameters.

The mean variations discovered in the duplicated medium-power lenses were more serious than those in the low-power lenses and provide some support for the hypothesis that the accuracy of duplication decreases with the severity of the prescriptive requirements. For every parameter, both the New York and Pennsylvania lenses came closer to -- and in several cases slightly exceeded -- the ANSI tolerances.[43]

Since the prism lenses were essentially identical to the medium-power lenses except for the existence of the prismatic correction,[44] the mean deviations found in those two groups of lenses are comparable for the sphere, cylinder, axis, and pupillary distance parameters. The mean deviation of the duplicated prism lenses from both New York and Pennsylvania greatly exceeded the ANSI tolerance for the prism parameter. It is

---

43 For sphere and cylinder, the absolute mean variations of the medium-power lenses were higher than for the low-power lenses. For axis and pupillary distance, the absolute variations were lower. But because the ANSI tolerances for axis and pupillary distances for the medium-power lenses were more stringent than those for low-power lenses, the medium-power lenses' variations were relatively more serious.

44 A prismatic correction in an ophthalmic lens can be achieved in a number of ways, depending on the type of prism desired. In our study a vertical prism was produced by decentering the optical center of one of the lenses along a vertical axis.

unlikely that a patient could accommodate or adjust to eyeglasses with such a large amount of prismatic error.[45]

The next set of charts examines the duplication results from a different perspective. It lists the percentages of duplicated lenses which exceeded the ANSI tolerances for each listed parameter.

---

45 The prismatic imbalance in the lenses was nearly a full diopter. According to Allen Kosh, Chairman of the ANSI Z80.1 Subcommittee on Ophthalmic Lenses, the consensus of the optical community is that in most instances, a consumer could not tolerate a vertical prismatic imbalance of that magnitude. Telephone conversation between Terry S. Latanich and Allen Kosh, April 18, 1980.

INDIVIDUAL FAILURE RATES[46]

1. Low-Power Lenses

Parameter	% from N.Y. exceeding ANSI tolerance	% from Pa. exceeding ANSI tolerance
Sphere	2	12
Cylinder	2	4
Axis	12	12
Pupillary Distance	0	0

2. Medium-Power Lenses

Parameter	% from N.Y. exceeding ANSI tolerance	% from Pa. exceeding ANSI tolerance
Sphere	22	25
Cylinder	29	24
Axis	22	24
Pupillary Distance	22	12

3. Prism Lenses

Parameter	% from N.Y. exceeding ANSI tolerance	% from Pa. exceeding ANSI tolerance
Sphere	16	31
Cylinder	19	27
Axis	8	9
Pupillary Distance	6	16
Prism	89	71

The chart shows that the highest "failure rate" for any of the individual parameters in the low category was 12%, which was the number of lenses duplicated both in New York and Pennsylvania which failed to meet the ANSI tolerance for axis. At the other extreme, all of the low-power lenses were within tolerance for pupillary distance.

The failure rates for the medium-power lenses were, as

---

46 Duplication Study, Appendix B (Charts IV, VIII and XII).

hypothesized, uniformly higher. The highest failure rate for any individual parameter was found in the prism category. For the prism parameter, 89% of the prism lenses from New York and 71% of those from Pennsylvania exceeded the ANSI tolerance.

The extremely high failure rate on the prism parameter may reflect that opticians do not generally follow optimal duplication procedures. Standard practice is to neutralize the right lens first, and then the left lens. If the right lens is the higher power lens, the process is complete. But if the left lens is stronger, the procedure must be repeated in reverse.[47] Since a prismatic correction is produced by vertically shifting the position of the optical center of one lens relative to that of the other, it is crucial that optical centers be accurately located. And because the optical center can be more easily located in higher-power lenses, it is important that the stronger lens be neutralized first so that it may be used as a reference point.

The next chart shows the percentages of duplicated lenses which failed to meet ANSI tolerances for each and every relevant parameter. The numbers listed in parentheses represent the percentage of duplicate lenses which similarly failed to satisfy tolerances for each and every parameter, but taking into account only the "measurement error" introduced by the optician ordering the duplicate lens. That calculation excludes any error intro-

---

47 See Stimson, Ophthalmic Dispensing, at 469, 477 (2d ed. 1971).

duced in the fabrication process.[48]

Percentage of lenses exceeding tolerance[49] plus measurement variation on one or more measures

Type of Lens	% from N.Y. exceeding one or more ANSI tolerances	% from Pa. exceeding one or more ANSI tolerances
Low-power	16% (10%)	24% (15%)
Medium-power	66% (49%)	49% (36%)
Prism	95% (88%)	87% (92%*)

* In some cases the failure rate based solely on measurement error exceeds the overall failure rate because the fabrication error offset the measurement error and brought the lens back within the tolerance.

Comparing individual failure rates to total failure rates results in some interesting observations. For example, 24% of the low-power lenses from Pennsylvania failed to meet all of the ANSI tolerances simultaneously, even though no more than 12% exceeded any individual tolerance. And 66% of the medium-power lenses from New York exceeded at least one of the four relevant ANSI tolerances, while no more than 29% failed to meet any individual tolerance.

We must emphasize that some of the variation between original and duplicated lenses we have detected is due more to the practical realities of ophthalmic dispensing than to any fault on the part of the opticians whose duplication work was analyzed in this study. In other words, an error may not always be an

---

48 See p. 112, supra.

49 Duplication Study, Appendix B (Chart XIV).

error. An example may help to illustrate this point.

Assume the spherical power of a lens sent to one of the opticians in our sample was -4.10 diopters. Standard industry practice is to order lenses in gradations of 0.25 diopters. If the optician neutralized the lens correctly, he or she could not come closer to the original lens than a -4.00 diopter replacement lens. Thus, even if the optician measured the lens correctly at -4.10 diopters, the order blank would show a -4.00 diopters. Our data would therefore show a "measurement error" of 0.10 diopters, even though in fact there is no real error at all.

We do not view this problem as a shortcoming in the design of our study. To the contrary, it points out the limited state of the art of ophthalmic dispensing and suggests one of the difficulties encountered when optician performance is evaluated on the basis of the ANSI tolerances. If a lens were -4.11 diopters, and the optician read the lens as being -4.13 diopters, and ordered a -4.25 diopter lens, the resulting lens would fail to meet the ANSI standard. Yet the performance of the optician, given the performance limits of manual focimeters, was virtually perfect.

G. Repeated Examination v. Duplication -- A Comparison of Variation

If duplication is not permitted, (and the consumer does not wish or is unable to return to his or her original provider for eyeglasses) he or she has three choices: (1) simply do without a duplicate pair of eyeglasses (or in the case of a consumer seeking to replace broken lenses, do without any eyeglasses);

(2) use his or her original prescription and obtain new eyeglasses from a different provider[50] or (3) obtain an eye examination. It is appropriate, therefore, to compare the amount of error introduced through the duplication process with the variation which may result from the examination process. Data from the BE study juxtaposed against the data from the duplication study permit us to make this comparision.

In its study, BE sent survey subjects into the field to purchase eye examinations and eyeglasses. Before obtaining the field examinations, each survey subject received two complete eye examinations, one by members of the optometry faculty at the Pennsylvania College of Optometry (PCO) and the other by the faculty of the School of Optometry of the State University of New York (SUNY).

Each of the two schools was instructed to perform an independent eye examination and determine a "correct" prescription for each survey subject. The only difference was that SUNY had access to each subject's eyeglasses when its faculty members performed the eye examinations, whereas PCO faculty did not.[51] PCO and SUNY knew in advance that the prescriptions they derived would be compared against each other and that the prescriptions would be used as benchmarks to evaluate the pre-

---

50 We have discussed the current problems which exist if the consumer chooses this alternative on pp. 103-106, supra.

51 Telephone interview with Jack Phelan, Bureau of Economics, June 18, 1980.

scriptions determined by the optometrists practicing in the field.[52]

The chart which follows presents the differences between the prescription determined by experts at the two colleges of optometry for each eye of the nineteen survey subjects. In addition to showing the absolute differences between the two schools for the spherical, cylindrical and axis parameters, the mean deviation and standard deviation for each of the three parameters was computed. (None of the BE study survey subjects required prismatic correction so no comparison between examination and duplication could be made for that parameter.)

For all of the spherical powers found by PCO and SUNY the tolerance under the ANSI Z80.1 standard is + or - .13 diopters. Yet, as the data show, the mean deviation between PCO and SUNY on this parameter is 0.289 diopters, or approximately twice the ANSI standard. With respect to the cylinder power, the same + or - .13 diopter standard applies. The mean deviation between the two schools was 0.270 diopters. Finally, the mean deviation in axis measurements between PCO and SUNY was 9.067 degrees, against the ANSI tolerance which varies from 3 degrees to 7 degrees, depending upon the power of the lenses, with the appropriate tolerance for most of the prescriptions being in the vicinity of 5 degrees.

---

52 See pp. 49-92, supra, for a more detailed discussion of the BE Study.

DIFFERENCES BETWEEN PRESCRIPTIONS DETERMINED BY PENNSYLVANIA COLLEGE OF OPTOMETRY AND THE SCHOOL OF OPTOMETRY OF THE STATE UNIVERSITY OF NEW YORK, FOR EACH SUBJECT, FOR OPTOMETRIC MEASURES INDICATED - EACH EYE CONSIDERED SEPARATELY.

	SPHERE			CYLINDER			AXIS		
SUBJECT	PCO	SUNY	DIFF	PCO	SUNY	DIFF	PCO	SUNY	DIFF
01 Right Eye	-4.25	-3.50	0.75	-1.25	-1.00	0.25	145	135	10
Left	-6.25	-5.00	1.25	-0.75	-0.50	0.25	20	45	25
02 Right	-1.00	-1.50	0.50	-0.75	-0.25	0.50	180	180	0
Left	-1.50	-1.50	0.00	-0.50	-0.25	0.25	5	180	5
13 Right	-2.25	-2.25	0.00	-1.75	-1.75	0.00	160	158	2
Left	-2.75	-2.50	0.25	0.00	0.00	0.00	--	--	--
14 Right	-3.75	-4.00	0.25	-0.50	-0.25	0.25	170	180	10
Left	-3.75	-4.00	0.25	-1.00	-0.75	0.25	180	5	5
15 Right	-0.75	-0.50	0.25	-0.75	-1.00	0.25	95	105	10
Left	-1.00	-0.75	0.25	-0.75	-1.00	0.25	80	75	5
16 Right	-0.50	-0.25	0.25	-0.25	-0.50	0.25	120	125	5
Left	-0.50	0.00	0.50	-0.50	-0.75	0.25	105	75	30
17 Right	-3.25	-2.50	0.75	-0.75	-1.00	0.25	85	90	5
Left	-3.00	-2.75	0.25	-0.50	-0.50	0.00	95	90	5
21 Right	-4.50	-4.75	0.25	0.00	0.00	0.00	--	--	--
Left	-4.00	-4.00	0.00	-0.50	-0.50	0.00	105	90	15
22 Right	-7.25	-7.00	0.25	0.00	-1.00	1.00	--	180	--
Left	-6.50	-6.75	0.25	-0.75	-1.00	0.25	180	180	0
23 Right	-1.25	-1.25	0.00	-1.00	-0.50	0.50	75	75	0
Left	-1.50	-1.75	0.25	-0.50	0.00	0.50	75	--	--
24 Right	-1.25	-1.75	0.50	-1.25	-0.75	0.50	90	95	5
Left	-2.00	-1.75	0.25	-0.50	-1.00	0.50	105	85	20
25 Right	-1.00	-1.25	0.25	-0.75	0.00	0.75	75	--	--
Left	-1.75	-1.50	0.25	0.00	0.00	0.00	--	--	--
26 Right	-2.00	-1.75	0.25	-1.25	-1.00	0.25	180	175	5
Left	-1.00	-1.00	0.00	-0.75	-0.50	0.25	180	170	10
27 Right	-3.00	-3.25	0.25	0.00	-0.25	0.25	--	140	--
Left	-2.75	-2.50	0.25	-0.50	-0.25	0.25	175	125	50
28 Right	-1.00	-0.75	0.25	-0.75	-0.75	0.00	145	145	0
Left	-1.25	-0.75	0.50	-0.50	-0.75	0.25	45	35	10
29 Right	-1.00	-1.00	0.00	-0.50	-0.50	0.00	160	165	5
Left	-0.25	-0.50	0.25	0.00	0.00	0.00	--	--	--
30 Right	-4.00	-4.25	0.25	-0.75	-1.00	0.25	85	90	5
Left	-4.00	-3.50	0.50	-1.00	-1.00	0.00	100	105	5
31 Right	-5.25	-5.00	0.25	-0.25	-0.25	0.00	155	135	20
Left	-5.50	-5.25	0.25	-0.50	-0.75	0.25	45	45	0
32 Right	-2.50	-2.50	0.00	-1.50	-0.75	0.75	170	170	0
Left	-1.75	-2.00	0.25	-1.50	-0.75	0.75	10	5	5
NUMBER			38			38			30
MEAN DEVIATION			0.289			0.270			9.067
STANDARD DEVIATION			0.243			0.249			10.808

Source: Data from Bureau of Economics Study

The next chart below compares the deviations from the PCO/ SUNY comparison and the Duplication Study. For purposes of this comparison, we selected the mean deviation from the "medium" category in the duplication study, the category which is of equal or greater severity of prescriptive requirement (and tolerances) than the prescriptions found in the BE study.

	Sphere	Cylinder	Axis
SUNY/PCO Variation	.289	.270	9.067
Duplication Variation	.091	.122	3.12

As is evident, the mean error introduced through the duplication process is substantially smaller than the average amount by which the two colleges, under ideal conditions, varied in determining the "correct" prescription for the survey subjects. Indeed, the "error" from repeated examination, even where there were only two sets of exams, is two to three times greater than the mean deviation in the duplication sample.

We hesitate to call the variations between the two schools "error." The variations between the PCO and SUNY prescriptions may in part be explained by the state of the art in refracting equipment and techniques, by the fact that SUNY examined each subject with his or her eyeglasses on, by the fact that there may be a difference in a patient's prescriptive needs as a function of the time of day, or other factors which might affect the physiology of the eye.[53] Whatever the basis for the deviation

---

53 See generally, Sloane and Durphy, A Comparison of Refraction Results on the Same Individuals, 37 Am. J. Ophthalmology (Footnote Continued)

between the two schools, is the amount of deviation introduced through duplication acceptable, given that the alternative -- obtaining another eye examination -- would likely introduce a substantially greater deviation from the original prescription? It would be disingenuous at best to term both PCO's and SUNY's prescriptions "correct" while terming the optician's deviation "error."

As stated earlier, in addition to the examinations performed by the faculties at PCO and SUNY, each survey subject underwent a number of eye examinations in the course of the BE survey by practicing optometrists who were unaware that the prescriptions would be compared. The repeated examinations were obtained over a short time span to ensure that the refractive status of the subjects' eyes did not change.

The chart which follows shows the average difference between the prescriptions determined by the practicing optometrists and each of the prescriptions determined by PCO and SUNY.

---

53 (Footnote Continued)

(Jan.-June 1954).

> "It seems clear that test findings will differ from examiner to examiner even under the best conditions and that one cannot properly be dogmatic about a given refractive error."

Humphriss, Periodic Refractive Fluctuations in the Healthy Eye, 15 Brit. J. Physiol. Opt. 30-34 (1958).

AVERAGE DIFFERENCES BETWEEN PRESCRIPTIONS AS DETERMINED BY OPTOMETRISTS IN THE FIELD AND BY EXPERTS AT EITHER OF THE TWO COLLEGES OF OPTOMETRY, FOR EACH SUBJECT, FOR THE OPTOMETRIC MEASURES INDICATED - EACH EYE CONSIDERED SEPARATELY.

		PCO			SUNY		
SUBJECT	MEASURE	NUMBER OF OBSERVATIONS IN THE FIELD	MEAN DEVIATION	STANDARD DEVIATION	NUMBER OF OBSERVATIONS IN THE FIELD	MEAN DEVIATION	STANDARD DEVIATION
01	SPHERE	66	.500	.288	66	.545	.311
	CYLINDER	66	.112	.132	66	.206	.156
	AXIS	66	11.636	6.683	66	6.045	7.085
02	SPHERE	52	.240	.220	52	.173	.200
	CYLINDER	52	.233	.206	52	.170	.124
	AXIS	49	5.694	6.001	49	6.000	8.021
13	SPHERE	72	.295	.235	72	.177	.207
	CYLINDER	72	.188	.144	72	.188	.144
	AXIS	36	2.417	2.568	36	4.194	2.724
14	SPHERE	48	.255	.196	48	.130	.163
	CYLINDER	48	.151	.161	48	.214	.163
	AXIS	48	6.312	5.725	48	3.438	2.828
15	SPHERE	66	.201	.118	66	.117	.182
	CYLINDER	66	.286	.124	66	.074	.122
	AXIS	66	7.712	14.541	66	5.939	14.563
16	SPHERE	38	.125	.165	38	.394	.228
	CYLINDER	38	.204	.173	38	.375	.238
	AXIS	23	17.174	11.949	23	7.609	8.100
17	SPHERE	30	.192	.182	30	.692	.224
	CYLINDER	30	.121	.156	30	.171	.162
	AXIS	28	5.000	2.667	28	1.429	2.395
21	SPHERE	36	.306	.311	36	.431	.367
	CYLINDER	36	.236	.198	36	.236	.198
	AXIS	12	10.000	4.767	12	5.000	4.767
22	SPHERE	34	.250	.185	34	.221	.211
	CYLINDER	34	.441	.269	34	.257	.199
	AXIS	17	4.941	6.905	34	6.265	7.042
23	SPHERE	26	.558	.408	26	.510	.409
	CYLINDER	26	.423	.306	26	.269	.254
	AXIS	20	44.600	28.162	10	39.200	22.817

Source: Data from Bureau of Economics Study

AVERAGE DIFFERENCES BETWEEN PRESCRIPTIONS AS DETERMINED BY OPTOMETRISTS IN THE FIELD AND BY EXPERTS AT EITHER OF THE TWO COLLEGES OF OPTOMETRY, FOR EACH SUBJECT, FOR THE OPTOMETRIC MEASURES INDICATED - EACH EYE CONSIDERED SEPARATELY.

		PCO			SUNY		
SUBJECT	MEASURE	NUMBER OF OBSERVATIONS IN THE FIELD	MEAN DEVIATION	STANDARD DEVIATION	NUMBER OF OBSERVATIONS IN THE FIELD	MEAN DEVIATION	STANDARD DEVIATION
24	SPHERE	12	.271	.271	12	.188*	.113
	CYLINDER	12	.292	.279	12	.292	.179
	AXIS	12	7.917	6.557	12	5.417	2.575
25	SPHERE	50	.270	.201	50	.210	.191
	CYLINDER	50	.238	.253	50	.287	.314
	AXIS	19	10.895	7.164	0	--	--
26	SPHERE	40	.332	.561	40	.294	.543
	CYLINDER	40	.356	.282	40	.256	.250
	AXIS	37	3.811	5.082	37	7.189	3.799
27	SPHERE	42	.286	.244	42	.298	.283
	CYLINDER	42	.271	.221	42	.182	.124
	AXIS	8	23.125	27.895	19	27.632	16.136
28	SPHERE	36	.271	.242	36	.201	.222
	CYLINDER	36	.250	.239	36	.236	.239
	AXIS	32	14.156	12.488	32	9.469	11.271
29	SPHERE	56	.281	.179	56	.219	.159
	CYLINDER	56	.188	.240	56	.188	.240
	AXIS	12	12.500	9.886	12	10.000	7.071
30	SPHERE	38	.303	.314	38	.401	.276
	CYLINDER	38	.250	.240	38	.217	.241
	AXIS	36	5.778	4.072	36	6.278	6.810
31	SPHERE	40	.225	.186	40	.262	.219
	CYLINDER	40	.231	.173	40	.331	.236
	AXIS	15	12.800	16.511	15	8.800	11.688
32	SPHERE	56	.317	.240	56	.206	.171
	CYLINDER	56	.835	.271	56	.192	.208
	AXIS	52	7.058	4.434	52	5.904	4.852

Source: Data from Bureau of Economics Study

The data show high variations in the prescriptions determined by the sampled optometrists. Examination of the deviations in spherical power shows mean deviations of 0.500 diopters (patient 01), 0.588 diopters (patient 23) and 0.692 diopters (patient 17). Indeed, the lowest mean deviation for either the SUNY or PCO comparison is barely under the ANSI tolerance of 0.13 diopters. Of the total number of observations, only a very few are under the ANSI tolerance, and none are lower than the mean deviation introduced via duplication. Similar examinations of the cylinder and axis measures also show mean deviations substantially in excess of the ANSI tolerance, and far in excess of the duplication study variances.

Thus, we question whether the "failure" rates as measured by the ANSI standard determined in our duplication study have significance for consumers. Rather, the more important statistic may be the comparative mean deviation for each of the parameters. In each case --low, medium and prism -- the sphere, cylinder and axis means were substantially lower for the duplication sample than for repeated examination.

The data also would seem to cast doubt upon the widely-held belief that there is a single "correct" prescription for a patient. The results of the PCO/SUNY comparison indicate that experts, under ideal conditions, could not achieve agreement, or even come close to the ANSI standard.

H. Recommendation

The preceding analysis suggests three conclusions.

First, to the extent that consumers are required to obtain

new eye examinations earlier than necessary to detect changes in vision in order to obtain duplicate eyeglasses, or replacements for broken lenses or frames, consumers are incurring a substantial and unnecessary economic expense.[54]

Second, a consumer is more likely to get a duplicate or replacement pair of eyeglasses which more accurately produce the visual correction present in his or her existing eyeglasses through the process of neutralization than by obtaining a new eye examination.

Third, the greater the power of the prescriptive requirements of a pair of eyeglasses, the greater is the "error" likely to be introduced via duplication. With respect to duplication of prism lenses, the error introduced via duplication is of an unacceptable magnitude. However, we believe in the vast majority of instances (i.e., non-prismatic lenses)[55] the opticians' performance are likely to be acceptable in terms of how much

---

54 Our discussion with members of optometric and ophthalmologic groups, have revealed that there is no consensus concerning how often a person should have his or her eyes checked. The range appears to be anywhere from every 6 months to every 3 years, depending on one's age and medical and visual history.

Medical Eye Services of Michigan, Inc., a non-profit corporation whose membership consists of Michigan ophthalmologists, has stated that if an eye exam shows that one's eyes are healthy, the next exam need not occur until two or three years have passed. Letter from Lawrence M. Glazer, counsel to Michigan Optometric Association to the Federal Trade Commission, with attachments, at p. 10 (February 13, 1980).

55 Industry members estimate that over 90% of all single-vision lenses fall into our "low" and medium" categories. See Staff Report, supra note 25, at R.24528 (p. 156).

deviation a patient is able to accomodate.

On the basis of these findings, we do not recommend that the Commission preempt existing bans on the duplication of lenses. There appears to be at least some potential for introducing a significant margin of error through the duplication process, although this "error" is substantially less than the consumer will experience by employing the alternative to duplication, a new eye examination. Rather than preempting state-imposed bans on duplication, we recommend that the Commission act to ensure that consumers have the ability to obtain their current spectacle prescriptions. We recommend that the Commission extend the prescription release requirement of Section 456.7 of the Eyeglasses I Rule to require that upon filling a prescription for spectacle lenses[56] the dispenser, whether an ophthalmologist, optometrist or optician, return a fillable prescription to the consumer. This will enable the consumer to obtain replacement or duplicate pairs of eyeglasses from the original lens specifications. Potential errors which might occur in the duplication process will be eliminated. Consumers will be able to obtain duplicate or replacement eyeglasses in the most efficient manner, without any compromise in the quality of care they receive. Indeed, adoption of this remedy will enhance the quality of eye care received by those consumers who wish to obtain replacement or duplicate pairs of eyeglasses

---

56 Our recommendations regarding contact lens prescriptions are contained in Part IV of this report.

which produce the visual correction present in their existing eyeglasses both in states which permit and those which prohibit the duplication of lenses. The preparation of duplicate lenses from the original lens specifications is more accurate than either of the existing alternatives.

Under our recommendation, the ability of the states to impose an expiration date on the prescription will not be affected. That is, the states would retain their authority to impose a requirement that a prescription be valid for whatever period of time the state determines is reasonable. Such a requirement would prevent consumers from bypassing needed examinations by obtaining duplicate lenses with an outdated prescription.

We believe that the failure of refractionists and opticians to return prescriptions to consumers constitutes a violation of Section 5 of the FTC Act for the same reasons articulated in support of the original prescription release requirement contained in Section 456.7 of the Eyeglasses I TRR. The failure of the dispenser to return the prescription to the consumer limits the ability of the consumer to obtain replacement or duplicate lenses. This action may not only subject the consumer to unnecessary expense (a potentially unnecessary eye examination) but also to the possibility that the replacement lenses he or she obtains will be inaccurate (whether they are obtained by duplication or reexamination).

However, the BE study data raise a difficult question concerning the relationship between the prevalence of an unfair

act or practice, and the scope of the Commission's remedial authority. Our data show that in a few cases, consumers were denied return of their prescriptions. In a higher percentage of cases, the prescription returned to the patient probably could not be filled. However, in states which permit duplication, the ability of the consumer to obtain a copy of his or her lens specifications, even if that prescription cannot be directly filled, does enable the subsequent provider to compare the results of the "neutralization" against the original lens specifications, and then fill the old prescription. In essence, the old prescription could be filled. It is only in those states which prohibit duplication where the validity of the prescription becomes critical.

Two prevalence issues thus arise. First, can the Commission require that providers in all states return the original signed prescription to the consumer after purchasing eyeglasses, simply because a small percentage of providers fail to do so when requested? Second, can the Commission require all providers in all states to return prescriptions to their patients where the failure to do so only results in consumer injury in states which ban duplication? In other words, can the Commission create a nationwide remedy to an unfair act or practice existing in only 12 to 15 states?

First, we believe that the percentage of instances in which consumers cannot obtain their prescriptions after dispensing, although small, is sufficient to justify the recommended relief. The remedy which we recommend enhances the

quality of vision care received by those consumers who wish to obtain duplicate or replacement eyeglasses which produce the visual correction present in their existing eyeglasses and is, at most, a minimal burden on providers. Clearly the parameters of the lenses must have been determined in order to prepare the eyeglasses. Our recommended remedy does no more than require that a signed copy of this be returned to the consumer. Thus, we believe that the imposition of a non-preemptive remedy which accomodates all of the states' concerns without preempting state laws can and should be imposed nationwide.

Our proposed remedy does not alter states' determinations as to what functions a provider is permitted to perform. Rather, we will simply be ensuring that consumers retain the right to seek out a provider qualified under state law to fill a lens prescription. This is an example, we believe, of how the Commission should proceed in the area of "scope of practice" regulations. Although it may be undesirable for the Commission to preempt state "scope of practice" determinations, there may be instances (such as this) where the states' goals can be achieved, or even enhanced, by Commission action which alleviates unnecessary consumer injury.

One final issue remains to be resolved in the rulemaking proceeding if the Commission accepts our recommendation: should the Commission impose a requirement that prescriptions be given out over the telephone? The rule which we recommend would not impose a telephone release requirement. It must be recognized that by not preempting bans on duplication, in some instances,

consumers, who may have lost or misplaced their prescriptions, will still not be able to obtain duplicate lenses readily. Placing an obligation on practitioners to release prescriptions over the telephone would alleviate the problems facing consumers who lose their prescriptions or who are away from home, or who lose or damage their eyeglasses and are not carrying copies of their prescriptions with them.

The issue of telephone release of prescriptions raises two practical considerations. First, who has the right to receive the lens specifications from the original dispenser by telephone -- the consumer or the new dispenser? And second, we must focus in the rulemaking proceeding on the length of time records are currently maintained by eye doctors and opticians. Imposing a requirement that prescriptions be given out over the telephone implicitly requires that records be maintained to comply with that requirement. If records are currently maintained for a period of time less than the obligation imposed by the Commission, then we would be imposing an additional cost of doing business on those practitioners. Thus, during the course of the rulemaking proceeding, we will need to gather data on the current practice with respect to record retention, and the costs to practitioners if they were placed under an obligation to release prescriptions over the telephone.

If the answer to this latter question shows that the cost of telephone release would be high, it may well be advisable to require that the dispenser return the prescription to the patient at the time it is filled, but not impose a telephone release requirement.

III. Restrictions On The Over-The-Counter Sale Of Ready-To-Wear Reading Glasses

A. Introduction

In this section, we will discuss the issues raised by state laws which restrict the sale of ready-to-wear, non-prescription reading glasses. In the past, these eyeglasses have been sold without prescription in all but five states. Evidence has been presented to us that several states have rewritten or are considering rewriting their optometry laws to restrict the over-the-counter sale of reading glasses.

Ready-to-wear reading glasses are simply magnifying lenses placed in regular eyeglass frames to provide magnification for close vision tasks. These eyeglasses are primarily used by people who suffer from presbyopia, which is the decreased ability of the normal eye to focus on near objects and printed material.[1]

Around age forty-five, many people who have never worn eyeglasses before begin to have difficulty focusing on near objects and find that their eyes become tired after reading. With age, the lens within the eye loses its flexibility and as a result, the eye is not able to change focus for near and far vision. Focusing at close range becomes difficult and the presbyope must either hold reading material further away or else wear eyeglasses to do the focusing which the eye is no

---

1 H. Solomon and W. Zinn, The Complete Guide to Eye Care, Eyeglasses, and Contact Lenses 241 (1977).

longer able to do for itself.[2]

In most states, ready-to-wear reading glasses are sold without prescription in department stores, drug stores, and other commercial establishments.[3] Reading glasses are generally available in ten different focus numbers, each of which corresponds to a particular spherical power.[4]

If a consumer with presbyopia has a copy of his or her eyeglass prescription, he or she can use it to obtain reading glasses with the correct magnification. Otherwise, he or she can simply try on different pairs of reading glasses and find what he or she perceives to be the best magnification.

B. Industry Profile

The only American manufacturer of reading glasses is Pennsylvania Optical Company (POC), which supplies approximately 55% of the market.[5] A number of other companies are involved in importing and distributing reading glasses in the United States.[6]

---

2 B. Esterman, The Eye Book, 17, 229, 249 (1977).

3 See Section B, infra, which discusses the state laws on the sale of ready-to-wear reading glasses.

4 Letter from Robert B. Clark, attorney for Pennsylvania Optical Company, to Michael Pertschuck (June 20, 1979) at 4.

5 Letter from Robert B. Clark, attorney for Pennsylvania Optical Company, to Patricia Bangert, Renee Kinscheck, and Christine Latsey, (Sept. 19, 1979) at 2 (hereinafter cited as "Letter from Clark").

6 Letter from Clark, supra note 5, at 3.

It is estimated that approximately four million people purchase reading glasses each year in the United States. Annual sales to consumers total over 36 million dollars.[7] Reading glasses retail from $5.00 to $13.00 per pair.[8] Single-vision prescription eyeglasses usually cost two to ten times as much as ready-to-wear glasses.[9]

C. Analysis of State Laws

Many optometric practice acts have exemptions which permit ready-to-wear reading glasses to be sold without an ophthalmic prescription.[10] But five states have statutorily restricted the sale of these eyeglasses, permitting them to be sold only by

---

7 Letter from Clark, supra note 5, at 2.

8 Id.

9 Bureau of Consumer Protection, Federal Trade Commission Staff Report on Advertising of Ophthalmic Goods and Services and Proposed Trade Regulation Rule at R. 24451-61 (pp. 79-89) (May 1977). (discussing surveys which provide figures on the range of single-vision eyeglasses prices).

10 See, e.g., Tenn. Code Ann. § 63-816 which provides:

> Persons and practices exempt. -- Nothing in this chapter shall be construed: . . . (3) To prevent persons, firms, and corporations to sell ophthalmic lenses or ophthalmic products at wholesale, in a permanently established place of business on prescription to those who are legally qualified to prescribe them, nor to prevent an optical mechanic from doing the merely mechanical work upon such lenses or frames or fitting, nor to prevent a wholesale house from selling ready-to-wear eyeglasses or spectacles as merchandise, at wholesale, to merchants for purpose of resale as merchandise, when neither the wholesaler nor purchaser to whom he sells practice optometry.

optometrists and ophthalmologists, or by opticians upon the prescription of an ophthalmologist or optometrist.[11] In two of these five states, ready-to-wear glasses may also be sold by opticians under the direct supervision of an optometrist or ophthalmologist.[12] In three of these states, opticians must be licensed.[13]

There is some evidence of a growing trend to enact this type of restrictive state legislation. Within the past year, one state has enacted such a law.[14] In at least three other

---

11 These states are Louisiana, Massachusetts, Minnesota, New York and Rhode Island: La. Rev. Stat. Ann. § 37:1065 (West Supp. 1979); Mass. Gen. Laws Ann. ch. 112, § 73 (West 1971); Minn. Stat. Ann. § 148.56 (West 1970); N.Y. Educ. Law §§ 7106, 7126 (McKinney 1972); R.I. Gen. Laws § 5-35-21 (1976).

Several of these statutes state explicitly that eyeglasses or lenses for the correction of vision may be sold only upon prescription of a physician or optometrist or by optometrists or ophthalmologists. N.Y. Educ. Law §§ 7106, 7126 (McKinney 1972); La. Rev. Stat. Ann. § 37:1065 (West Supp. 1979); R.I. Gen. Laws § 5-35-21 (1976). Other statutes define the practice of optometry to include "adaptation or prescribing of lenses . . . " and then explicitly exclude the sale of lenses on prescription of physicians or optometrists and the sale of lenses not for the purpose of correcting defective vision. Minn. Stat. Ann. § 148.56 (West 1970); Mass. Gen. Laws. Ann. ch. 112, § 73 (1971).

12 Minnesota and Rhode Island: Minn. Stat. Ann. § 148.56 (West 1970); R.I. Gen. Laws § 5-35-21 (1976).

13 Massachusetts, New York and Rhode Island: Mass. Gen. Laws Ann. ch. 112 § 73C et. seq. (West 1971); N.Y. Educ. Law § 7120 et. seq. (McKinney 1972); R.I. Gen. Laws § 5-35-23 (1976).

14 La. Rev. Stat. Ann. § 37:1065 (West, Supp. 1979).

states, legislation was introduced to add such restrictions.[15] While one of these proposals has been defeated,[16] two are still pending in the state legislatures.[17]

It is unclear whether the changes which would remove ready-to-wear reading glasses from the exclusionary sections of the optometric practice acts have been deliberate or inadvertent. Since the adoption of the Eyeglasses I Rule, state sunset review of licensing regulations and public awareness of Eyeglasses II, numerous states have, or are in the process of, rewriting their practice acts.

D. Effects on Consumers

Although laws restricting the over-the-counter sale of ready-to-wear reading glasses currently exist in only five states, the number of people affected by those laws is not insignificant. As stated earlier, it is estimated that four million people buy reading glasses each year. This is approximately 2% of the population of those states where the sale is not restricted.[18] Two percent of the population of these five restricted states amounts to over 600,000 people. It is reason-

---

15 Connecticut (proposed Senate Bill No. 393, 1979); Pennsylvania (proposed Senate Bill No. 770, 1978); Tennessee (Tennessee House Bill #485, introduced on Feb. 15, 1979).

16 The proposal was defeated in Connecticut, allegedly as a result of presentation of evidence by the Pennsylvania Optical Company. Letter from Clark, supra note 5, at 3.

17 Id.

18 1970 Census of Population, Vol. 1, at 1-41, 20-7, 23-7, 25-7, 34-7, 41-7.

able to estimate, therefore, that over 600,000 people are directly affected by restrictions on the over-the-counter sale of reading glasses. If current legislative trends continue, that number may soon increase.

One effect of such a restriction is to require a consumer who needs eyeglasses for reading or other near- vision tasks to visit an optometrist or ophthalmologist and obtain prescription eyewear after an eye examination is performed.[19] A recent survey of optometrists practicing in the U.S. found that the mean price for examination of a presbyope was about $25.[20] The inconvenience of obtaining eye examinations and the transportation costs involved must also be added to the expense of obtaining an eye examination.

In addition, regular single-vision prescription eyeglasses, which have higher production costs and involve more professional service for dispensing, generally retail for more than ready-to-wear glasses.[21]

While we are uncertain whether dispensing optometrists, ophthalmologists and opticians would offer ready-to-wear

---

19 It is conceivable but unlikely that the refractionist would prescribe ready-to-wear glasses rather than made-to-order prescription eyeglasses.

20 James W. Begun, Ph.D., Professionalism and the Public Interest: Price and Quality in Optometry 50 (Ph.D. dissertation, University of North Carolina) (June 1977).

21 See p. 140 supra. Ready-to-wear glasses are already fit into frames; no frame selection is involved and thus the lenses need not be ground and fit into the frames as with prescription eyeglasses.

reading glasses if their over-the-counter sale were prohibited, some preliminary evidence tends to refute such an assumption. According to POC, none of their reading glasses are sold in states with restrictive laws.[22] We do not now know whether POC has seriously tried to market reading glasses in these states. We will endeavor to answer this question in the rule-making proceeding. If they have tried, their lack of success indicates that practitioners in those states are grinding reading glasses themselves or having them ground by laboratories. Consumers who would purchase the ready-to-wear glasses in those states must either obtain the more expensive prescription eyewear or do without.

The available evidence indicates that restrictions on the over-the-counter sale of ready-to-wear glasses have the effect of raising the cost of purchasing eyewear to that segment of the population which would purchase such eyewear. The issue of restrictions on the sale of ready-to-wear glasses was not one of the issues originally addressed by us in our Eyeglasses II investigation. Rather, the majority of the data we have collected on this question was submitted by POC in a request made to the Commission for a formal investigation under Section 2.2 of the Commission's Rules of Practice.[23] At least on the

---

22 Letter from Frank Brink, President of Pennsylvania Optical Company, to Renee Kinscheck, FTC (Aug. 22, 1979); Letter from Clark, supra note 5, at Enclosure 2.

23 14 C.F.R. §2.2. Letter from Robert Clark to Michael Pertschuck (June 20, 1979).

issue of consumer cost, restrictive state regulations in this area appear to cause consumer loss. The question, therefore, becomes whether restrictions on the sale of ready-to-wear glasses have countervailing benefits to the population.

E. Justifications for Restrictive State Laws

Because this issue was not among those considered in the Eyeglasses I proceeding or initially examined in the Eyeglasses II investigation, we have little evidence concerning the "quality of care" justifications for state bans on the sale of ready-to-wear glasses.

From informal contacts with industry members, we have identified two possible quality justifications for such restrictions. First, the quality of ready-to-wear eyeglasses may be lower than that of prescription eyeglasses.[24]

---

24 There is no standard for ready-to-wear glasses comparable to the American National Standards Institute (ANSI) Z80.1 standard for prescription eyewear. However, the ANSI Z80.1 standard is (in most states) a voluntary one. The extent of industry-wide compliance to that standard is unknown.

The real issue is the comparative quality betwen prescription eyeglasses and ready-to-wear glasses. The quality issues for each, however, may be different. The ANSI standards for prescription lenses concern how closely the fabricated lenses match the eyeglasses prescription. Since ready-to-wear glasses are generally sold without prescription, the quality issue involves not only the manufacture of the lenses but also whether the ability to purchase these lenses without a prescription, and hence without professional supervision, may be harmful to the wearer.

Reading glasses have been classified as a medical device by the Food and Drug Administration. 21 U.S.C. § 321 et. seq. They must also meet FDA impact resistance standards. 21 C.F.R. § 801.410.

Second, presbyopic consumers whose visual needs are satisfied by ready-to-wear glasses might feel no need to obtain regular eye examinations. Without such examinations, consumers run the risk of allowing ocular or systemic diseases to remain undetected.[25]

F. Conclusion

Although we do not perceive this issue to be as significant as the others which are under investigation in Eyeglasses II, we feel that the potential economic injury which results from restrictions on the sale of ready-to-wear glasses warrants a thorough examination of this issue. Specifically, we have identified two critical questions which we believe must be answered before the Commission can determine whether these restrictions violate Section 5 of the Federal Trade Commission Act:

---

25 The over-the-counter sale of reading glasses enables consumers to bypass regular eye examinations. Assuming the reasons for a person's increased difficulty in performing close vision tasks is presbyopia, such an individual could, in addition, be suffering from eye disease or other medical problems. The use of ready-to-wear reading glasses could mask pathological problems involving a person's eyes. Since presbyopia generally occurs in middle age, which is the time when glaucoma and other eye problems become a concern, the need for regular eye examinations to detect potential conditions is obvious. It has been asserted, however, that if a person has symptoms of eye problems other than simple presbyopia, these symptoms will continue despite use of reading glasses. If this is so, such persons should not be deterred from seeking proper medical attention as a result of their purchase of reading glasses. Therefore, it is necessary to consider how the use of reading glasses affects the consumption of eye examinations.

1. Is the quality of ready-to-wear glasses lower than that of "prescription" eyeglasses, to the degree that consumer welfare may be jeopardized?

2. If consumers are able to purchase ready-to-wear glasses, will the glasses improve consumers' vision sufficiently to mask pathological conditions of the eye, thereby allowing consumers to forego eye examinations, and permitting ocular and systemic diseases to remain undetected?

IV. Contact Lens Fitting by Opticians

A. Introduction

Since the invention of the plastic corneal contact lens in 1948, millions of Americans have been fitted with contact lenses. These contact lens wearers invested substantial sums of money when they were initially fitted for lenses, and they will continue to spend money on replacement lenses, special chemical solutions, and follow-up examinations as long as they continue to wear contact lenses.

Anyone who wishes to wear contact lenses must first go to an ophthalmologist or optometrist for an eye examination, which will include a determination of the refractive state of the consumer's eyes.[1] If the examination shows that the consumer needs eyeglasses or contact lenses to correct his or her vision, the refractionist is required by the Commission's "Eyeglasses I Rule" to give the prescription to the consumer at the conclusion of the examination.[2] This written prescription contains the refractive measurements of the patient's eyes as determined from that examination.

But additional steps must be taken if the consumer is to

---

1 In no state are opticians (also known as ophthalmic dispensers or ophthalmic technicians) permitted to measure refractive powers or ranges. For a detailed description of each of the three different groups of eye care practitioners, see Bureau of Consumer Protection, Federal Trade Commission, Staff Report on Advertising of Ophthalmic Goods and Services and Proposed Trade Regulation Rule, Exhibit III-2 at R.24387-24403 (pp.15-31) (May 1977) [hereinafter cited as Staff Report].

2 16 C.F.R. § 456.7 (1980)

be fitted with contact lenses. The fitter must measure the curvatures of the consumer's corneas with a device known as a keratometer[3] and must determine the various physical specifications of the contact lenses. The consumer must be taught how to insert and remove his or her contact lenses, and how to clean and care for them. The fitter must evaluate the fit of the lenses, typically through the use of flurorescein (a fluorescent substance applied to the cornea) and a biomicroscope, both when the lenses are first placed on the consumer's eyes and on subsequent follow-up visits to the fitter's office.

As long as the consumer continues to wear contact lenses, he or she will need replacements for lost or damaged lenses. Most consumers who need replacement lenses will obtain them from the original fitter. Those who wish to purchase replacements from another source must first obtain the lens specifications from the original fitter, or must be completely refitted.

Contact lenses have been successfully used in the correction of many visual conditions, including: myopia (nearsightedness); hypermetropia (farsightedness); corneal astigmatism (an irregular or aspherical cornea); presbyopia (an age-related inability to focus on near objects); keratoconus (a progressive thinning

---

3 Bausch & Lomb, Inc. has patented its particular instrument as the "Keratometer." Other similar devices are known generically as ophthalmometers. Since the measurement of corneal curvatures is more accurately described as keratometry than as ophthalmometry, all such instruments will be referred to as keratometers in this document. W. Sampson and J. Soper, Keratometry, in Corneal Contact Lenses 65-92 (L. Girard ed. 2nd ed. 1970).

of the center of the cornea which results in a bulging or nipple-shaped cornea); aphakia (lack of the natural crystalline lens, usually due to cataract surgery); aniseikonia and anisemetropia (conditions where there is a difference in size or shape between the two retinal images); strabismus (crossed eyes); and amblyopia ("lazy eye").[4] Contact lenses provide superior vision correction or therapy in many of these conditions, and may be the only means of correcting certain visual problems satisfactorily.

For the millions of people who have moderate to high degrees of myopia, hypermetropia, or astigmatism, the use of contact lenses may result in a more normally-sized retinal image, a larger visual field, and freedom from the discomfort caused by wearing thick, heavy spectacles. Contact lenses offer even more dramatic advantages to the keratoconic wearer. Patients with keratoconus are usually unable to obtain satisfactory vision with spectacles. Contact lenses provide the only satisfactory alternative to keratoplasty (corneal transplantation) for those with keratoconus.[5]

Patients who have undergone cataract surgery are also often greatly benefitted by contact lenses. Compared to aphakic vision with thick cataract spectacles, aphakic vision with contact lenses

---

4 Definitions of these and other optical and ophthalmic terms used in this section are paraphrased from those which appear in H. Solomon and W. Zinn, The Complete Guide to Eye Care, Eyeglasses, and Contact Lenses 235-43 (1977).

5 L. Girard, Indications and Contraindications for the Use of Corneal Contact Lenses, in Corneal Contact Lenses 108-09 (2nd. ed. 1970).

is much less distorted, the visual field is greatly enlarged, and near vision is improved. Most importantly, the contact lens magnifies image size only 7%, while cataract spectacles increase image size 30%. While image size magnification of this magnitude causes problems to all aphakic patients ("aphakes"), it is particularly troublesome to those patients who have had cataract surgery on only one eye. With cataract spectacles, a monocular aphake perceives two images which differ in size by 30%. But with contact lenses, the image size difference is only 7%, a difference to which many monocular aphakes can accommodate comfortably.[6]

Contact lenses are often worn primarily for "cosmetic" reasons. Cosmetic wearers range from those who suffer from albinism (absence of eye pigment) and aniridia (complete or partial absence of the iris) to those who simply dislike their appearance in eyeglasses. The importance of appearance to contact lens wearers cannot be categorized as mere vanity. The use of an opaque contact lens rather than an eye patch to occlude the eye of a six-year-old amblyopic child may be termed "cosmetic," but may lead to the avoidance of serious psychological damage. Even in less dramatic cases -- adolescent myopes who wear contact lenses simply because they do not want to wear glasses -- the use of contact lenses, wearers report, has resulted in better grades and increased extracurricular activities.[7]

---

6 Id. at 109-14.

7 L. Glatt and A. Schwartz, Contact Lenses for Children and Adolescents - A Survey, 32 Journal of the American Optometric Association 143-146 (1960).

And teenagers who wear contact lenses wear their corrective lenses much more frequently than do those who wear eyeglasses.[8]

B. Industry Profile[9]

Approximately 15 million Americans wear contact lenses.[10] Of those, about half are hard lens wearers and half are soft lens wearers.[11] About 70% of all contact lens wearers are females.[12] The average age of contact lens wearers is 30 years (compared to an average age of 22 years in 1973).[13] Most contact lens wearers are myopes, but a significant percentage have more unusual conditions such as keratoconus or aphakia,

---

8 A 1976 study of 1300 adolescent females found that those who had contact lenses wore them for an average of 14.3 hours per day, while eyeglass wearers averaged only 8.6 hours of wear a day. Only 62.4% of those with eyeglasses wore them every day, while 94% of those who had contact lenses were daily wearers. "Contact Survey Eyes Teenage Girls," American Optometric Association News, Dec. 15, 1976, at 1, col. 1.

9 For a detailed description of the ophthalmic industry as a whole, see Staff Report supra note 1, at R.24383-24403 (pp. 11-31).

10 "New Price Rivalry in Soft Contact Lenses," Business Week, May 14, 1979, at 36. The American Optometric Association estimates that several million others have worn or attempted to wear contact lenses at one time or another. American Optometric Association, Contact Lens News Backgrounder 1 (April 1978).

11 "New Price Rivalry in Soft Contact Lenses," Business Week, May 14, 1979, at 36.

12 "1979 CLMA Convention Program Reflects Industry Strength and Growth," 20/20, January-February 1980 at 96 (quoting speech by William Applegate of the Replacement Lens, Inc.).

13 Id.

for which contact lenses offer unique advantages.[14]

The percentage of the population that wears contact lenses is steadily increasing. About 1.5 million people were fitted with contact lenses in 1978,[15] and over 2.7 million were fitted in 1979.[16] Although sales of hard lenses have flattened out and are expected to decline in future years, the soft lens market is growing at an annual rate of 25%.[17] Since some 50 or 60 million Americans are potential soft lens wearers, this rapid growth rate could continue indefinitely.[18] 1978 sales of soft lenses and lens care solutions and devices were about $150 million,[19] and 1979 sales are estimated to have been almost double that amount.

In 1975, the most recent year for which data are available, optometrists dispensed about three-fourths of all contact lenses;

---

14 Aphakic contact lens wearers are usually either very young (in the case of congenital cataracts) or very elderly. Of the several million American aphakes, as many as a million may be contact lens wearers.

15 One major lens manufacturer estimated total contact lens sales in 1978 at 3 million pairs. Frigitronics, Inc., 1978 Annual Report 14. Approximately half of all sales were to new wearers, while the other half were replacement or duplicate lenses. Interview with Edward A. Porter, Group Counsel, Opticks, Inc., April 13, 1979.

16 Of that number, 600,000 were fitted with hard lenses and 2.1 million were fitted with soft lenses. "1979 CLMA Convention Program Reflects Industry Strength and Growth," supra note 12, at 96.

17 Frigitronics, Inc., 1978 Annual Report 14.

18 Id.

19 Id.

opticians and ophthalmologists shared the remainder of the market.[20]

C. Analysis of State Laws

Ophthalmologists and optometrists are permitted in all 50 states and the District of Columbia to perform all the procedures necessary to prescribe, and fit contact lenses.[21]

---

20 Gordon R. Trapnell Consulting Actuaries, The Impact of National Health Insurance on the Use and Spending for Sight Correction Services, Table 11 (January 1976), Exhibit II-68 at R. 1973. It is staff's opinion that these three fitter groups share the contact lens market somewhat more equally now.

21 The prescription, fitting, and dispensing of contact lenses is often defined as the practice of optometry.

> Any person who is engaged in ... the prescribing of contact lenses, or the fitting or adaptation of contact lenses to the human eye ... is engaged in the practice of optometry.

Colo. Rev. Stat. 12-40-102. See, e.g., Del. Code tit. 24 § 2101(a)(3); Mich. Comp. Laws Ann. § 33.17401(iv); W. Va. Code § 30-8-2(c).

These optometric practice acts usually explictly exempt physicians and surgeons.

> This article shall not apply to the practices of his profession by a physician or surgeon.

Colo. Rev. Stat. 12-40-105(a). See, e.g., Md. Ann. Code art. 43. § 380(1); Mont. Rev. Code Ann. § 66-1302(k)(2); Vt. Stat. Ann. tit. 26, § 1603.

Optometrists or ophthalmologists are generally permitted to delegate their authority to perform these procedures to ancillary personnel they employ.

> A technician in the office ... [and] acting under the direct responsibility and supervision of the physician and surgeon or optometrist may fit prescription lenses.

Cal. Bus. & Prof. Code § 2544 (Deering). See, e.g., Ala. Code tit. 34, § 34-33-4; Colo. Rev. Stat. 21-4-105(a);

(Footnote Continued)

Opticians may never prescribe contact lenses,[22] and are prohibited (or apparently prohibited) from performing independently some or all of the acts necessary to fit contact lenses in many states.

In a few states, opticians are explicitly authorized to perform the post-refraction procedures necessary to fit contact lenses. Opticians in such states may measure the curvature of the corneas, specify the various elements of the physical design of the lens, and evaluate the fit of the lenses.[23]

Some states expressly forbid opticians to fit contact lenses.[24]

Other states allow opticians to fit contact lenses only if they do so under the supervision of or on the direction of

---

21 (Footnote Continued)

Ill. Rev. Stat. Ch 111, § 3803. Contra, N.J. Stat. Ann § 52:17B-41.1(West).

22 In no state are opticians permitted to test or measure the refractive state of the eye. Whether they are fitting and dispensing eyeglasses or contact lenses, opticians must work pursuant to the prescription prepared by the ophthalmologist or optometrist.

23 "Dispensing optician" . . . means any person . . . who dispenses . . . contact lenses . . . to the intended wearer on written prescription from a . . . physician or optometrist, and in accordance with such prescription interprets, measures, adapts, fits or adjusts the same for the aid of correction or vision.

Ariz. Rev. Stat. § 32-1671. See, e.g., Conn. Comm'n of Opticians Regulations § 20-141-10a.

24 A[n] [ophthalmic dispenser or ophthalmic technician] . . . is specifically prohibited from engaging in the practice of . . . fitting contact lenses . . .

N.J. Stat. Ann. § 52: 17B-41 (West). See, e.g., Op. Atty. Gen. of Vt. No. 10 (Sept. 29, 1966).

an optometrist or ophthalmologist.[25]

Some states permit opticians to sell contact lenses, but require that all the lens design specifications be determined by an ophthalmologist or optometrist.[26]

In several states, the practice of optometry is statutorily defined to include the adaptation of contact lenses (or all lenses) for the purpose of correcting visual problems. The role which opticians may play in contact lens fitting in some of these states (particularly those which do not have analogous statutes defining the scope of practice of opticians) is not clear. The state courts and state attorneys general which have been called upon to judge (under a variety of factual contexts) whether or not an optician was violating such a statute have come to inconsistent conclusions.[27]

---

25 [D]ispensing opticians may fit contact lenses in the presence of and under the direct supervision of a licensed optometrist or ophthalmologist.

Tenn. Code Ann. § 63-1402. Cf. Op. Atty. Gen. of Va. (March 17, 1977) (Virginia statute which allows opticians to fit contact lenses on the prescription of or under the direction of an ophthalmologist or optometrist does not require that optician be physically located on the same premises as the prescriber).

26 Hard contact lenses may be sold or dispensed in a retail optical dispensary . . . only when authorized by an optometrist or ophthalmologist and the prescription therefor contains all necessary data.

Ala. Code tit. 34, § 34-22-4.

27 In State ex rel. Londerholm v. Doolin & Shaw, 209 Kan. 244, 497 P. 2d 138 (1972), the Kansas Supreme Court inter-
(Footnote Continued)

The following chart represents an attempt at categorizing state laws, board regulations, and judicial and attorneys' general opinions which affect opticians' ability to fit and dispense contact lenses. Making such categorizations is often difficult,

---

27 (Footnote Continued)

preted the Kansas optometry statute (Kan. Stat. Ann. § 65-1501 et seq.), which includes within the definition of the practice of optometry the adaptation of lenses for the aid of visual defects. The court held that opticians could, after receiving a simple spectacle lens prescription and a statement that the patient may be fitted with contact lenses from the refractionist, do everything else necessary to fit contact lenses.

But the Missouri Supreme Court, interpreting similar statutory language, came to the opposite conclusion in State ex rel. Danforth v. Dale Curteman, Inc., 480 S.W. 2d 848 (Mo. 1972). Although the Missouri court admitted that defendant opticians were recognized as proficient contact lens fitters by outstanding physicians, it felt compelled by the language of the Missouri optometry law (Mo. Ann. Stat. § 336.010 et seq.) to enjoin defendants from engaging in contact lens fitting.

Therefore, even though both states have enacted almost identical statutes, opticians in Kansas are allowed to use a keratometer, trial lenses and fluorescein, to determine lens diameter, thickness and curve specifications, and to establish a wearing schedule and make subsequent assessment of lens fit, while opticians in Missouri are permitted to do none of those things.

Compare Fla. Ass'n of Dispensing Opticians v. Fla. State Bd. of Optometry, 238 So. 2d 839 (Fla. 1970); State Bd of Optometry v. Chester, 169 So. 2d 468 (Miss. 1964); High v. Ridgeway's Opticians 129 S.E. 2d 301 (N.C. 1963); and State ex rel. Clifton v. Reeser, 543, P. 2d 1379 (Okla. 1975) with Fields v. D.C., 232 A.2d 300 (D.C. 1967); People ex rel. Watson v. House of Vision, 322 N.E.2d 15 (Ill. 1974); Commonwealth ex rel. Ky. Bd. of Optometric Examiners v. Economy Optical Co., 522 S.W. 2d 444 (Ky. 1975); and S.C. Bd. of Examiners in Optometry v. Cohen, 180 S.E.2d 650 (S.C. 1971). For a discussion and analysis of most of these cases, see 77 A.L.R. 3d 817.

either because the applicable state law is ambiguous or because actual practices in a jurisdiction appear to be inconsistent with state law.

CONTACT LENS FITTING BY OPTICIANS: A CATEGORIZATION OF STATE LAWS

I. States where opticians are expressly permitted to fit contact lenses:

Arizona
Connecticut
Kansas
Massachusetts
North Carolina
Ohio

II. States where opticians are expressly forbidden to fit contact lenses:

Missouri
New Jersey
New Mexico
Vermont

III. States where opticians may fit contact lenses on the direction of or under the supervision of an ophthalmologist or optometrist:

Alaska
California
Colorado
Delaware
Florida
Hawaii
Illinois
Kentucky
Mississippi
Nevada
New York
Oregon
South Carolina
Tennessee
Texas
Virginia

IV. States where opticians may dispense contact lenses on a fully-written prescription:

Alabama
District of Columbia
Florida

V. States where law on the question is ambiguous or non-existent:

Arkansas
Georgia
Idaho
Indiana
Iowa
Louisiana
Maine
Maryland
Michigan
Minnesota
Montana
Nebraska
New Hampshire
North Dakota
Oklahoma
Pennsylvania
Rhode Island
South Dakota
Utah
Washington
West Virgina
Wisconsin

D. Justification for Restrictions on Contact Lens Fitting by Opticians

It is clear that errors of omission or commission by an incompetent contact lens fitter can cause serious harm to a contact lens wearer.

The wearing of contact lenses always produces certain changes in corneal physiology. Some of those changes are usually considered acceptable, while others are not. Most unacceptable tissue changes, such as corneal abrasions (erosion of the cell layers on the surface of the cornea) and corneal edema (swelling caused by the accumulation of fluid in corneal tissue), are reversible. Other physiopathological changes, such as fungal infections and corneal vascularization (extension of blood vessels into the normally avascular cornea) may lead to permanent damage, including blindness.[28]

Some ophthalmologists and optometrists feel that opticians generally do not have sufficient knowledge and skill to fit contact lenses safely and effectively and that, as a result, the removal of restrictions on the fitting of contact lenses by opticians would lead to an increase in the kinds of problems described above.[29] Those opinions seem generally to be based

---

28 J. Dixon, Physiopathology of the Cornea as Related to Contact Lenses, in Corneal and Scleral Contact Lenses 30-39 (L. Girard ed. 1967).

29 It is also true that some ophthalmologists feel that optometrists are unqualified to fit contact lenses, and vice versa. See, e.g., Honan, Indiana M.D. Describes "Short Route to Medicine," The Pen, June 1, 1978, at 3-4; Globus, Meaningful Communications Marketing from Optometry -- Part 3, Optometric Monthly, April 1978, at 63-66.

on the fact that there are no formal educational standards for opticianry, or that the majority of states do not require that opticians be licensed.[30]

E. Effects of Public Regulation of Contact Lens Fitters and Dispensers

Little reliable evidence of the economic effects of current regulation of contact lens fitting or the comparative quality of fittings performed by opthalmologists, optometrists, and opticians is currently available.[31]

The evidence which does exist tends to show that prices are lower in areas where opticians are permitted to engage in contact lens fitting. A 1975 price survey of contact lens fitters in Alameda and Contra Costa Counties, California, found that opticians charged an average of $50 less than optometrists and $65 less than ophthalmologists for hard contact lenses, and an average of $45 less than optometrists and $60 less than ophthalmologists for soft lenses.[32] In May, 1978, a prominent Delaware optician stated that his prices for contact

---

30 Only 20 states license opticians. See p. 16 note 43, supra.

31 The results of the Commission's "Contact Lens Wearer Study" will provide more complete cost information. Information concerning comparative contact lens prices has been collected, but has only been preliminarily analyzed. A discussion of the preliminary findings concerning cost is found in Section F, infra.

32 D. Schletter, Optical Illusion: A Consumer View of Eye Care 56 (San Francisco Consumer Action, 1976), Exhibit II-65. Because the prices reported by opticians in that study probably did not include the initial eye examination, that price differential is somewhat exaggerated.

lenses were, on the average, $70-$75 lower than optometrists and ophthalmologists who practiced in that area.[33] A South Carolina optician claimed that the price of contact lenses in that state dropped 50% when opticians entered the market.[34]

There also exists evidence which indicates that state-imposed restrictions which prevent opticians from fitting contact lenses may be unnecessary to protect consumers from harm.

It is clear that some opticians are thoroughly qualified to fit contact lenses successfully.[35] In fact, some individual opticians have demonstrated an ability to fit consumers who were unsuccessfully fitted by ophthalmologists and optometrists.[36]

The use of opticians (or "contact lens technicians") in contact lens fitting is recognized in the professional literature

---

33 Interview with Edwin P.J. Kuhwald, May 25, 1978. The price differentials cited by Mr. Kuhwald do take the cost of the initial eye examination into account.

34 Letter from K. Richard Davenport to Terry Latanich, April 30, 1979.

35

> The individual defendant has been an optician since 1955; since 1959 he has fitted contact lenses to at least 8,000 people, with no complaint or injury. There is no indication that the health, safety or welfare of the residents of Massachusetts has been in any way endangered by any activity of the defendants.

Attorney General v. Kenco Optics, Inc., 340 N.E.2d 868, 869 (Mass. 1976).

36 Letter from Edwin P.J. Kuhwald to Terry S. Latanich, December 1, 1977 (author of letter is an optician who states that he has successfully refitted 250 consumers who were previously fitted improperly by optometrists).

as an accepted practice.[37] Many ophthalmologists and optometrists routinely delegate much of the contact lens fitting function to opticians whom they employ,[38] and some willingly release prescriptions to patients who wish to be fitted by independent opticians.[39]

To generate more detailed and trustworthy data about the effects of public regulation of contact lens fitters and dispensers than is currently available, we have designed and have conducted a study of contact lens wearers.

F. The Contact Lens Wearer Study

---

37 L. Girard, The Ophthalmologist-Technician Relationship, in Corneal Contact Lenses 269-74 (2nd ed. 1970) (the optician should be responsible for keratometry, use of trial lenses, lens design, initial fitting, lens modification, instruction of patient in lens handling, and wearing time scheduling).

38 Testimony of Dr. Gordon S. Black, Tr. 4567-69; testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2012.

39

> Customarily, a person who wants contact lenses in Massachusetts is examined by an ophthalmologist or an optometrist and a prescription is secured. The ophthalmologist rarely fits the contact lenses. Fitting may be made by the optometrist, or either the ophthalmologist or the optometrist may send the person with a prescription to an optician for fitting. . . . Forty-eight ophthalmologists in the Boston-Lynn area have referred patients to the individual defendant [optician] for such fitting, as have the Boston University Medical Center Clinic, the Boston City Hospital Eye Clinic, and the Harvard University Health Services.

Attorney General v. Kenco Optics, Inc., 340 N.E.2d 869, 869 (Mass. 1976).

Because there is no known source of statistically reliable data concerning the effects of current public and private restrictions on the price and quality of contact lenses dispensed by the different provider groups, we designed and administered a study to gather this information.

The "Contact Lens Wearer Study" had its genesis in the summer of 1978, when we began to explore the feasibility of performing such research. The basic methodology of the study was designed after meetings with representatives of ophthalmology, optometry, and opticianry, in October, 1978.[40] The major methodological features of the study were finalized in March, 1979, and the individual field examiners and examination sites were identified. The on-site data collection process began in June, 1979, and was completed in February, 1980.

Two national market research firms identified, through the use of mailed questionnaires, approximately 500 representative consumers in nineteen metropolitan areas who were willing to be interviewed and examined by the Commission's staff and consultants.[41] Inter-

---

40 The Contact Lens Association of Ophthalmologists (through its executive vice-president), the American Optometric Association, and the Opticians Association of America (through the National Committee of Contact Lens Examiners) have contracted to assist FTC staff design, perform and evaluate the study.

41 The mailing has also identified several hundred people who have been fitted for contact lenses but who are no longer wearing them. Each of these "failures" was asked to identify his or her fitter and explain why he or she is no longer wearing lenses. Data about these unsuccessful wearers will be analyzed and compared to the data gathered from current wearers who are examined and interviewed in (Footnote Continued)

views and examinations took place at medical or optometric school clinical facilities or private practitioners' offices in each of those metropolitan areas.

Members of the Commission's staff interviewed each wearer to ascertain the source of the initial contact lens fitting and replacement lenses, the price of the lenses and related services, the lens care and wearing habits of the wearer, and other significant information.

Each wearer was then examined by a team consisting of an ophthalmologist, an optometrist, and an optician (assisted by certain ancillary personnel).

First, the wearer's visual acuity with contact lenses was tested. Then, a refraction was performed to determine whether the wearer's vision had been over- or under-corrected by his or her fitter.

Then, the wearer removed his or her lenses, and biomicroscopic and keratometric examinations were performed. These procedures were designed to detect the presence and degree of various physiological or pathological conditions, including: epithelial and microcystic edema (intercellular accumulation of fluid which causes the cornea to swell); corneal staining (abrasions or lesions of the cornea); corneal vascularization (impingement of blood vessels into the normally avascular cornea, which may

---

41 (Footnote Continued)

person. If necessary, follow-up interviews of these unsuccessful wearers may be performed.

cause part or all of the cornea to opacify); corneal striae (ridges or furrows on the cornea); corneal warpage (change in the curvatures of the cornea); and injection ("bloodshot" eyes or eyelids). At the same time, the lens itself was measured and examined for dirtiness and physical damage (such as scratches, chips, tears, or warpage).

Each wearer's original fitter will now be asked to provide information about his or her mode of practice and about various facets of the wearer's visual history. By obtaining information about the wearer's history, we will be able to detect changes in visual acuity or corneal physiology over time.

This methodology represents an attempt to quantify and objectify what constitutes successful (or unsuccessful) contact lens fitting. This simple fact that we and the rival professional groups involved were able to reach a consensus as to what constitutes "quality" in this area is itself significant.

The results of these interviews and examinations, as quantified on the data forms designed by the Commission's staff after consultation with the three participating industry groups,[42] will be analyzed and then formally commented upon by those groups.

The study will, in our estimation, provide the most reliable data in existence on the following questions:

---

42 Copies of these forms are found in Section K, infra.

1. Are there systematic price differentials between ophthalmologists, optometrists and opticians in states where all three groups compete in the contact lens fitting market?

2. Do ophthalmologists and optometrists in states where opticians are not permitted to compete in the contact lens fitting market charge systematically higher prices than their counterparts in states which permit opticians to fit contact lenses? If so, can the higher prices be attributed to the absence of opticians in the contact lens fitting market?

3. What is the comparative level of quality of contact lens fitting services provided by ophthalmologists, optometrists and opticians?

With these data, the Commission will have the evidence necessary to make an informed decision as to what, if any, action is appropriate.

Although data collection is not yet complete[43] and analysis of the data that has been collected has just begun, we are able to make some very crude and preliminary predictions about what the answers to the above questions will be.

It now appears more likely than not that the final results will show that prices for both soft and hard contact lenses are generally lower in states where opticians are permitted to fit contact lenses and in states where high-volume "commercial" optometric practices thrive than in states where opticians are excluded from the contact lens market and where commercial providers are less prevalent. (It is impossible to say now whether the

---

43 We plan to send a follow-up questionnaire to the original fitters to obtain information which will enable us to identify and categorize each fitter as an optometrist, opthalmologist or optician. In addition, we will obtain from the fitters the original contact lens specifications of the survey subjects.

presence of opticians or the presence of commercial optometric practices has the greater effect on contact lens prices).

It also appears that very few contact lens wearers exhibit any serious pathological conditions due to poor fitting practices. At this time, there is no reason to believe that opticians have fitted a relatively higher proportion of those people with serious problems than optometrists or ophthalmologists have fitted.

Our recommendations concerning initial contact lens fitting by opticians are found in Section I below. But first we will discuss the related issue of dispensing of replacement or duplicate contact lenses.

G. Effects of Private Regulation of Replacement or Duplicate Contact Lens Dispensing

The average contact lens wearer has to replace one lens every year, either because the lens is damaged or because it is lost.[44] Those who initially fit contact lenses usually also provide replacement lenses. If the fitter refuses to release contact lens specifications to a consumer who needs a replacement lens, the consumer is forced to purchase the lens from the original fitter or undergo a complete refitting process.[45]

---

44 American Optometric Association, Contact Lens News Backgrounder 14 (April 1978).

45 In such a situation, the original fitter has a virtually unchecked unilateral power to fix the price of the replacement lens. The only limiting factors on this power are the prices charged by competing fitters for complete refittings and the presence of competing fitters who are willing to release contact lens specifications (although

(Footnote Continued)

It is likely that a large number of contact lens wearers are denied access to their lens specifications and, therefore, are forced to purchase replacement lenses from their original fitters.[46] The economic effects of such privately-imposed restrictions on replacement lens wearers are analogous to the economic effects of refusals to release eyeglass prescriptions.

As part of the study, wearers were asked several questions about the source of replacement or duplicate lenses, the cost of the lenses, whether an examination was performed at the time the lens was dispensed, and whether the wearer attempted to purchase lenses from a source other than the original fitter (and, if so, what his or her experiences were). We believe that these data will provide some guidance on the desirability

---

45 (Footnote Continued)

it is very doubtful that many consumers take this factor into account when choosing the initial fitter).

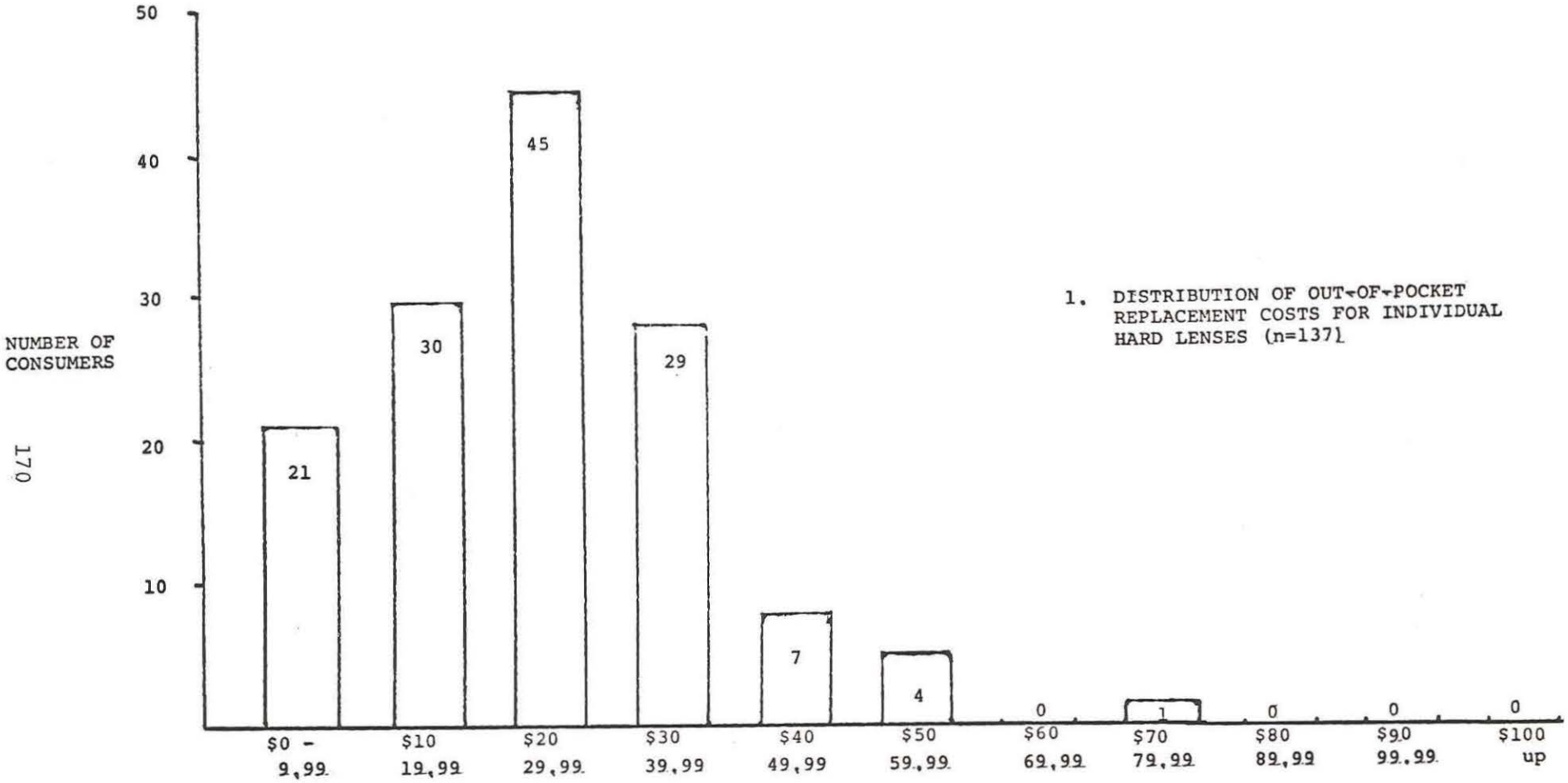
46 See, e.g., letter from Louanna Gaiser to Federal Trade Commission (March 20, 1980); letter from Edwin J. Verrette to Federal Trade Commission, (March 11, 1980); letter from Carol Osufsen to Federal Trade Commission (December 20, 1979); letter from Teresa Stinnett to Federal Trade Commission (October 12, 1979); letter from Marjorie Gallo to Federal Trade Commission (June 25, 1979); letter from Larry A. Fenner to Gary Hailey (July 9, 1979); letter from Ronald L. Williams to Federal Trade Commission (June 28, 1979); letter from Lea Monath to Federal Trade Commission (May 10, 1979); letter from Gretchen Matteson to Federal Trade Commission (March 28, 1979); letter from Sylvia Chipp to Albert H. Kramer, Federal Trade Commission, (March 12, 1979); letter from Laura Kochones to Federal Trade Commission (February 2, 1979); testimony of Billie J. Odom, Tr. 55 at 63.

of requiring that the original fitter provide each consumer with a complete set of contact lens specifications which that consumer could use to obtain replacement lenses from the provider of his or her choice.

A preliminary analysis of that data indicates that prices charged for replacement lenses vary widely.[47] The four charts below illustrate the disparity in both out-of-pocket costs and "total" costs (defined as out-of-pocket cost plus insurance premium cost, if any) for hard and soft lenses.

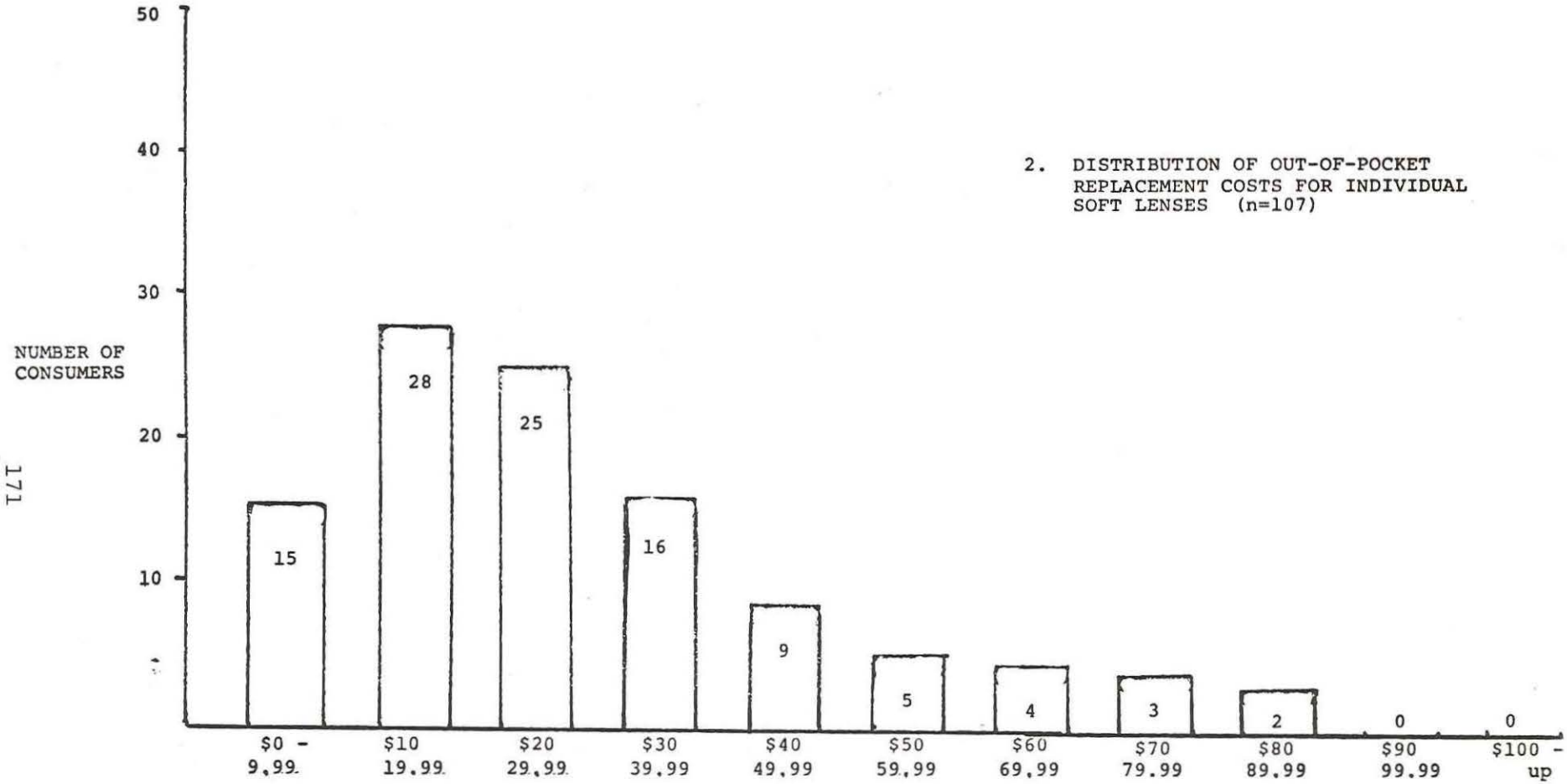
---

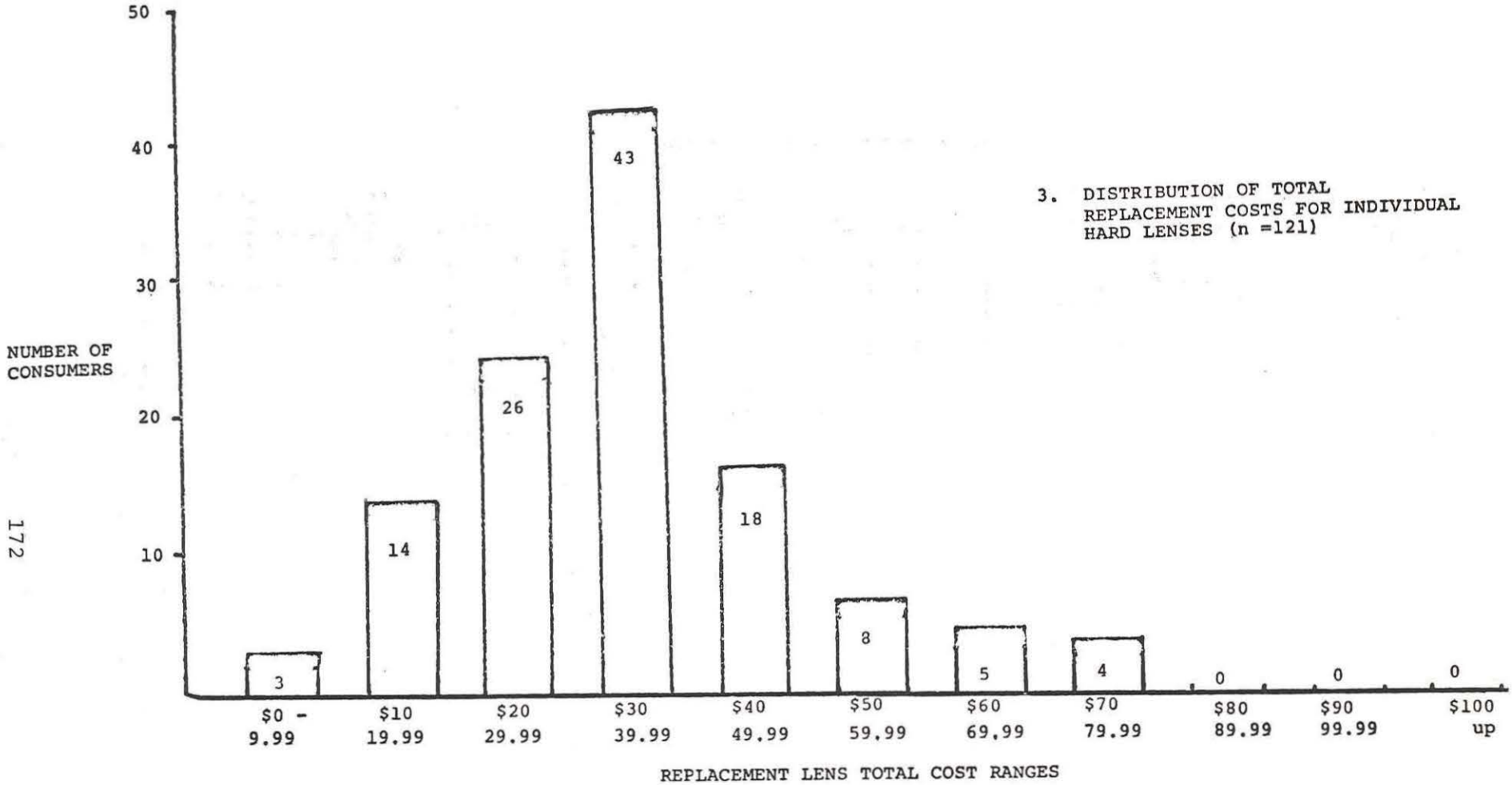
47 Several of the consumers who have written to complain that they could not obtain replacement lenses from low-cost providers because their fitters would not release complete contact lens prescriptions have also cited wide price variances. Letter from Lea Monath to the Federal Trade Commission (May 10, 1979) (cost of lenses from fitter was "more than double" that of competitor); letter from Gretchen Matteson to Federal Trade Commission (March 28, 1979) (fitter charged $100 per pair for replacement lenses; competitor would have charged $20 per pair); letter from Laura Kochones to Federal Trade Commission (February 2, 1979) (fitter's price was $60 per pair; competitor's was $20 per pair).



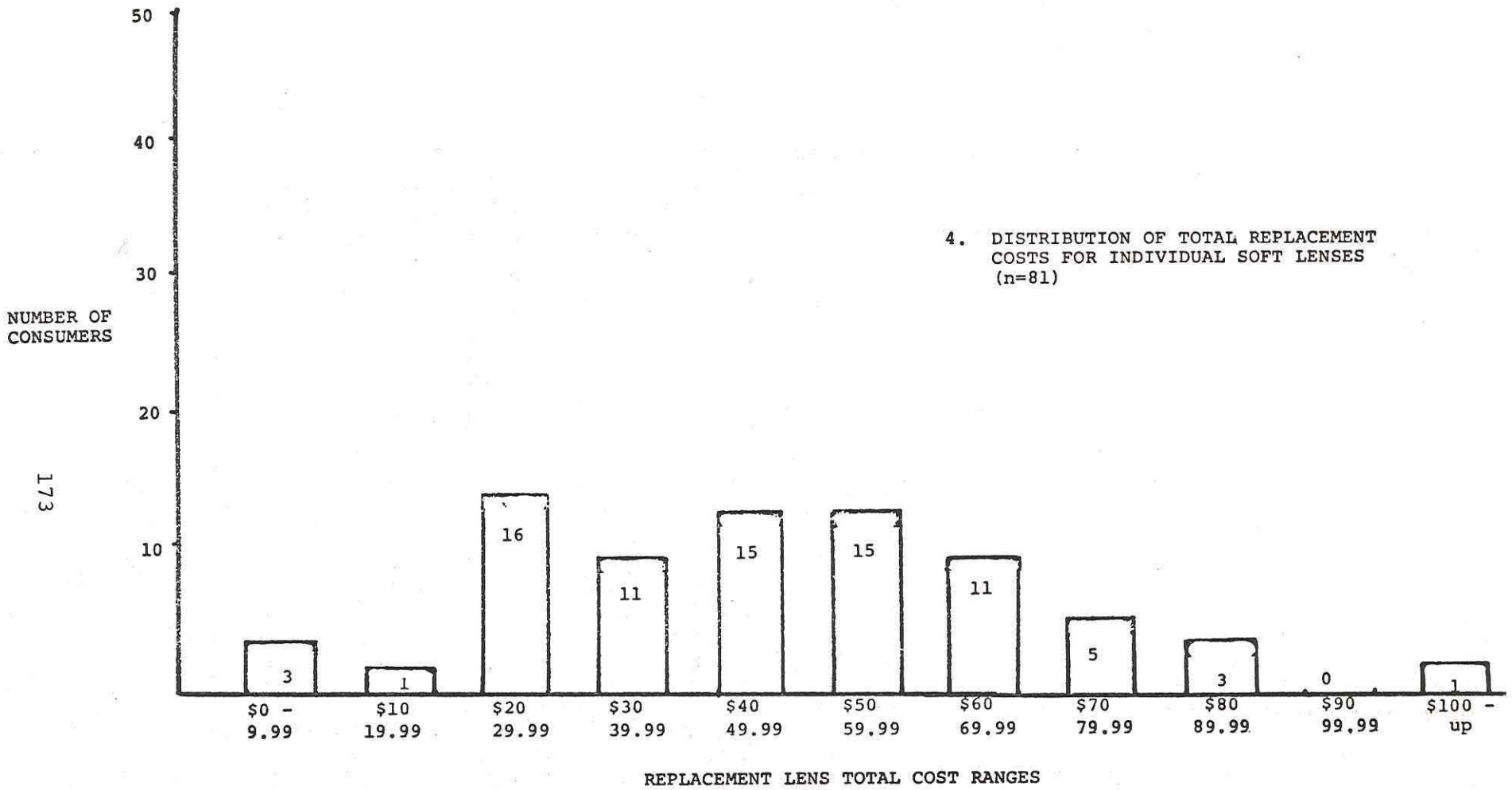
1. DISTRIBUTION OF OUT-OF-POCKET REPLACEMENT COSTS FOR INDIVIDUAL HARD LENSES (n=137)

2. DISTRIBUTION OF OUT-OF-POCKET REPLACEMENT COSTS FOR INDIVIDUAL SOFT LENSES (n=107)





3. DISTRIBUTION OF TOTAL REPLACEMENT COSTS FOR INDIVIDUAL HARD LENSES (n =121)



4. DISTRIBUTION OF TOTAL REPLACEMENT COSTS FOR INDIVIDUAL SOFT LENSES (n=81)

H. Recommendations Concerning Replacement Contact Lenses

We recommend that the release-of-prescription requirement in the Eyeglasses I Rule be expanded to require that ophthalmologists, optometrists and opticians (where permitted by state law to fit contact lenses) who dispense contact lenses give to the patient a complete set of his or her contact lens specifications at the completion of the initial contact lens fitting process. This recommendation does not in any way affect who may initially fit or dispense contact lenses under state law.

A rule requiring that consumers be given a complete contact lens prescription (that is, a spectacle prescription combined with contact lens specifications) would enable those who have been forced to purchase replacement lenses from higher-priced providers to obtain lenses from lower-priced providers without undergoing a new fitting procedure. Our preliminary analysis fails to indicate how such a rule would have any adverse impact on the quality of care that contact lens wearers would receive. There is no currently available evidence indicating that the lenses dispensed by lower-priced providers are of any lower quality than those dispensed by higher-priced providers.[48]

---

48 Some of the most prominent low-priced hard lens providers claim to obtain their lenses from the same laboratories from which higher-priced providers also obtain lenses.

The identity of the retail provider has virtually nothing to do with quality of soft lenses. Unlike hard lenses, soft lenses are not custom-prepared for individual wearers; rather, they are uniform, mass-produced lenses supplied by only a few manufacturers. Soft lens manufacture and distribution is closely regulated by the Food and Drug Administration. The vast majority of soft lens wearers wear the Bausch and Lomb "Soflens."

Neither is there any evidence now available which shows that higher-priced providers offer higher quality services than do lower-priced providers. Some replacement lens providers verify that the lens specifications are correct and examine the fit of the lens upon the cornea before dispensing it to the consumer, a procedure which some practitioners claim is necessary to detect any problems with the replacement lens, while others simply order the lens from the manufacturer or distributor and deliver it to the wearer. Although it was impossible in the context of the contact lens wearer study to evaluate the thoroughness or skillfulness with which such examinations were performed, that study did determine the extent to which examinations were performed at all when replacement lenses were dispensed.

Further statistical analysis will be necessary before it is known whether or not higher-priced providers are more likely to examine consumers when lenses are dispensed. But the table below shows that fewer than half of the contact lens wearer study subjects interviewed had been examined when replacement lenses were provided and that, furthermore, there were no statistically significant differences in examination frequency among opticians, optometrists, and ophthalmologists.

PERCENTAGE OF FITTERS PERFORMING EXAMINATION OF WEARER WHEN REPLACEMENT LENS IS PROVIDED

Type of Fitter	% Performed Examination	% Did Not Examine
Opticians	48% (n=19)	52% (n=21)

Optometrists	48% (n=51)	52% (n=56)
Ophthalmologists	39% (n=20)	61% (n=32)
All Fitters	41% (n=102)	59% (n=149)
All Hard Lens Fitters	36% (n=52)	64% (n=91)
All Soft Lens Fitters	49% (n=57)	51% (n=59)

Requiring the release of a complete contact lens prescription would also enable consumers to purchase replacement lenses from mail-order lens providers. Although the few mail-order firms currently operating provide only a relatively small number of replacement lenses, their market share could increase significantly if all contact lens wearers were able to obtain their complete lens specifications. Some practitioners feel that ordering replacement lenses by mail is a dangerous procedure because, obviously, mail-order firms cannot examine the wearer to make sure the lens fits properly.[49] We intend to explore more fully the issue of mail order replacement contact lenses in the rulemaking proceeding.

Of course, consumers may be able to obtain such an examination from a local fitter. Advertising materials and order forms supplied by the most prominent mail-order replacement

---

49 See, e.g., Fritz, Mail Order Replacement Contact Lenses: Do Consumers Benefit?, New England Optician, March 1979, at 9-13; letter from Paul R. Honan, M.D., to Christine Latsey (March 1, 1979).

lens firms advise consumers to go to a local practitioner for follow-up care.[50] At this time, it is impossible to say whether or not a lower percentage of mail-order replacement lens consumers receive examinations than do other wearers. (It should also be noted that several contact lens wearer study subjects stated that their fitters had mailed replacement lenses to them when it was inconvenient for the wearers to pick them up in person.)

I. Reasons for Severing Certain Issues from Rulemaking Proceeding.

We believe that recent developments make it advisable to sever our examination of initial contact lens fitting practices from this rulemaking proceeding. We recommend that those issues be explored in separate public hearings (which could result in the issuance of a model state law or other appropriate action).

The decision in American Optometric Association v. FTC[51] did not provide the anticipated judicial resolution of questions concerning the scope (or existence) of the Commission's preemption authority. So we are left with a substantial commitment of Bureau of Consumer Protection resources to matters which potentially involve preemption and no firm basis for predicting the ultimate legal viability of any of those projects. If an

---

50 One firm even mails the lenses to the original fitter for dispensing rather than to the consumer. Untitled pamphlet from Contact Lens Guild, Inc., received December 10, 1979.

51 No. 78-1461 (D.C. Cir. Feb. 6, 1980).

"Eyeglasses II" rule is promulgated (whether or not in its recommended form), it may help define the Commission's authority to preempt state laws.

The proposed rule which we are recommending only preempts state restrictions on the form of practice -- business activities in which the Commission has recognized expertise -- not on the scope of practice. In light of the growing sentiment (in both the legislative and judicial arenas) in favor of increased deference to state governments, we feel it would be unwise for the Commission to assert the authority to preempt state determinations of who can provide certain goods and services.

The complexities surrounding initial contact lens fitting are such that the Commission could not simply preempt outright bans of contact lens fitting by opticians (which would, in reality, force the states to respond with more carefully tailored entry requirements). Preemption of scope of practice restrictions may prove appropriate in another context, but we cannot recommend such a course in this matter at this time.[52]

Because it is clear that scope of practice regulation is a major factor which limits competition in the health care

---

52 It should also be noted that our preliminary analysis of the contact lens wearer study data fails to demonstrate with certainty that the presence of opticians in the initial fitting market has a significant beneficial impact on price. So there is some question as to whether or not we could satisfy the Section 5 unfairness standard in this area.

and other professional service markets, we make this recommendation reluctantly. But the fact is that scope of practice determinations in the health care area have traditionally been made solely by the states. Proposing and promulgating a rule on initial contact lens fitting may encourage a reviewing court to extend the holding of National League of Cities v. Usery[53] to matters of traditional state control as well as to matters integral to the functioning of the state as a sovereign. Such a result would jeopardize any exercise of preemption by the Commission.

Therefore, our recommendation is that the issue of initial contact lens fitting by opticians be explored separately and dealt with, if necessary, by issuing a model state law. If efforts to implement reform at the state level fail (and if any legal challenges to an "Eyeglasses II" rule are resolved favorably), the Commission may wish to pursue formal rulemaking in the area of initial fitting.

There are many practical difficulties which face the drafters of a trade regulation rule or model state legislation on this subject. It is reasonable to assume the available evidence might support neither the absolute exclusion of non-optometrist, non-ophthalmologist contact lens fitters nor a completely unrestricted market. But any solution other than those two extremes must address the problem of determining who and under what circum-

---

53 426 U.S. 833 (1976).

stances someone other than an optometrist or ophthalmolgist should be permitted to fit contact lenses.

The traditional means of limiting entry only to qualified practitioners is licensing. Several states do require opticians to pass special licensing examinations before they can fit contact lenses.[54] And at least one private group has developed a voluntary certification examination for contact lens fitters.[55] As in any other profession or occupation, the design and administration of a licensing scheme for contact lens technicians would be a complicated and controversial endeavor. It would be particularly difficult in this area -- where new fitting techniques and new lens materials and designs seem to appear almost daily -- to ensure that the licensing examination was up to date. It might also be necessary to prevent the scope of contact lens fitting by opticians from including certain situations where lens are used therapeutically to treat diseased or tramautized eyes.[56]

Although these practical difficulties should not be minimized, we are confident that the Commission will be able to deal with these issues once sufficient relevant evidence has

---

54 See, e.g., N.Y. Educ. Law § 7124(b) (McKinney).

55 The "Contact Lens Registry Exam," developed by the National Committee of Contact Lens Examiners with the assistance of the Educational Testing Service, has recently been adopted for use as a licensing examination by some states.

56 Because so few of these relatively rare conditions appeared in contact lens wearer study subjects, that study will provide little or no useful data on this issue.

become available. Although the Commission may fashion remedies under the "preventive" clause of Section 18(a)(1)(B), its rule-making authority is primarily proscriptive -- that is, it may prohibit conduct found to be unfair. Such a grant of authority is not well-suited to the complexities and subtleties of creating a new kind of health care provider. Such considerations are not troublesome if the problem is addressed through model legislation rather than a trade regulation rule.

J. Conclusion

As stated above, we believe that it is advisable to sever the issues concerning initial contact lens fitting from this rulemaking proceeding. We recommend that the evidence provided by this study, as it relates to the questions about initial contact lens fitting posed above, be explored in public, quasi-legislative hearings held separately from but concurrently to the rulemaking hearings. Such a procedure could result in the issuance of a model state law on the subject.

We recommend that the issue of whether or not the release-of-prescription rule be expanded to cover complete contact lens specifications be explored in the rulemaking hearings. The political, legal, and practical considerations which led us to recommend separate treatment of the evidence involving initial contact lens fitting do not apply in the context of replacement lenses.

K. Contact Lens Study Forms

In the pages which follow we have attached copies of the forms used in the contact lens study. The "Assistants' Form" was used to record the contact lens wearer's visual acuity and to record information about the physical condition of the contact lens itself. The "Examiners' Form" was used by the optometrist, ophthalmologist and optician examiners to record the presence and degree of various physiological or pathological conditions found during the examination procedure. The "Patient Interview Form" was used by an FTC staff member to record the responses to an oral interview of each wearer.

ASSISTANTS' FORMS

Location: _____

Patient: _____

Examiner: _____

	O.D.	O.S.
I. VISUAL ACUITY	_____	_____
II. POWER OF LENS (if applicable)	_____	_____
III. LENS STATUS	_____	_____
Cleanliness	0 1 2 3	0 1 2 3
Damage (Chips, tears, or scratches)	0 1 2 3	0 1 2 3
Warpage	0 1 2 3	0 1 2 3

0= no dirt, damage, or warpage (or condition not applicable)
1=minimal dirt, damage, or warpage
2=moderate dirt, damage, or warpage
3=considerable dirt, damage, or warpage

Patient Interview Form

Patient ID Number _____

Time of Interview _____

Interviewer _____

1. What type of lenses do you wear, hard or soft?

_____ hard

_____ soft

2. What time today did you insert your lenses?

_____

3. When did you purchase them? (MONTH and YEAR)

_____

Now, I'd like to ask you a few questions about how you like your lenses.

4. Do they cause you any discomfort?

No -----PROBE: What about when you first put them in, or late at night after you have been wearing them for a long time?

_____ No/Very Rarely (Only under unusual circumstances)

_____ Minimal (on insertion; after very long wearing period)

Yes-----PROBE: Are you able to wear them all day, or only for short periods of time?

_____ Moderate (throughout the day)

_____ Severe (only intermittant wear possible)

5. How about your vision? In general, would you say that you are very satisfied, satisfied, or not satisfied with your vision when you wear you lenses?

_____ Very satisfied

_____ Satisfied

_____ Not satisfied

6. Do you notice any difference at night? (E.G., GLARE PROBLEMS)

_____ Yes (Specify) _____

_____ No--PROBE ON GLARE

Now I'd like to get some information about where you bought your lenses.

7. First, who fit and sold you your lenses? Do you recall his/her address?

_____

_____

_____

INTERVIEWER: IF RESPONDENT GIVES NAME OF M.D. OR O.D., CHECK APPROPRIATE LINE BELOW (IF KNOWN - OTHERWISE CHECK LATER IN YELLOW PAGES). IF RESPONDENT GIVES TRADE NAME, E.G., "THE CONTACT LENS CLINIC," PROBE TO GET IDENTITY OF FITTER.

CHECK ONE:

_____ Ophthalmologist

_____ Optometrist

_____ Optician

8. Before you were fitted for contact lenses you had an eye examination. Was that examination done by the person who fitted your lenses, or did you first have an examination by someone else at a different location?

_____ Fitter (Skip to #10)

_____ Someone else was "prescriber"

NAME: _____ ___ O.D. ___ M.D.

ADDRESS: _____

_____

9. Did Dr. [PRESCRIBER] suggest that you go to [FITTER] to get your lenses?

_____ Yes

_____ No

10. Thinking back to when you were trying out your lenses,

(a) were you instructed how to insert and remove them?

(b) were you taught how to clean and care for them?

[GO THROUGH ENTIRE SERIES ON INSERTION/REMOVAL, THEN REPEAT FOR CLEANING/CARE]

Insertion/removal	cleaning/care	
_____	_____	Yes
_____	_____	No

11. Who taught you, [FITTER] or his/her assistant?

Insertion/removal	cleaning/care	
_____	_____	Fitter
_____	_____	Assistant
_____	_____	Both
_____	_____	Don't remember

12. Were you taught individually, or were you in a group?

Insertion/removal	cleaning/care	
_____	_____	Individual Instruction
_____	_____	Group Instruction

13. Were any materials used? For example, were you given any written instructions (OTHER THAN WEARING SCHEDULES) or did you see a movie? [IF RESPONDENT ONLY MENTIONS WEARING SCHEDULE - PROBE TO SEE IF IT CONTAINED ANY INFORMATION ON INSERTION, CARE, ETC.]

_____ Printed materials

_____ Manufacturer's instructions (package inserts)

_____ Audio-visual instruction

_____ None

[MAKE SURE YOU'VE GONE THROUGH ABOVE SERIES TWICE]

14. Now I'd like to ask about follow-up care. By "follow-up care," I mean care you received while you were getting used to wearing your lenses. How many times did you return to [FITTER] for follow-up care after you were first given your lenses to take home.

(INTERVIEWER: INQUIRE ABOUT THE TIME INTERVALS OF VISITS TO CHECK THAT THEY'RE FOLLOW-UP CARE AND NOT ROUTINE CHECK-UPS. VISITS MORE THAN 6 MONTHS AFTER DISPENSING ARE NOT CONSIDERED FOLLOW-UP CARE.)

_____ (number of visits)

15. We've just discussed follow-up visits. After you finished that sequence, were you instructed to come back after a certain time period for a check-up? [PROBE TO GET SPECIFIC RESPONSE]

_____ Instructed by fitter to return to fitter

_____ Instructed by fitter to return to prescriber

_____ Instructed by fitter to return to both fitter and prescriber

_____ No instruction by fitter

_____ Instructed by prescriber to return for re-examination

16. How often were you told to come back? [IF TOLD TO GO TO BOTH, NOTE TIME RECOMMENDATION FOR BOTH]

Every _____months (to fitter)

Every _____months (to prescriber)

17. Have you gone back for regular check-ups? [PROBE]

_____ Yes, to fitter

_____ Yes, to prescriber (if other than fitter)

_____ Yes, to both

_____ No, did not have re-examination

_____ No, not time to go yet (recently fitted)

18. Now, I'd like to ask you about how you take care of your lenses. Specifically, what do you do to clean and care for them?

SOFT LENS WEARERS	HARD LENS WEARERS
_____ Heat sterilization/ saline solution	_____ Cleaning solution
_____ Chemical sterilization	_____ Wetting solution
_____ Neither	_____ Soaking solution
	_____ Tap water
	_____ Other (baby shampoo?)
	_____ "Dry" storage

19. Can you tell me the brand names of the products that you use?

_____

[INTERVIEWER: IF NOT EASILY ANSWERED, DO NOT PROBE]

20. Do you wear lenses every day, or nearly every day?

_____ Yes

_____ No

21. In general, about how many hours a day do you wear them?

_____ hours a day

22. Do you usually wear them continuously, or do you remove and reinsert them during the day?

_____ One continuous wearing period

_____ Two wearing periods

_____ Three or more wearing periods

23. How much did you pay for your lenses?

$_____ (Amount)

24. Does that amount include:

a. The eye examination?

_____ Yes

_____ No, extra charge was $_____

b. Follow-up care?

_____ Yes - PROBE: Were you told that you would have to pay extra if follow-up visits exceeded a set number?

_____ Yes

_____ No

_____ Don't remember

_____ No, extra charge was $_____

c. Initial care kit, solutions, equipment, etc.

_____ Yes

_____ No, extra charge was $_____

d. Insurance?

_____ Yes (Skip to #25)

_____ No

Did you buy any insurance?

_____ No

_____ Yes, at a cost of $_____

25. Have you ever tried to wear contact lenses before?

_____ No (Skip to #29)

_____ Yes - PROBE: How many times?

_____ Once

_____ More than once (RECORD INFORMATION FOR EACH ATTEMPT)

26. What happened? Why weren't you satisfied? Any other reasons?

(INTERVIEWER: DO NOT READ RESPONSES. CHECK ALL REASONS MENTIONED BY RESPONDENT.)

	Experience #1	Experience #2
_____	Discomfort	_____
_____	Abrasion/Medical Problems	_____
_____	Like eyeglasses better	_____
_____	Unsatisfied with vision	_____
_____	Spectacle blur	_____
_____	Too much trouble to care for	_____
_____	Didn't replace lost lenses	_____
_____	Didn't trust fitter	_____
_____	Other (Specify) _____	

27. When did this previous fitting occur?

28. Do you recall the name and address of the person who fit your lenses that time?

Experience #1	Experience #2
_____	_____
_____	_____
_____	_____

29. Have you ever lost or scratched a lens (or pair of lenses) and had to buy a replacement?

_____ No (TERMINATE INTERVIEW)

_____ Yes

30. How much did it cost you (per lens)? If you've replaced a lens/lenses more than once, let's just take the most recent replacement.

$_____

31. Did you have any insurance coverage?

_____ No

_____ Yes, policy paid $_____ per lens

32. Where did you buy your replacement lens?

_____ Original fitter (Skip to #35)

_____ Other - NAME : _____

ADDRESS: _____

_____

33. Did [SUPPLIER - NAMED IN QUESTION 32]:

a. examine your eyes?

_____ Yes

_____ No

b. instruct you to have the fit evaluated by someone else?

_____ Yes

_____ No

34. Why didn't you go back to [FITTER] to buy the replacement lens?

_____ Price

_____ Convenience (consumer had changed residence, etc.)

_____ Other (Specify) _____

TERMINATE INTERVIEW

35. When you got your new lens/lenses, were your eyes examined or did you simply pick it up at [FITTER'S OFFICE]?

_____ Fitter examined consumer when new lens was dispensed

_____ No exam

36. Did you try to buy a replacement lens/lenses from someone other than [FITTER]?

_____ No (TERMINATE INTERVIEW)

_____ Yes

37. What happened?

_____ Original fitter would not release contact lens specifications

_____ Other (specify) _____

V. LEGAL ISSUES

A. Legal Basis for the Proposed Rule

1. Introduction

We believe that the evidence discussed earlier in this report -- in particular the results of our studies -- shows that restrictions on commercial ophthalmic practice and duplication of lenses by opticians and the failure of contact lens fitters to release complete contact lens prescriptions may be unfair acts or practices within the meaning of Section 5(a)(1) of the FTC Act. We recommend that the Commission initiate a formal rulemaking proceeding under Section 18 of the FTC Act to determine if these restrictions are unfair acts or practices.

Section 18(a)(1)(B) of the Federal Trade Commission Act[1] contains the Commission's rulemaking authority concerning "unfair acts or practices":

> The Commission may prescribe rules which define with specificity acts or practices which are unfair or deceptive acts or practices in or affecting commerce (within the meaning of such Section 5(a)(1)).[2] Rules under this subparagraph may include requirements prescribed for the purpose of preventing such acts or practices.

A thorough analysis of the meaning of "unfair" was presented

---

1 15 U.S.C. § 57a(a)(1)(B).

2 Section 5(a)(1), 15 U.S.C. 45 (1976), of the FTC Act, provides that unfair acts or practices in or affecting commerce are unlawful.

in the Eyeglasses I Statement of Basis and Purpose.[3] As a result of that analysis, set forth in the footnote below to facilitate reference,[4] the Commission concluded that no single formulation

---

3 Advertising of Ophthalmic Goods and Services, Statement of Basis and Purpose, 16 C.F.R. Part 456, 43 Fed. Reg. 23992 (June 2, 1978) (hereinafter referred to as "Eyeglasses I Statement of Basis and Purpose").

4

> The term "unfair" cannot be narrowly defined. When the Federal Trade Commission was created, Congress made a deliberate policy choice to adopt a general standard, giving the Commission, subject to review by the courts, both the responsibility and the authority to develop more precise articulations of the meaning of "unfair" in the context of specific industries or situations. Nor did the Congress intend that the meaning of the term be static. Economic and social development creates new problems which require new answers, and time and thought bring new insights into the nature of trade regulation problems and the efficacy of possible remedies. The Commission is charged with the responsibility of combining the functions of a court of equity with those of an expert body to develop concepts of "unfair acts or practices" appropriate to the issues of the present time.
>
> Instead of undertaking to define what practices should be deemed unfair, as had been done in earlier legislation, the act left the determination to the Commission. Experience with existing laws had taught that definition, being necessarily rigid, would prove embarrassing and, if rigorously applied, might involve great hardship . . . Furthermore, an enumeration, however comprehensive of existing methods of unfair competition, must necessarily soon prove incomplete, as with new conditions constantly arising novel unfair methods would be devised and developed. [FTC v. Gratz, 253 U.S. 421, 436-37 (1920) (dissenting opinion of Mr. Justice Brandeis), dissent adopted, FTC v. Brown Shoe Co., 384 U.S. 316, 320-21 (1966); cited with approval in FTC v. Sperry & Hutchinson Co., 405 U.S.

(Footnote Continued)

of unfairness is appropriate in all contexts. The unfairness

---

4 (Footnote Continued)

> 233 (1972). See also H.R. Rept. No. 1142, 63rd Cong., 2d Sess. 18-19 (1914); S. Rept. No. 597, 63rd Cong., 2d Sess. 13 (1914).]
>
> * * * * *
>
> In the last analysis, the Commission's responsibility in this area is to enforce a sense of basic fairness in business conduct. For while Section 5 "does not authorize regulation which has no purpose other than . . . censoring the morals of businessmen" [FTC v. R.F. Keppel & Bro., Inc., 291 U.S. 304, 313 (1934)], the Commission cannot shirk the difficult task of defining and preventing those breaches of the principles of fair dealing that cause substantial and unjustifiable public injury. [Statement of Basis and Purpose of Trade Regulation Rule 408, Unfair or Deceptive Advertising and Labeling of Cigarettes in Relation to Health Hazards of Smoking, 29 Fed. Reg. 8324, 54-55 (1964)].
>
> * * * * *
>
> In a complex economy, consumer injury can be caused by intricate chains of interaction among many participants, and the Commission is not prevented from acting simply because it is difficult to pinpoint the blame. Section 5, like other statutes administered by the Commission, is "unfinished law which the administrative body must complete before it is ready for application." [(FTC v. Ruberoid Co., 343 U.S. 470, 485 (1952) (dissenting opinion of Mr. Justice Jackson) (footnote omitted)]. The intent of the Congress was to protect consumers from unwarranted injury in the marketplace. Thus, in carrying out its mandate to "finish" the law, since 1964 the Commission has increasingly concentrated on the examination of whether particular acts or practices are, in fact, causing injury, and on how and why they do so. [(Schwartz, Regulating Unfair Practices Under the FTC

(Footnote Continued)

test used in Eyeglasses I had two components:

> (1) Whether the acts or practices result in substantial injury to consumers. In making this determination both the economic and social benefits and losses flowing from the challenged conduct must be assessed.[5]
>
> (2) Whether the challenged conduct offends public policy.[6]

In the AOA decision, the D.C. Circuit upheld that portion of the Eyeglasses I Rule which requires that ophthalmologists

---

4 (Footnote Continued)

> Act: The Need for a Legal Standard of Fairness, 11 Akron L. Rev. 1 (1977)]. In addition, the Commission examines other public policies as articulated by other responsible bodies in the society that have weighed the acts or practices, to see if they have found some justification or compensatory benefit, and to determine whether the Commission's action does promote public policy as expressed in other contexts. [This inquiry is not always an easy one. There are many possible sources from which a sense of prevailing public policy can be gleaned, and they are not always consistent with each other. The Commission must often balance conflicting policies and come to its own conclusions. And, of course, a practice may offend Section 5 even if it is specifically approved by state law. See FTC v. Sperry & Hutchinson Co., 405 U.S. 233, 239 n. 4 (1972); Spiegel, Inc. v. FTC, 540 F.2d 287 (7th Cir. 1976)].

Eyeglasses I Statement of Basis and Purpose, supra note 3 at 24000.

5 Id. This consumer injury determination has also been called a "balancing of interests" or "marketplace fairness" test which can be used to decide whether prohibiting the practice provides greater social or economic benefit than permitting it to continue. Pfizer, Inc., 81 F.T.C. 23, 60-63 (1972), (complaint dismissed). See FTC v. Sperry v. Hutchinson Co., 405 U.S. 233, 244 (1972).

6 Eyeglasses I Statement of Basis and Purpose, supra note 3 at 24001.

and optometrists provide each of their patients with a copy of his or her prescription at the conclusion of an eye examination.[7] This provision was based on the two-part test of unfairness set forth above. We believe that the court's upholding of that provision can be viewed as support for the appropriateness of this standard for Section 5 unfairness.

Both Eyeglasses I and Eyeglasses II focus on state and private restrictions on ophthalmic practice which may injure consumers by increasing costs and limiting the availability of eye care goods and services without offering countervailing benefits. The justification offered for the restrictions at issue in Eyeglasses II -- they protect the public health and safety by assuring high-quality eye care -- is the same one offered in support of the restrictions which were the subject of the Eyeglasses I investigation. Because of the similarities between the Eyeglasses I and Eyeglasses II investigations, we believe that the same unfairness standard that was used in the first proceeding should be used in this one.

2. Consumer Injury

We believe the evidence presented above shows substantial consumer injury is occurring due to the public and private restrictions at issue. Parts I, II, and IV of our report describe in detail the increased costs that result from each of these restrictions. That evidence also indicates that these

---

7 American Optometric Association v. FTC, CCH 1980-1 Trade Cas. ¶ 62,165 at 77,810 (D.C. Cir. 1980).

restrictions reduce consumption of ophthalmic products and services.

The consumer injury test requires a finding of net injury to consumers. So, the Commission must also determine whether these restrictions have produced any offsetting economic or social benefits.[8] The justification advanced in support of these restrictions is that they are necessary to ensure that consumers receive high-quality eye care. The studies described above provide a statistical measure of the effect of these restrictions on the quality of eye care received by consumers.[9] We believe that those studies prove that the quality of care is not enhanced by the restrictive laws and practices at issue.

(a) Commercial Practice Restrictions

In determining whether commercial practice restrictions result in net consumer injury, we must first measure how these restrictions affect the price of vision care. The results of the Bureau of Economics study, which measured both the price and quality effects of restrictions on commercial practice, show that these restrictions increase the prices consumers pay for vision

---

8 Eyeglasses I Statement of Basis and Purpose, supra note 3, at 24000.

9 The measurement of quality must examine not only the quality of care delivered to consumers, but also whether some consumers are receiving no care at all. If higher quality raises costs, decreasing the frequency of care, then there may not be any quality gain at all when viewed from the perspective of the level of care received by the population as a whole.

care.[10] The study found that average prices for vision care goods and services were significantly lower in cities where commercial ophthalmic practice was not restricted. Specifically, the average price charged for an eye examination plus eyeglasses was $72 in cities where commercial practice was permitted but $94 in cities where commercial practice was restricted.[11] Commercial providers charged significantly lower prices than non-commercial providers (the largest price differential of $32 was between large commercial firms in cities where commercial practice was permitted and non-commercial providers in cities where commercial practice was proscribed), and non-commercial providers who operated in cities where commercial practice was permitted charged on the average $20 less than their counterparts in cities where commercial practice was restricted.[12]

A second component of net consumer injury is the effect of commercial practice restrictions on the frequency with which eye care is purchased. In Part I of this report, we show that the level of consumption of vision care is inversely related to its price.[13] Thus, to the extent that commercial practice

---

10 The Bureau of Economics study's findings on price are corroborated by earlier studies. These studies are discussed in Part I of this Report.

11 Bureau of Economics, Federal Trade Commission, Economic Report -- Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry at p. 5 (April 1980) [hereinafter cited as "BE study"].

12 Id. at 4-5.

13 See pp. 84-86, supra.

restrictions result in higher prices, they prevent some consumers from obtaining care at all (or from obtaining it as frequently as they otherwise would). In addition, we have shown that office location may have an effect on a consumer's decision to purchase vision care.[14] Available information indicates that commercial providers tend to locate in high-traffic, easily accessible areas.

Although commercial practice restrictions cause prices to be higher and make vision care less accessible, net consumer injury will occur only if there is no countervailing justification or consumer benefit that flows from these restrictions. The data from the Bureau of Economics study show that restrictions on commercial practice are correlated with thorough eye examinations when comparing non-commercial and commercial providers, but do not correlate with the accuracy of prescriptions written by the different categories of providers, the quality of eyeglasses produced or the extent of unnecessary prescribing of eyeglasses. When comparing average quality between commercial and non-commercial states there is no difference in quality at all. In measuring the efficacy of commercial practice restrictions in terms of maintaining or elevating the quality of vision care, the BE study results show that quality is the same in both types of markets -- an equal percentage of optometrists in cities where commercial practice is proscribed offer less thorough eye exam-

---

14 Id.

inations as in cities where commercial practice is permitted.

Based on these results, we believe that the overall costs of commercial practice restrictions are not offset by increases in quality. Some commercial firms may offer a less thorough eye examination, but so do some non-commercial optometrists in cities where commercial practice is restricted. And when quality is held constant, a package consisting of an eye examination and eyeglasses costs significantly less in markets where commercial practice is permitted.

(b) Duplication of Lenses

We believe that state restrictions on duplication of lenses without a prescription also cause net consumer injury. If duplication is not permitted, one alternative available to the consumer is to return to the original eyeglass dispenser who probably has a copy of his or her prescription on file. If forced to return to the original provider, the consumer can not shop for a better bargain. (In addition, it may be inconvenient or even impossible for the consumer to return to the original dispenser, as where the consumer has moved to another city.)

The second alternative available to a consumer who wishes to obtain duplicate or replacement eyeglasses in a state where duplication of lenses without a prescription is prohibited is to undergo another eye examination. This will cost, on the average, $25 in addition to the cost of the new eyeglasses.[15]

---

15 See p. 93, supra.

The data we have presented in Part II of this report demonstrate that state restrictions on duplication clearly force some consumers to undergo needless eye examinations.[16]

The results of the duplication study show that there is some quality of care concern associated with the process of duplication.[17] However, the remedy we recommend does not involve the preemption of state-imposed bans on duplication. Rather, we recommend that consumers be guaranteed access to their current eyeglasses prescriptions. The evidence from the duplication and Bureau of Economics studies shows that preparation of duplicate lenses from the original prescription is more accurate than the process of neutralization of existing eyeglasses or undergoing a new eye examination.[18] So our remedy would not only mitigate the existing economic injury but would also increase the quality of care received by consumers who desire to obtain duplicate or replacement eyeglasses which accurately produce the visual correction present in their existing eyeglasses.

(c) Replacement Contact Lenses

Our preliminary analysis of the data from the contact lens study indicates that prices for replacement contact lenses vary widely. Given that the average contact lens wearer loses or damages one lens every year, the ability to engage in comparison

---

16 See p. 102, supra.

17 See pp. 115-123, supra.

18 See pp. 125-131, supra.

shopping for replacement lenses could result in substantial savings for consumers.

If a contact lens fitter refuses to release contact lens specifications to a consumer who needs a replacement lens, the consumer is forced to purchase the lens from the original fitter (without being able to shop around), or to undergo a complete refitting process (the cost of which will include a substantial professional fee as well as the cost of the replacement lens or lenses). Thus, we believe that these privately-imposed restrictions which prevent contact lens wearers from obtaining replacement lenses from the dispenser of their choice cause significant economic injury to consumers.

Our recommendation -- that a consumer be given a copy of his or her complete contact lens prescription -- would enable those contact lens wearers who have been forced to purchase replacement lenses from higher priced providers to obtain replacement lenses of equal quality from lower priced providers without undergoing a new fitting procedure.

There is no evidence that contact lenses dispensed by lower priced providers are of a lower quality than those dispensed by higher priced providers. Nor is there any evidence that higher priced providers offer higher quality care than lower priced providers. Although some practitioners claim that when replacement contact lenses are dispensed the dispenser should first verify that the lens specifications are correct and examine the fit of the lens upon the cornea, preliminary analysis of the contact lens study data indicate that fewer than half of the

contact lens wearer study subjects interviewed had been examined when replacement lenses were dispensed and that substantially equal proportions of ophthalmologists, optometrists, and opticians performed such examinations.

3. Public Policy

The second part of the unfairness test requires a determination that these public and private restrictions offend public policy.[19] The evidence presented earlier indicates that these restrictions may have two negative effects on consumers: (1) they may increase the costs of eye care goods and services, and (2) they may decrease consumer access to these goods and services.

Both of these effects are contrary to clear national policies. The National Health Planning and Resources Development Act of 1974 explicitly presented these policies as a finding of Congress: "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government."[20]

The 1979 Amendments to Titles XV and XVI of the Public Health Service Act call for:

---

19 The fact that these restrictions are established by state law does not shield them from an unfairness analysis that determines whether they may violate other public policies. Spiegel, Inc. v. FTC, 540 F.2d 287 (7th Cir. 1976).

20 42 U.S.C. § 300k(a)(1)(1976).

Some commentators have indicated that there is a national consensus that every American ought to have access to necessary medical care that meets minimal standards of quality. David Mechanic, The Medical Marketplace and its Delivery Failures in Area Studies: Public Interest Law in Action, 350-51 (1978).

> . . . the strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve . . . to advance the purposes of . . . cost effectiveness and access.[21]

This Congressional finding evidences two related public policies. The first focuses on the cost of and the second examines consumers' access to quality health care.

a. Cost Control

Congress and the States have enacted a number of statutes that are directed at controlling the rapidly increasing costs of quality health care.

Some of this legislation has taken a direct regulatory approach, attempting to control supply or limit third-party reimbursement for unnecessary medical services. State certificate-of-need legislation restricts the building and expansion of unnecessary health care facilities by requiring review and certification prior to new investments exceeding a specified dollar threshhold.[22] The National Health Planning and Resources Development Act of 1974 requires states to institute certificate-of-need programs by 1980 to receive federal funds[23] and the Social Security Act Amendments of 1972 denies Medicaid-Medicare reimbursement

---

21 Pub. L. No. 96-79, § 1502, 93 Stat. 592.

22 Office of Policy Planning, Federal Trade Commission, Health Services Policy Session Briefing Book 53 (June 5, 1979) [hereinafter cited as "Health Policy Briefing Book"]. Some of the discussion in this section is adapted from this source, which provides a more complete description of many of these health policy issues.

23 42 U.S.C. § 300k et. seq. (1976).

to health care facilities that have expanded without meeting state certificate-of-need requirements.[24] These Social Security Act Amendments also provide for the creation of Professional Standards Review Organizations which are groups of physicians who review the medical practice of other physicians in their community to decide if the prescribed treatment was medically necessary or if it could have been performed at a lower cost in a different setting.[25]

Other legislation designed to lower the cost of health care does not rely on direct regulation. Instead, it adopts a market-oriented strategy that is designed to encourage the growth of alternative delivery systems.[26]

The appearance of new kinds of health care practitioners should result in increased competition. These alternative providers, such as nurse practitioners, physician assistants, and dental auxiliaries, perform many of the routine tasks in the provision of primary health care.[27] Recognizing that increased

---

24 42 U.S.C. § 1320a-1(1976).

25 42. U.S.C. § 1320c-4.

26 For a fuller discussion of market-oriented approaches, see Health Policy Briefing Book, supra note 22 at 58-68.

27 H.R. Report No. 94-266, 94th Cong., 2d Sess. 22, 59-61, reprinted in 1976 U.S. Code Cong. and Ad. New 4964.

Some studies indicate that these providers may be able to deliver certain services at lower cost than doctors or dentists. See Congressional Budget Office, U.S. Congress, Physician Extenders: Their Current and Future Role in Medical Care Delivery 12-22 (1979); Health Policy Briefing Book, supra note 22 at 65.

competition may lead to lower health care costs, Congress has supported the development of these new health practitioners. The Health Professions Educational Assistance Act of 1976 provides grants to medical and dental schools or other institutions to meet the costs of programs for the training of physician assistants and dental auxiliaries.[28]

A second market strategy aims at reducing costs by shifting the saving incentive from the consumer to the health care provider. In prepaid health plans, such as Health Maintenance Organizations, consumers do not pay on a fee-for-service basis, but rather are provided with comprehensive health care services for a single prepaid fee.[29] By putting the provider at risk, cost containment incentives may be shifted from the consumer to the provider. This may lead to preventative medical visits which can eliminate the need for costly intensive care.[30] As with alternative providers, Congress has supported the growth of these prepaid plans because of their potential for curbing rising costs. The Health Maintenance Organization Act of 1973 supports the growth of HMO's by providing for grants, loans, and loan guarantees for the planning and operation of HMO's[31] and preempts state

---

28 42 U.S.C. § 295g-3 (1976).

29 S. Rep. No. 93-129, 93rd Cong., 1st Sess. (1973), reprinted in 1973 U.S. Code Cong. and Ad. News 3033.

30 Id.

31 42 U.S.C. § 300e2-8 (1974).

laws that restrict the cost-containing HMO delivery format.[32]

b. Access to Health Care

Because of the geographic maldistribution of health manpower and income barriers, many Americans find it difficult to gain access to health care. Recent legislation has evidenced a strong national policy of making health care more accessible.

Medicare and Medicaid were designed to remove income barriers to health services by providing reimbursement for hospital and medical expenses of the aged and the poor.[33] Hospitals that received construction funds under the Hill-Burton program had to promise to provide a reasonable volume of services to those persons unable to pay for them.[34]

Initial efforts to correct geographic maldistribution of health care personnel were aimed at increasing the number of physicians.[35] Despite significant increases in total supply, however, geographic maldistribution persisted.[36] Congress has therefore directed its most recent efforts at shifting the distribution of health care personnel. In establishing and expanding the National Health Service Corps Scholarship program, Congress provided scholarships and funds to medical, dental, nursing

---

32 42 U.S.C. § 300e-10 (1974).

33 42 U.S.C. § 1395 et. seq. (1976).

34 42 U.S.C. § 291(e) (1976).

35 See Health Policy Briefing Book, supra note 22, at 54, n. 19.

36 H.R. Rep. 94-266, supra note 27, at 26-38.

and other health care students and former Corps members who are willing to serve for a designated period of time in a health manpower shortage area.[37]

A provision of the Health Professions Educational Assistance Act of 1976 authorized funds for new Area Health Education Centers to train residents in remote sites, retrain personnel living in remote areas, plan programs to meet an area's health manpower needs, encourage the use of nurse practitioners and physician assistants in these areas and provide education to individuals in these areas on the availability and appropriate use of health services.[38] Federal funding also has helped to establish and promote health care centers in areas where existing facilities or medical personnel are in short supply.[39]

Because "physicians might be attracted to or remain in underserved areas if they were assisted by new health practitioners who would enable physicians to focus on the more difficult medical problems in the community,"[40] Congress has moved to allow allied health personnel to perform more primary care tasks. The Rural

---

37 42 U.S.C. § 294t(b)(4)(1976).

38 42 U.S.C. § 295g-1 (1976).

39 See, e.g., 42 U.S.C.§ 246 (Supp. 1979) (grants for comprehensive health planning and public health services); 42 U.S.C. § 2689 et seq. (Supp. 1979) (grants for community mental health cetners); 42 U.S.C § 254c (1976) (grants to develop community health centers).

40 H.R. Rep. No. 94-266, supra note 27, at 60.

Health Clinic Services Amendments to the Social Security Act[41] broadened Medicare-Medicaid coverage to include services performed by primary care practitioners (nurse practitioners and physician assistants) in rural health clinics. This new program shows that Congress has recognized that alternative providers may be more likely to locate in areas of physician scarcity and can therefore provide care to many who have not received it before.

Our discussion has shown that increasing consumers' access to quality health care is an important national policy. State laws which restrict commercial practice or prevent duplication of lenses by opticians and private refusals to release ophthalmic prescriptions may have the effect of limiting this access. First, by increasing the cost of care, these restrictions help maintain income barriers to vision care. Second, commercial firms and opticians may locate in near or underserved inner-city areas where they can provide highly-visible, low-cost care.[42] Even

---

41 42 U.S.C. § 1395k (1976).

42 Recent HEW regulations designated health manpower shortage areas throughout the United States, 44 Fed. Reg. 46222 (Aug. 6, 1979). In establishing criteria for areas having shortages of vision care manpower (which includes ophthalmologists and optometrists), consideration was given to economic or cultural barriers which would limit a population's access to ophthalmic resources. 42 C.F.R. 5. These criteria encompass medically underserved inner-city areas as well as rural areas.

In order to determine if there is any correlation between areas of vision care manpower shortages and commercial practice restrictions, we compared restrictions (based on the information in our files) with shortage areas on

(Footnote Continued)

if no indication of relocation is found, we believe that removal of commercial practice restrictions may increase consumer access to vision care. Without commercial practice restraints, many providers choose to locate in high-volume mercantile locations. These areas may be more centrally located and more accessible to public transportation. These factors are especially important for the elderly who often suffer from decreased mobility.[43]

c. The Free Market

There is also a more general public policy on which we can rely. The public policy of this country favors the existence of free markets to the maximum extent possible.[44] The

---

42 (Footnote Continued)

a state by state basis. Our analysis showed that there is some support for the proposition that these restrictions may limit consumer's access to vision care. The data from twenty-six states and the District of Columbia supported the hypothesis by showing that states with restrictions had at least some areas of manpower shortage, and those without restrictions had none. On the other hand, the information from 17 states did not support the proposition and the data from seven states is inconclusive.

Although no firm conclusion may be drawn from this data, we believe that it presents some reason to believe that commercial practice restraints do limit access to care. We plan to explore this issue in much greater detail.

43 See Testimony of Donald Reilley, Deputy Commissioner on Aging, Administration on Aging, Department of HEW, Tr. 111 at 115; Testimony of Edith Barksdale-Sloan, Director, D.C. Office of Consumer Affairs, Tr. 609 at 615.

44 See, e.g., Sherman Act, 15 U.S.C. § 1; Clayton Act, 15 U.S.C. § 12; Federal Trade Commission Act, 15 U.S.C. § 41 et. seq.; BNA's Antitrust and Trade Regulation Report, Nos. 895-920 (Jan.-June 1979), Report to the President and the Attorney General of the National Commission for the Review of Antitrust-Laws and Procedures at 50-51 (Jan. 22, 1979) (exceptions to the free market should be justified by compelling reasons).
(Footnote Continued)

restrictions that are the subject of this investigation must be examined in light of this fundamental policy.

There are several factors that are essential for the proper functioning of the free market. A large number of buyers and sellers, availability of information, a lack of excessive transaction costs, a lack of costs or benefits external to the decision process, and mobility of resources all are required for a market to operate efficiently.[45] Both the scope of practice and commercial practice restrictions and private failures to release prescriptions may interfere with the existence of an efficient market.

Scope of practice restrictions limit entry into certain segments of the ophthalmic market. The number of providers of services that consumers may select are therefore limited and the large number of sellers necessary for an efficient allocation of resources may not be generated by market forces.

---

44 (Footnote Continued)

As the Commission said in the Eyeglasses I Statement of Basis and Purpose,

> . . . as a general proposition a market-perfecting solution to a perceived problem is preferable. There should be a heavy burden of proof on those who would opt for a different form of economic organization.

Eyeglasses I Statement of Basis and Purpose, supra note 3, at 24001.

45 See, e.g., Paul Samuelson, Economics 36-76, 371-616 (6th ed. 1964).

Failures to release prescriptions also limit the available number of providers. These limits on supply inhibit the normal downward pressure on prices that truly competitive market conditions exert.

Commercial practice restrictions impose barriers to an ophthalmic provider's decision to expand. Unable to increase the size of the firm to take advantage of various economies of scale, the firm may not be able to produce at its most efficient level. These restrictions also limit the number of provider outlets and reduce the availability of services. Consumers may spend more time searching out and obtaining ophthalmic services, increasing their transaction costs.

4. Conclusion

While the proposed rule is supported by all of these public policies, there are no direct precedents or closely analogous case law or statutes on which to base the rule. In the past, consumer protection activities were basically limited to stopping unethical marketing practices and policing deceptive advertising. Identifying cases or statutes to support such activities was relatively simple since the conduct had long been condemned as unfair or immoral. Although these traditional consumer protection activities are still important, it has become apparent that many major consumer problems will not be solved unless the Commission moves beyond these areas.

The Commission is not precluded from acting merely because the acts and practices have not previously been considered unlawful or because there is no specific precedent for the proposed action.

As Judge Hand stated:

> Its [the Commission's] powers are not confined to such practices as would be unlawful before it acted; they are more than procedural; its duty in part at any rate, is to discover and make explicit those unexpressed standards of fair dealing which the conscience of the community may progressively develop.[46]

We believe that the general public policies we have discussed, together with the evidence providing strong indications that consumers suffer serious injury as a result of the restrictions at issue, support a finding that these restrictions may be unfair acts or practices. We therefore recommend that the Commission initiate a formal Magnuson-Moss rulemaking proceeding to examine these ophthalmic practice restrictions.

B. Remedial Considerations

1. Introduction

Although we recommend that the Commission initiate a Magnuson-Moss rulemaking proceeding to consider the issues raised in the Eyeglasses II investigation, we admit that questions concerning the ultimate likelihood of a trade regulation rule affecting scope of practice in this matter remain. One issue that must be examined is the extent to which a Commission trade regulation rule can preempt state law.

The remedial problems we must face in this proceeding are not limited to preemption. The state and private restrictions

---

46 FTC v. Standard Education Society, 86 F.2d 692, 696 (2d Cir. 1936), rev'd on other grounds, 302 U.S. 112 (1937). See Sperry and Hutchinson, supra note 5, at 244-45.

under investigation are defended as necessary to protect the public health and safety by maintaining or elevating the quality of care delivered by the three professions. Our initial examination of that justification indicates that, in some instances, there may be tradeoffs between price and quality and that some of these restrictions may provide some measure of protection for the public.[47] (However, in the areas in which we are recommending preemption in this proceeding, the price-quality tradeoff is not an issue.)

Because of the rising cost of health care and the fact that some people cannot afford to obtain care at all, we must ask whether there are less restrictive forms of regulation which will accomplish the state's objectives without unnecessarily stifling the growth of alternative forms of delivery and the use of alternative providers.

2. Preemption

Under the Supremacy Clause,[48] Congress is able to "preempt" or declare unenforceable any state law, as long as the federal action is within the boundaries of federal constitutional authority.

---

47 See Parts I, II, and IV, supra.

48 U.S. Constitution, Art. VI, cl. 2: "This Constitution and the laws of the United States which shall be made in pursuance thereof, . . . , shall be the supreme law of the land. . . , anything in the Constitution or laws of any state to the contrary notwithstanding."

For a full discussion of the preemption issue, see Office of Policy Planning, Federal Trade Commission, Report of the State Regulation Task Force (March 14, 1978) [hereinafter cited as "Preemption Task Force Report"].

Federal laws may preempt state regulations in two ways. First, the federal law may explicitly preempt an entire area covered by state law,[49] in which case the federal rules are viewed as having "occupied the field."[50] Second, a federal law may preempt state regulations only to the extent that the federal statute requires or authorizes conduct which is inconsistent with state law.[51] This form of preemption is referred to as "conflict" or "inconsistency" preemption.

Although Congress may explicitly grant preemptive authority, courts also may infer the preemptive grant. A statute's legislative history, the nature of the subject matter, or a finding that the enforcement of the state law would hinder or conflict with Congressional policy have all been used to infer preemptive authority.[52] However, an intent to preempt will not be inferred lightly.[53]

The Supreme Court held in Parker v. Brown that state laws which rise to the level of "state action" are immune from antitrust

---

49 See, e.g., Jones v. Rath Packing Co., 430 U.S. 519, 526-33 (1977).

50 See, e.g., National Labor Relations Act, 29 U.S.C § 151 et seq.; NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1 (1937).

51 See, e.g., Castle v. Hayes Freight Lines, Inc., 348 U.S. 61 (1954); Preemption Task Force Report, supra note 48, at 2.

52 Preemption Task Force Report, supra note 48, at 2.

53 Id.

scrutiny under the Sherman Act.[54] As we noted in the introduction to this Staff Report, the question of whether a Magnuson-Moss trade regulation rule preempts inconsistent state laws, particularly those which rise to the level of "state action" under the Parker doctrine has not yet been conclusively decided. It is our belief that section 18 rules do preempt inconsistent state activity.

The legislative history of the Magnuson-Moss amendments, particularly the legislative history surrounding the expansion of FTC jurisdiction to matters "in or affecting" interstate commerce makes clear Congress' intent that the expansion of Commission jurisdiction in section 201 would not by itself operate to remove states from the field of consumer protection altogether.[55] Translated into preemption terms, Congress did not intend for the Commission to occupy the entire field of consumer protection. The legislative history of the Magnuson-Moss Act, however, clearly sanctions "conflict" preemption authority.[56]

---

54 317 U.S. 341 (1943). For a full discussion of the Parker Doctrine and its applicability to the FTC Act see Preemption Task Force Report, supra note 48, at 4-74.

55 See S. Rep. No. 92-269, 92nd Cong., 1st Ses. 23 (1971) in which the Senate Commerce Committee reported that it was "[n]ot the Committee's intent in expanding the jurisdiction of the Commission" to make the FTC the sole consumer protection agency, and that "State and local consumer protection efforts are not to be supplanted by this expansion of jurisdiction." However, the Committee was equally clear that to the extent that there was an actual conflict between specific implementation of our Section 18 authority (through Section 201) and state activities, conflict preemption would be the inevitable result. Id. at 62.

56 Id. See full discussion in Preemption Task Force Report, supra note 48, at 52-64.

We realize that the distinction between "conflict" preemption and "occupation of the field" preemption is often difficult to define. In Eyeglasses I, the Commission preempted bans on advertising of eyeglasses and eye examinations. Is the "field" for preemption purposes the field of regulation of vision care (in which case it is clear that the Commission has not occupied the field) or the regulation of the advertising of vision care (in which case there was a borderline occupation of the field)? If the Commission chooses to adopt a rule which preempts state laws and regulations affecting the form of practice in which optometrists, ophthalmologists and opticians may engage and redefining to some degree what functions each may perform, it may have crossed the line from "conflict" preemption to "occupation of the field" preemption. Ultimately this decision hinges on the narrowness or breadth of the "field" by which preemption is measured. If it is held that such a rule occupies the field, then a reviewing court may decide that the Commission does not have the preemptive authority to promulgate such a rule. This issue is one that the Commission must examine closely in this proceeding.

The recent decisions of the Second Circuit in Katharine Gibbs v. FTC,[57] and the D.C. Circuit in American Optometric Association v. FTC,[58] have not resolved these and other critical preemption

---

57 612 F.2d 658 (2d Cir. 1979).

58 CCH 1980-1 Trade Cas. ¶ 63,165 (D.C. Cir. 1980).

questions which must be faced in this proceeding.

In Gibbs the Second Circuit struck section 438.9 of the Vocational School Rule, which made explicit the Commission's intent to preempt inconsistent state laws. In doing so the court held that FTC rules were preemptive -- but held that section 438.9 of the rule (coupled with the the Commission's failure to define sufficiently the acts or practices violative of Section 5 in the rule) went beyond "conflict" preemption and was thus invalid.[59]

In the AOA decision, the D.C. Circuit left unresolved questions such as: (1) are the states "persons" within the meaning of the FTC Act and as such subject to FTC jurisdiction? (2) does the "state action" doctrine of Parker v. Brown apply to the FTC Act? and (3) does the scope of the Commission's delegated power permit it to preempt state laws to the extent of preempting the whole field of ophthalmic advertising?[60] The scope of the Commission's preemption authority thus remains open to question. We remain committed to the position that the Commision does have preemptive authority, that Parker does not apply to the FTC Act, and that the Eyeglasses I Rule did not constitute an occupation of the field.

Assuming for the purposes of this discussion that the promulgation of a rule altering state form and scope of prac-

---

59 Katharine Gibbs v. FTC, 612 F.2d 658, 666-67 (2d Cir. 1979).

60 American Optometric Association v. FTC, CCH 1980-1 Trade Cas. ¶ 63,165 at 77,806 (D.C. Cir. 1980).

tice limitations would not exceed the Commission's authority, there remain considerable remedial obstacles in Eyeglasses II. We will discuss the remedial issues associated with restrictions on the fitting of contact lenses by opticians and restrictions on employment of optometrists by non-professional corporations.

3. The Fitting of Contact Lenses by Opticians

The remedial issues confronting the Commission in its examination of state restrictions on the ability of opticians to fit contact lenses typify those raised by its entry into the "scope of practice" area.

A hypothetical example is the best method of explaining the remedial dilemma which caused us not to recommend that the Commission propose a rule preempting such restrictions. Suppose that at the conclusion of the Eyeglasses II proceeding the evidence shows that some, but not all opticians, are qualified to fit contact lenses. Assume further that the evidence suggests that patients fitted by opticians pay substantially less than consumers who are fitted by ophthalmologists or optometrists, but receive a slightly lower average quality of care. Given this set of assumptions, the following remedial questions arise.

If the evidence shows that opticians who have passed a currently-administered examination of clinical competency are qualified to fit contact lenses, but those who have not passed this test are not, can the Commission condition entry into this field on passage of this examination? How can the Commission ensure that as time and technology advance, this test will continue to be an adequate measure of competency? Moreover, would

the Commission want to take on the task of setting qualifications for entry into any professional field, monitoring performance of that group of entrants over time and revising entry standards when necessary? We assume the answer is unequivocally no.

Alternatively, can the Commission simply override existing state restrictions and require that the states adopt more narrowly tailored requirements for licensure? In a line of cases involving the Environmental Protection Agency, a number of courts have struck down EPA rules which required the states either to adopt air quality standards of their own which met minimum federal standards, or to face the possibility of having to accept and enforce EPA-imposed standards.[61]

In one of these cases, the Court of Appeals for the District

---

61 See, e.g., District of Columbia v. Train, 521 F. 2d 971 (D.C. Cir. 1975), vacated on other grounds, 431 U.S. 99 (1977). In their decision, the D.C. Circuit stated:

> [W]e draw the line and hold that the Administrator, in the exercise of federal power based solely on the commerce clause, cannot against a state's wishes compel it to become involved in administering the details of the regulatory scheme promulgated by the [EPA].
>
> In essence, the Administrator is here attempting to commandeer the regulatory powers of the states, along with their personnel and resources, for use in administering and enforcing a federal regulatory program. . . . We are aware of no decisions of the Supreme Court which hold that the federal government may validly exercise its commerce power by directing unconsenting states to regulate activities affecting interstate commerce, and we doubt that any exist. Id. at 992.

of Columbia held that EPA's regulations represented an unallowable federal intrusion into state sovereignty.

> [T]he Tenth Amendment may prevent Congress from selecting methods of regulating which are "drastic" invasions of state sovereignty where less intrusive approaches are available. . . . [T]he mere fact that direct federal regulation. . . would be less "efficient" would not appear sufficient to override the serious intrusion on state sovereignty involved in forcing the states to supplant federal officials in policing the details of federal regulations."[62]

The court noted that, if Congress had intended to adopt this novel scheme of empowering a federal agency to order unconsenting states to enact statutes and regulations, it would have made its intent clear.[63] So, in considering a preemptive remedy which hands the whole matter back to the states and orders them to adopt "better" requirements, the Commission must take into account the limitations on federal power expressed in these cases.

And in National League of Cities, v. Usery,[64] the Supreme Court struck down provisions of the Fair Labor Standards Act which attempted to set minimum wage standards for state employees. The Court held that there was a limitation on the commerce clause authority of the federal government where that exercise of authority would "directly displace the State's freedom to structure integral operations in areas of traditional governmental functions . . ."[65]

---

62 Id. at 994.

63 Id. at 984.

64 426 U.S. 833 (1976).

65 Id. at 852.

The courts have not been willing to expand National League of Cities to cover areas which have traditionally been regulated by the states, but have limited its applicability to those situations in which federal action would impair the functioning and existence of the state as a state.[66] It is clear that preemption of form or scope of practice regulations would not impair the functioning of the state as a separate entity.

4. Corporate Employment of Optometrists

Some of the remedial concerns raised above apply with equal force to the form of practice issues under consideration in Eyeglasses II. Questions concerning the implications of National

---

66 See, e.g., Amersbach v. City of Cleveland, 598 F. 2d 1033 (6th Cir. 1979) in which the Sixth Circuit spelled out criteria for determining whether state activity was protected from federal intervention under the National League of Cities doctrine. The court stated:

> By analyzing the services and activities which the Court [in National League of Cities] characterized as typical of those performed by governments, we note certain elements common to each which serve to clarify and define a method by which a protected government function may be identified. Among these elements are (1) the government service or activity benefits the community as a whole and is available to the public at little or no expense; (2) the service or activity is undertaken for the purpose of public service rather than for pecuniary gain; (3) government is the principal provider of the service or activity; and (4) government is particularly suited to provide the service or perform the activity because of a communitywide need for the service or activity. Id. at 1037.

Under this analysis, state control of professional conduct would not be protected under National League of Cities.

League of Cities and other cases involving federalism stated above are essentially the same.

But some of the issues are different. Again, a hypothetical example may be the best way to explain the remedial concerns at issue here. Assume that the Commission were to find that corporate employment resulted in lower consumer prices, greater consumption of vision care (attributable to the lower cost of care provided by commercial providers), and little or no diminishment in the quality of care delivered. The data also might show that in some situations lay employers had interfered in the judgment of the licensed professionals so that the patients' welfare had been compromised. Should the states then retain the ability to enforce narrowly drawn requirements for the purpose of preventing interference in the doctor/patient relationship by the commercial corporation? If so, what is to prevent the state from imposing overly broad restrictions which not only prevent corporate interference but also effectively make all corporate practice impossible?

If the Commission prevents the states from acting, then the Commission must not only police the states to ensure compliance with the rule but also regulate the market to provide protection for consumers. But, if states are given the freedom to act, the Commission's attempt to permit commercial practice may be circumvented by state action.

In Section 456.5 of the Eyeglasses I Rule, the Commission limited the ability of states to impose affirmative disclosure requirements on ophthalmic advertising because such disclosures

could have indirectly accomplished what the rule directly proscribed. Yet in the AOA decision, the D.C. Circuit at least intimated that it might not be willing to uphold a preemption of state laws that was founded in a prediction or speculation that the states might respond in bad faith to the Commission's rule.[67] Therefore, it can be argued that the Commission is precluded from "fencing-in" a state or local governmental entity (unlike situations involving private litigants where the Commission's authority is firmly established). In Eyeglasses II, the Commission must closely examine the threat to the rule and the alternative methods available to protect consumers.

5. Is the Supreme Court's Decision in Friedman v. Rogers a Bar to Commission Preemption of Trade Name Bans?

a. Introduction

In Friedman v. Rogers,[68] the Supreme Court held that a Texas statute which prohibited optometrists from practicing under a trade name did not violate the First Amendment.[69] The

---

67 American Optometric Association v. FTC, CCH 1980-1 Trade Cas. ¶ 63,165 at 77,808 (D.C. Cir. Feb 6, 1980).

68 440 U.S. 1 (1979).

69 The original suit was brought in federal district court by Dr. Rogers, a "commercial optometrist" who was also a member of the Texas Board of Optometry. He challenged the constitutionality of several provisions of the Texas Optometry Act, one of which was the trade name ban. Specifically, he alleged that the ban denied him equal protection because it did not extend to ophthalmologists and was also a violation of the First Amendment right of commercial free speech. The district court found that the state's justification for the trade name ban was outweighed by the importance of commercial speech. Rogers v. Friedman, 438 F. Supp. 428 (E.D. Texas 1977).

Court's decision, and the analysis which led it to that decision, draw into question the legal authority of the Commission to preempt state trade name bans if those bans are found to be unfair to consumers.

In Friedman, the Court concluded that the state of Texas could find that a trade name ban was necessary to protect consumers from deception and, as such, the Texas trade name ban did not infringe on the First Amendment.[70] The trade name ban, Justice Powell wrote,

> ensures that information regarding optometrical services will be communicated more fully and accurately to consumers than it had been in the past when optometrists were allowed to convey the information through unstated and ambiguous associations with a trade name.[71]

Given the Court's holding that trade name bans serve a legitimate state interest, the question is whether the Commission can find such laws to be unfair.

As we discussed above, the legal basis for the proposed Eyeglasses II Rule is a two-part unfairness test which balances the costs and benefits to consumers which flow from particular state regulations, and determines whether those regulations are contrary to public policy. The Supreme Court's decision is relevant to the Commission's unfairness analysis, not only because it suggests that there are significant benefits to con-

---

70 440 U.S. 1, 15 (1979). A discussion of the deception issue in Friedman is found on pp. 39-43, supra.

71 Id. at 16.

sumers from trade name bans, but also because the Commission naturally looks to Supreme Court decisions as an expression of public policy.

Nonetheless, we feel that the Friedman decision does not bar the Commission from determining that state laws banning the use of optometric trade names are unfair. Friedman was a First Amendment case; the evidence available to the Court and the balancing test used in First Amendment cases are significantly different from the evidence and balancing of interests used by the Commission in evaluating unfairness. These differences permit the Commission to reach a different conclusion than the Supreme Court reached in Friedman concerning the need for trade name bans to prevent consumer deception.

The case of Spiegel, Inc. v. FTC,[72] has often been cited in support of the proposition that conduct which is constitutionally permissible may nonetheless be unfair and therefore violate Section 5 of the FTC Act. As we discuss below, we do not believe that Spiegel by itself is dispositive of the issues raised by the Friedman decision. The Spiegel case does lend support to our conclusion that the Commission may determine that trade name bans are unfair.

b. The First Amendment Analysis in Friedman[73]

---

72 540 F.2d 287 (7th Cir. 1976).

73 Commentators who have analyzed the Court's opinion have also criticized its holding. See Birenbaum and Kamarck, Freedom of Commercial Speech Threatened by Friedman Decision, The National Law Journal at 20 (Apr. 23, 1979).

The majority opinion in Friedman began by stressing that the commercial speech at issue was significantly different[74] from that considered in Virginia State Board of Pharmacy v. Virginia Citizens Consumers Council[75] and Bates v. State Bar of Arizona.[76] Distinguishing the price information involved in those cases, the Court held that trade names are a form of commercial speech with "no intrinsic meaning."[77] A trade name, the Court concluded, does not convey information about the price and quality of services, but rather forms the basis for "ill-defined associations" in the minds of consumers.[78]

The Court clearly saw little threat to First Amendment interests from trade name bans. Justice Powell characterized

---

74 Although the majority indicated that the speech was different in Friedman, the opinion failed to articulate the standard of deference due the commercial speech involved. As the dissenting opinion noted:

> Without engaging in any rigid categorization of the degree of scrutiny required, the Court has distinguished between permissible and impermissible forms of state regulation. Friedman v. Rogers, 440 U.S. 1, 20-21 (1979) (Blackman, J. dissenting).

75 425 U.S. 748 (1976).

76 438 U.S. 850 (1977).

77 Friedman v. Rogers 440 U.S. 1, 12 (1979). The Court stated that in Bates and Virginia Pharmacy, the State had proscribed advertising by lawyers and pharmacists that contained statements about the prices of the products or services offered. Such statements were "self-contained" and "self-explanatory" as opposed to the form of commercial speech found in Friedman. Id.

78 Id.

the regulation as having "only the most incidental effect" on content and as merely preventing a deceptive manner or presentation.[79] The Court rejected the argument that the solution to the problem is to require disclosure of ownership when a trade name is used, although Justice Blackmun stated in his dissenting opinion that

> [C]orrected falsehood, however, is truth, and, absent some other regulatory justification, a state may not prohibit the dissemination of truthful commercial information. By disclosing his individual name along with his trade name, the commercial optometrist acts in the spirit of our First Amendment jurisprudence, where traditionally "the remedy to be applied is more speech, not enforced silence." [citation omitted][80]

But the majority disagreed with Blackmun's assertion that trade names convey information and therefore saw no reason to use a "least restrictive alternative" approach to permit the use of trade names accompanied by affirmative disclosures.

In analyzing the Court's opinion of the First Amendment interest in trade names, it is important to note Justice Powell's statements regarding the use of the First Amendment claims to challenge economic regulation by the states. In a lengthy footnote, Justice Powell emphasized that the states do not lose their power to regulate commercial activity simply because speech is a component of the activity, stating that "we act with caution in confronting First Amendment challenges to eco-

---

79 Id.

80 Id. at 25.

nomic legislation that serves legitimate regulatory interests."[81]

Since the Court accorded little weight to the First Amendment interest in using optometric trade names, it did not closely scrutinize the state's rationale for restricting trade names. It accepted the argument that trade names are easily manipulated and offer significant possibilities for deception.[82]

---

81 Id. at 11, n. 9.

82 The adequacy of the evidentiary base on which the Court made its findings of deception has been questioned. See Birenbaum and Kamarck, supra note 73 at 20-21. This commentary on Friedman states that the Court "relied heavily on findings of deceptive practices made by the Texas Supreme Court in a case decided two years before enactment [of the trade name ban]." Id.

The major evidence of deception which the Court had before it in Friedman was a deposition of Robert Shannon, O.D., an owner of an optometric chain in Texas prior to the adoption of the trade name ban. Dr. Shannon stated that, in most cases, a patient visiting a trade name practice did not in advance know the name of the optometrist who would be performing the examination and that the patient was not usually introduced to the optometrist at the time of the exam. As a result, the opponents of trade names asserted that personal responsibility deteriorated under trade name practice and the optometrist employed in such a practice tended to become less concerned with the welfare of his or her patients. See Jurisdictional Statement of Appellant, Texas Optometric Association, Inc. at Appendix B, pp. 13-17, Friedman v. Rogers, 440 U.S. 1 (1979). A second piece of evidence was taken from a 1967 Texas Supreme Court decision, Texas State Bd. of Examiners in Optometry v. Carp, 412 S.W. 2d 307, appeal dismissed and cert. denied, 389 U.S. 52 (1967). In that case, the defendant Carp was found to have operated 71 optometric offices in Texas under at least 10 different trade names. Friedman v. Rogers, 440 U.S. at 14. A deposition was introduced as evidence of false and misleading uses of optometric trade names in Carp. The deponent was a former associate of Carp who described trade name abuses that had occurred in their business. Id. at 15, n. 13.

From the above evidence, the Court concluded there was evi-

(Footnote Continued)

Justice Powell, writing for the majority, used very strong language to emphasize what he perceived to be the possibility of deception, and more generally the evils associated with commercialization of optometry.

> The possibilities of deception are numerous. The trade name of an optometrical practice can remain unchanged despite changes in the staff of optometrists upon whose skill and care the public depends when it patronizes the practice. Thus, the public may be attracted by the trade name that reflects the reputation of an optometrist no longer associated with the practice. A trade name frees an optometrist from dependence on his personal reputation to attract clients, and even allows him to assume a new trade name if negligence or misconduct casts a shadow over the old one. By using different trade names at shops under his common ownership, an optometrist can give the public the false impression of competition among the shops. The use of a trade name also facilitates the advertising essential to large-scale commercial practices with numerous branch offices, conduct the State rationally may wish to discourage while not prohibiting commercial optometrical practice altogether. The concerns of the Texas Legislature about the deceptive and misleading uses of optometrical trade names were not speculative or hypothetical but were based on experience in Texas with which the legislature was familiar when [it adopted the trade name ban.][83] [emphasis added]

---

82 (Footnote Continued)

dence of substantial harm to consumers from the use of optometric trade names. And in cases since Friedman, courts have referred to the "substantial and well-demonstrated harm" from the use of trade names in Texas. See, e.g., In re Oldtowne Legal Clinic, 47 U.S.L.W. 2762 (Md. Ct. App., June 5, 1979).

83 440 U.S. at 13.

Thus, the Court found little reason to extend First Amendment protection to trade names. The State of Texas was able to identify several possibilities for deceptive use of trade names and some cases in which deception had occurred. This was sufficient, in the majority's view, to override the insubstantial First Amendment claim.

The dissent in Friedman recognized that the Texas trade name ban was being used to discourage otherwise legal conduct. The dissenters argued that "the fact that in Texas the practice of commercial optometry is legal was . . . of profound importance" in measuring First Amendment rights and concluded that the Texas statute "by absolutely prohibiting, without reasonable justification, the dissemination of truthful information about wholly legal commercial conduct" violated the First Amendment.[84]

The Court's opinion failed to address the cost and quality considerations raised by the commercial practice of optometry.[85] These issues, however, are essential for the Commission's examination of unfairness under Section 5 of the FTC Act.

c. Unfairness Analysis under Section 5 of the FTC Act.

It is our recommendation that the Commission include trade name bans within the category of commercial restrictions to

---

84 Id. at 20.

85 To date, most of the evidence concerning the alleged "evils" of commercial practice is anecdotal. The Commission has attempted to gather empirical evidence on cost and quality in the Bureau of Economics study on commercial optometry. See Part I and Appendix A of this report.

be explored in Eyeglasses II.[86] Notwithstanding the Friedman decision, we believe it is appropriate for the Commission to proceed in this area.

We do not believe that Friedman is a bar to Commission action because analysis of trade names using an unfairness theory is significantly different from a First Amendment analysis. First, the Section 5 test factors into its equation issues other than deception. For example, in Part I of this report, we detail the significant economic losses and decreased utilization of vision care services which accompany restrictions on commercial practice. At the same time, we discuss both the quality implications of commercial practice in "micro" terms (i.e., delivered quality) and "macro" terms (i.e., aggregate demand or frequency of care.) These are factors not considered by the Court in Friedman, but factors which are critical to the Section 5 balancing test.

---

86 We have consistently taken the position that the issue of trade name bans was not settled by the Eyeglasses I Rule. At the time the Eyeglasses Rule was proposed, staff gave serious consideration to the question of whether trade name bans would be preempted by the rule. Staff concluded that although trade names might convey certain useful information to the public, trade name bans were aimed more at regulating the conduct of optometrists. They were not, in staff's opinion, directed to the issue of whether an optometrist could advertise.

The intent of the rule was to eliminate burdens on the dissemination of information and not to alter state regulations regarding permissible forms of business practice. Staff concluded that since trade name bans do not refer to whether one can advertise but rather to the form in which one can do business, they were not preempted by the rule.

Second, the Commission must necessarily take a more intensive look at the evidence relating to deception than was possible in Friedman. The Court's opinion in Friedman is predicated on the finding that trade names foster deception. The Court itself noted that no evidence was before it concerning the possibility that the abuses identified in the record were attributable to some cause other than the use of the trade names.

> The plaintiffs argue that the fact that the public might be subject to similar deception by optometrists who do not use trade names but practice in partnerships or with numerous employees shows that the State actually was not concerned with misleading and deceptive practices when it enacted [the trade name ban.] The plaintiffs have not attempted to show, however, that any of the demonstrated abuses associated with the use of trade names also have occurred apart from their use.[87]

If the evidence produced during the course of a Commission rulemaking proceeding demonstrated that the abuses, if any, which accompany the use of trade names also accompany traditional partnership or professional corporation practice, the causal connection between trade names and deception would be drawn into question. The Commission would not be "second-guessing" the Court, but rather would be reaching a different conclusion than the Court on the basis of a different and much more complete evidentiary record.

The choice facing the Commission unlike that which faced the Court, is not one of leaving trade name bans intact or

---

87 Friedman v. Rogers, 440 U.S. 1, n. 14.

preempting the states from this area entirely. Rather, the Commission's obligation is to determine whether consumers should be able to obtain the benefits of commercial practice (if the preliminary evidence ultimately bears up under scrutiny), and at the same time preserve the states' ability to ensure "professional responsibility and identification."[88] The Commission can, we believe, make a determination as to whether professional identification can be achieved without sacrificing the benefits of commercial practice. Indeed, this is the course which the dissent endorsed.[89]

One final consideration concerns the portion of the test of unfairness which requires the Commission to ascertain public policy supporting its action. As we noted earlier, the discernment of public policy is at best a difficult task. The Supreme Court's decision in Friedman that the possibility of deception accompanying the use of trade names is sufficient to offset the First Amendment rights of commercial optometrists, particularly since it is so recent, poses a significant obstacle

---

88 The purpose of the trade name ban, as stated by the Texas Legislature, was as follows:

> The provisions of this section are adopted in order to protect the public in the practice of optometry, better able members of the public to fix professional responsibility, and further safeguard the doctor-patient relationship.

Id. at 14, n. 12.

89 Id. at 24-26.

to any determination that public policy supports elimination of trade name bans. We do have serious reservations about our ability to satisfy the elusive "public policy" standard of Section 5 with respect to trade name practice in the face of a contrary Supreme Court decision.

Our response to this difficulty is twofold. First, the availability of primary quality health care at an affordable cost, a factor not considered by the Court, is so fundamental a concern that we remain confident that this is a proper area for Commission inquiry. Second, the policy articulation of the Court in Friedman need not run contrary to the Commission's action. The Commission can eliminate total bans on the use of trade names, while at the same time permitting the states to impose less intrusive regulations to protect against the deceptive use of trade names. Such action would further national health care policies while accommodating the Court's concerns.

d. The Significance of Spiegel

In Spiegel, Inc. v. FTC[90] the court held that the Commission has the authority to prohibit conduct that, although constitutionally permissible, is unfair to the public. Unlike Friedman, however, Spiegel does not contain a judicial analysis of the constitutional issue. In Spiegel, the court assumed that the conduct in question - Spiegel's use of the Illinois' long-arm statute to sue delinquent catalog customers residing in distant

---

90 540 F.2d 287 (7th Cir. 1976).

jurisdictions - did not violate constitutional standards of due process.[91] In fact, the court observed that it could not make a general determination regarding the constitutionality of Spiegel's conduct because the evidence of sufficient contacts with a forum required to satisfy due process depends on the particular facts of each case.[92]

Assuming arguendo that no due process rights were infringed by Spiegel's conduct, the court nevertheless upheld the Commission's cease and desist order on the ground that, according to the Supreme Court's decision in FTC v. Sperry & Hutchinson Co.,[93] a practice may be banned under Section 5 although it is otherwise legally proper.[94] After assuming away the constitutional question, the court had no difficulty agreeing with the Commisson's conclusion that Spiegel's conduct was "patently offensive to clearly articulated public policies, intended to guarantee all citizens a meaningful opportunity to defend themselves in Court."[95] It is precisely because in Spiegel there was no explicit finding on the constitutional issue that the case does not resolve the questions raised concerning the impact of Friedman v. Rogers on Eyeglasses II.

---

91 Id. at 291.

92 Id.

93 405 U.S. 233 (1972).

94 540 F.2d at 292.

95 Id. at 293.

Nevertheless, we do believe that Spiegel has significant implications for Commission action on trade names. By virtue of its assumption that Spiegel's use of the long-arm statute comported with due process, the court was in effect finding that Spiegel's conduct did not, in the words of the prevailing legal standard, "offend traditional notions of fair play and substantial justice."[96] Yet, the court was still able to sustain a Commission finding of unfairness under Section 5. This is essentially what the Commission may do in Eyeglasses II: it may accept the Supreme Court's finding that trade name bans serve a legitimate state interest, and then apply the standard of unfairness embodied in Section 5.

Should the Commission follow our recommendation, we may be criticized for disregarding a clear directive of the Supreme Court. Both the fact that the Court employed a balancing test (and after doing so upheld bans on the use of trade names) and implicitly made a determination of public policy vis-a-vis the reach of the First Amendment make the Commission's choice a difficult one. However, we remain firm in our belief that the Commission may act to ensure ready access to affordable quality health care in this area.

6. Conclusion

The issues we have raised above ought to be explored critically in the Eyeglases II rulemaking proceeding. We continue

---

96 Id. at 291.

to believe that the rulemaking process permits the most orderly inquiry into the legal, factual, and policy questions which the Commission must address before it can take final action of any form. Ultimately, the considerations noted above may preclude Commission adoption of a trade regulation rule. If so, the Commission may choose to make a public report and recommendations to Congress or the States under Section 6 of the FTC Act, or draft model legislation implementing the Commission's findings, as was done in the generic drug investigation.[97] (We recommend such a course from the outset on the issue of contact lens fitting by opticians.)

The Commission, as well as individual Commissioners, have expressed concern that Staff Reports recommending the initiation of TRR proceedings have not sufficiently advised them of the potential pitfalls which might be encountered. We hope this section fully advises the Commission of the political and legal issues raised by Eyeglasses II. We do not believe that the existence of these issues should deter the Commission from proposing a Magnuson-Moss TRR proceeding.

We think the remedial limitations we have discussed above are a sufficient impediment to pursuing the issue of contact lens fitting by opticians that we have not recommended inclusion of this issue in the recommended trade regulation rule at this time; rather, we recommend that contact lens fitting

---

97 Drug Product Selection, Staff Report to the Federal Trade Commission, Bureau of Consumer Protection, January 1979.

by opticians be severed from Eyeglasses II and that a model state law on that subject be developed. The commercial practice area involves traditional business practices as opposed to a determination of who is competent to practice. We believe the two issues to be qualitatively different.

We do not mean to suggest that all so-called "scope of practice" restrictions should remain exempt from FTC scrutiny. In the area of duplication of lenses by opticians, we have not recommended a preemptive rule, but rather an extension of the prescription release requirement. This recommendation avoids preemption and other remedial difficulties, increases the quality of care available to consumers who wish to obtain replacement or duplicate eyeglasses which produce the visual correction present in their existing eyeglasses, and eliminates the current consumer injury attributable to those restrictions.

VI. Proposed Modifications Of The Eyeglasses I Rule

A. Introduction

In earlier sections of this report, we discussed our recommendations for Commission action. In those discussions, however, we did not address directly the effect those actions might have on the Eyeglasses I Rule. Should the Commission ultimately adopt a final rule as the result of the recommended rulemaking proceeding, it might affect provisions of the now final Eyeglasses I Rule. For example, as we discussed in the sections on Duplication of Lenses[1] and Contact Lens Fitting by Opticians,[2] proposals under consideration at this time might substantially affect the scope of the prescription release requirement currently embodied in section 456.7 of the Eyeglasses I Rule (16 C.F.R. Part 456).[3]

---

1 For a complete description of this remedy, how it may solve the problem of accumulation of tolerances and inaccuracy of duplication, and what new problems may result (such as expiration dates), see Part II, supra.

2 For a discussion of this remedy and its potential problems, see Part IV, supra.

3 Section 456.7 states:

> In connection with the performance of eye examinations, it is an unfair act or practice for a refractionist to:
>
> (a) fail to give to the buyer a copy of the buyer's prescription immediately after the eye examination is completed. PROVIDED: A refractionist may refuse to give the buyer a copy of the buyer's prescription until the buyer has paid for the eye examination but only if that refractionist would have required immediate payment from that buyer had the examination revealed that no ophthalmic goods were required;
>
> (Footnote Continued)

Given this situation, we believe that the Commission should propose the Eyeglasses II rulemaking proceeding as an amendment to the Eyeglasses I Rule. Logic dictates that any regulations promulgated as a result of this proceeding appear as part of an integrated section within the Code of Federal Regulations. Such a section would contain all Federal Trade Commission rules pertaining to the optical industry. We have drafted our rule recommendations based on the assumption that the new provisions will be integrated into the existing trade regulation rule. All advertising provisions of the original rule that were remanded by the D.C. Circuit have been deleted and the remaining provisions renumbered. The complete text of the proposal, with changes from the original rule indicated, is presented in Part VII of this report.

---

3 (Footnote Continued)

> (b) condition the availability of an eye examination to any person on a requirement that that person agree to purchase any ophthalmic goods from the refractionist;
>
> (c) charge the buyer any fee in addition to the refractionist's examination fee as a condition to releasing the prescription to the buyer. PROVIDED: A refractionist may charge an additional fee for verifying ophthalmic goods dispensed by another seller when the additional fee is imposed at the time verification is performed; or
>
> (d) place on the prescription, or require the buyer to sign, or deliver to the buyer a form or notice waiving or disclaiming the liability or responsibility of the refractionist for the accuracy of the eye examination or the accuracy of the ophthalmic goods and services dispensed by another seller.

In addition, we believe that the Eyeglasses II rulemaking proceeding, if proposed by the Commission, offers the Commission the unique opportunity to consider revisions to the Eyeglasses I Rule which time and experience may have shown to be necessary to make that rule work more effectively. This re-examination of certain issues would ensure that the rule is not causing problems which were unforseen at the time the rule was promulgated. The Eyeglasses II proceeding could, and we believe should, be used to open the question of whether certain requirements contained in Eyeglasses I should be scheduled for "sunset" termination. For example, the Eyeglasses II proceeding could be used to determine whether the prescription release requirement contained in section 456.7 should be phased out after the market has had an opportunity to respond to the requirements of the rule.

In this section of the Staff Report, we will briefly discuss some of the modifications of the first rule that may be required as a result of either the Eyeglasses II proposal, or our re-examination of the effects of the Eyeglasses I Rule.

B. Modifications Necessitated by Eyeglasses II

One specific action recommended for inclusion in Eyeglasses II would necessitate an extension of the prescription release requirement of section 456.7 of the Eyeglasses I Rule. In our discussion of state restrictions on the duplication of lenses by opticians we recommended a rule provision which would require that the consumer be given his or her prescription back after

it is originally filled.[4] This would enable the consumer to obtain subsequent pairs of eyeglasses from the original lens specifications, rather than relying on the duplication process to ascertain those prescriptive parameters. This action, if adopted, would in essence, extend the prescription release requirement of section 456.7 of the Eyeglasses I Rule to opticians as well as to refractionists.[5] New section 456.3(a) covers this situation.

In our discussion of the sale of replacement contact lenses, we recommended that the proposed Eyeglasses II Rule include a requirement that the original fitter of contact lenses be required to release to the patient the complete contact lens specifications determined by that provider.[6] Ultimate adoption of such a requirement would require new language to clarify the question of when the obligation of the refractionist to release the contact lens specifications has been triggered. We have drafted a provision to cover this situation. It appears at section 456.3(b) of the proposed rule.

Under the requirements of section 456.7 as currently written, questions have been raised as to whether an optometrist or ophthalmologist is required to specify on the prescription

---

4 See Part II, supra, at 133-134.

5 See p. 133, supra.

6 See Part IV, supra, at 174.

whether the patient is a suitable candidate for contact lenses.[7] Currently, a number of states may require that a prescription state "OK for contact lenses" before an optician can fit the patient with contact lenses.[8] We have interpreted the Eyeglasses I Rule as requiring that the refractionist include this information on the prescription if state law requires an optician to have it before he may fit contact lenses and if the eye doctor has actually determined that the patient is a suitable contact lens candidate.[9] However, some refractionists have expressed concern that including this statement on the prescription may expose them to liability

---

7 See, e.g., Letter from Dr. Liebergall to Eyeglasses staff, (May 23, 1979).

8 See Cal. Bus., & Prof. Code § 2542 (Deering); Opinions of the Attorney General and Report to the Governor of Virginia 191 (1977) (Opinion Letter to Virginia State Board of Examiners in Optometry, March 17, 1977).

9 See, e.g., FTC Eyeglasses Staff Response from R. Kinscheck to Dr. Liebergall (June 19, 1979). The basis of the staff's position on this point is as follows. The rule requires refractionists to release prescriptions to patients immediately after an eye examination (section 456.7). Although the prescriptions need contain only those measurements which would be included in a prescription for eyeglasses (section 456.1(g)) and additional measurements are needed before the prescription can be used to obtain contact lenses, in some states opticians are permitted under state law to take these additional readings. Consequently, in such states, the prescription which the rule requires refractionists to release after the examination will be sufficient to allow the patient to obtain contact lenses from an optician and therefore, is, in effect, a contact lens prescription. The refractionist should not be able to prevent patients from using this prescription to obtain contact lenses from an optician by writing "not for contact lenses" or by refusing to write "OK for contact lenses" simply because the refractionist does not want the patient to go elsewhere to purchase the contact lenses.

if it is subsequently found that contact lenses were contraindicated.[10] Because of this problem, and the potentially serious liability questions which arise from it, we recommend that the Commission clarify the rule to eliminate any requirement to place "OK for contacts" on the prescription. This change is con-

---

10 See, e.g., Letter from Dr. Liebergall, supra note 7. The question of the refractionist's liability depends on the meaning of the authorization for contact lenses. If the "OK for contacts" provision means that a refractionist is certifying that this person is actually a suitable contact lens candidate, then the refractionist will be liable if he or she gives the authorization when a patient should not wear lenses. Section 456.7(d) of the Eyeglasses I Rule prohibits a refractionist from disclaiming liability for his services. Therefore, to avoid this liability problem, a refractionist will have to perform additional tests, which may even include fitting trial lenses, to assure that the patient is actually "OK for contacts." The additional tests also may be performed by the actual fitter, causing the consumer to pay twice for the same services.

In addition, the refractionist may refuse to perform these tests if the patient wants to purchase contact lenses elsewhere, and thus could refuse to "OK" the prescription. Under the definition of eye examination in the Eyeglasses I Rule, (section 456.1(c)), the refractionist would not be required to perform these tests. Therefore, substantial problems may exist for consumers in states where refractionists are held liable for their decision to "OK" patients for contacts.

On the other hand, if the state requirement of contact lens authorization means that a refractionist has determined that a patient is "OK for contacts" based only on the tests that have been performed, then these problems would not arise. A refractionist would not be forced for his protection to perform additional tests to assure contact lens suitability. He could merely authorize the patient for lenses on the basis of those tests, usually a basic refraction, that he performed. The question of whether additional tests should be performed to assure that the patient is actually "OK for lenses" would be determined by the actual fitter and that fitter would assume liability for the decision, as well as for the actual fit.

sistent with our determination that the question of contact lens fitting should remain a matter of state law. Our rule proposal defines a prescription as those specifications necessary to obtain spectacle lenses. This would eliminate any requirement under the rule for a practitioner to place "OK for contacts" on the prescription.

C. Other Modifications

A second area of concern with the release of prescription provision deals with the release of prescription to patients who do not need a change in their prescription. On January 12, 1979, the Commission issued an interpretation of the Eyeglasses I Rule which stated that a prescription must be released to a consumer if the patient needed eyewear but did not require a change in his or her current prescription, unless, in the judgment of the optometrist or ophthalmologist to do so would interfere in medical or optometric treatment or therapy.[11] The purpose of this is to ensure that patients have their prescriptions in case they desire to change frames or in case they break a frame or lenses. However, some optometrists and ophthalmologists have stated that this is causing confusion and is resulting in unnecessary purchases of eyeglasses, especially among older patients.[12] According to these doctors, some patients do not

---

11 Interpretation of Trade Regulation Rule, 44 Fed. Reg. 2569 (Jan. 12, 1979).

12 See Letter from ophthalmologist concerning release of prescription requirement, XVI-12, Eyeglasses I Rulemaking Record, Dkt. 215-52.

understand that there is no need to purchase new eyeglasses when there is no change in prescription even when this is stated to them. If they receive a prescription, it is argued, they use it to purchase eyeglasses, believing that new eyeglasses are necessary. We believe the Commission should consider this problem and seek comment on whether a modification of the rule is necessary to correct it. Accordingly, we recommend that the Commission direct a question to this issue in the Federal Register notice.

The Commission's Eyeglasses I Rule requires that optometrists and ophthalmologists release prescriptions to their patients not only upon request, but in every instance. The Commission's reasoning for this requirement, which we recommended, was as follows:

> The major difficulty with adopting a provision which would require release only upon request is consumers' lack of awareness that the purchase of eyeglasses need not be a unitary process . . . [T]he right of the consumer to this prescription should be immunized from an evidentiary squabble over whether the consumer actually did or did not request the prescription. . . . In addition, there is no evidence in the record to suggest that any significant burden would attend the release of the prescription in every instance.[13]

In the two years that the rule has been in effect, there is reason to believe that the public has become considerably better informed about the availability of optical prescriptions.

---

13 Advertising of Ophthalmic Goods and Services, Statement of Basis and Purpose, 16 C.F.R. Part 456, 43 Fed. Reg. 23998 (June 2, 1978).

Thus, we believe that the Commission should direct a question in the Federal Register notice as to whether the prescription release obligation should be reduced to providing the prescription upon request.

In addition to the re-examination of the release of prescription requirement in these specific instances, we also recommend that the Commission raise the question of either terminating or reviewing the entire provision at a specified future date. If, in the long run, the majority of consumers learn that they can shop for eyewear by obtaining a prescription, they may begin to patronize only those refractionists who are willing to release the prescriptions. Refractionists, in turn, will be wary of not releasing prescriptions because they may lose patients. In effect, the market may produce the same result as the present rule requirement.[14] Because of this possibility, we recommend that the Commission consider whether a "sunset" or other form of mandatory review of the provision should occur at some date. The issues that should be considered include whether any type of review is necessary, what form it should

---

14 If all refractionists refused to release prescriptions, this market effect would not occur. The likelihood of this happening also must be considered in any review of the release of prescription provision. In addition, a small number of states have adopted similar release of prescription requirements. See, e.g., Tenn. Code Ann. § 63-822(25)(n)(1979) (release upon request). If all states require the release and also enforce it, then the need for federal regulation may disappear. This issue also should be considered in the review.

take, and when it should take place.[15]

The focus of the discussion to this point has been on the release of prescription requirements of section 456.7 of the Eyeglasses I Rule. Earlier versions of this staff report contained a discussion of whether the Commission should also re-examine the advertising disclosure section of the Eyeglasses I Rule, section 456.5(a). On February 6, 1980, however, the United States Court of Appeals for the District of Columbia Circuit (in American Optometric Association v. FTC, No. 78-1461) remanded for further consideration the entire advertising portion of the Eyeglasses Rule, including section 456.5(a) dealing with advertising disclosures. Because the court has suspended operation of this portion of the rule, modification of the Eyeglasses I Rule in this area is no longer at issue here.

---

15 The merits of different forms of review must be considered very closely. Section 18(d)(2)(B) of the FTC Act, 15 U.S.C. 57a(d)(2)(B), provides that a substantive amendment or repeal of any Magnuson-Moss rule shall be prescribed following the same procedures as are used in promulgating an initial rule. Thus, it is possible that the Commission would have to conduct a full-scale Magnuson-Moss proceeding to effectuate a "sunset" provision. Even if it were determined that "sunset" could operate without following the Magnuson-Moss procedures, a "sunset" provision could still impose significant resource costs. If at the time of "sunset" it were found that the provision was still necessary, the Commission would be forced to inititate a new Magnuson-Moss proceeding to re-promulgate the provision. A "sunset" could thus require the Commission to conduct a rulemaking proceeding, with its extensive resource commitment, even if no change in the rule is necessary. Other forms of review would enable the Commission to study first the need for the change in the rule before committing to a full-scale rulemaking. These are issues that must be fully discussed in any consideration of a "sunset" provision.

Note: The final two sections of this report (Sections VII and VIII) contain possible rule language and a section-by-section analysis of the draft rule. As is true of the rest of this report, the Commission has not adopted these sections of the staff report. At this stage of the investigation, the Commission staff is recommending that an advance notice of proposed rulemaking ("ANPR") be issued by the Commission requesting comment on the recommendations contained in this report, on alternative courses of action which the Commission might pursue, and on the general issues raised in Eyeglasses II.

In the past when initial staff reports were prepared, the Commission did not normally issue ANPR's in rulemaking but rather proceeded directly to formal rulemaking, with the issuance of an initial notice of rulemaking. The FTC Improvements Act of 1980 now requires that an ANPR be published and that a public comment period follow before the initiation of formal rulemaking. The Act does not, however, require the preparation or release of draft rule language at the time of the issuance of an ANPR. Therefore, it is the Commission's discretion to include in this staff report draft rule language and a section-by-section analysis. The decision in this case should not be viewed as precedent for future Commission proceedings at the ANPR stage. The Eyeglasses II proceeding presents an unusual case in that the entire staff report (including these two sections) was written by the staff before passage of the 1980 Amendments.

VII. The Proposed Rule

Set forth below is the text of our recommended proposed rule and a section-by-section analysis of the rule. Consistent with our earlier discussion the proposed rule is set forth as a modification to the Eyeglasses I rule, 16 C.F.R. Part 456. The rule appears in the form it would take if the provisions of the rule remanded by the D.C. Circuit are not repromulgated.

New provisions are bracketed, deleted provisions are scored.

16 C.F.R. Part 456
Advertising of Ophthalmic Goods and Services

Sections 456.1 Definitions

(a) A "buyer" ["patient"] is any person who has had an eye examination.

~~(b) The "dissemination of information" is the use of newspapers, telphone directories, window displays, signs, television, radio, or any other medium to communicate to the public any information, including information concerning the cost and availability of a product or service.~~

~~(c)~~ [b] An "eye examination" is the process of determining the refractive condition of a person's eyes or the presence of any visual anomaly by the use of objective or subjective tests.

~~(d)~~ [c] "Ophthalmic goods" consist of eyeglasses, or any component of eyeglasses and contact lenses.

~~(e)~~ [d] "Ophthalmic services" are the measuring, fitting, and adjusting of ophthalmic goods to the face subsequent to an eye examination.

[(e) An "ophthalmologist" is any Doctor of Medicine or Osteopathy who performs eye examinations.]

[(f) An "optometrist" is any Doctor of Optometry.]

~~(f)~~ [g] A "person" means any party over which the Federal Trade Commission has jurisdiction. This includes individuals, partnerships, corporations, and professional associations.

~~(g)~~ [h] A "prescription" is the written specifications for ophthalmic lenses which are derived from an eye examination. ~~The prescription shall contain all of the information necessary to permit the buyer to obtain the necessary ophthalmic goods from the seller of his choice. In the case of a prescription for contact lenses, the refractionist must include in the prescription only those measurements and directions which would be included in a preseriptien for spectacle lenses.~~

All prescriptions shall include all of the information specified by state law, if any, [necessary to obtain spectacle lenses.]

~~(h) A "refractionist" is any Doctor of Medicine, Osteopathy or Optometry or any other person authorized by state law to perform eye examinations.~~

(i) A "seller" is any person, or his employee or agent, who sells or provides ophthalmic goods and services directly to the public.

[(j) A "trade name ban" is any state law, rule or regulation which prohibits optometrists or sellers from practicing or holding themselves out to the public under assumed names, the name of the person by whom they are employed, or any name other than the name shown on their license or certificate of registration.]

~~Section 456.2 -- Private Conduct~~

~~(a) It is an unfair act or practice for sellers to fail to disseminate information concerning ophthalmic goods and services notwithstanding state or local law to the contrary. -- PROVIDED: Violation of this subpart by any seller acting alone shall not be deemed to be a violation of section 5(a)(1) of the Federal Trade Commission Act.~~

~~To prevent this unfair act or practice, any seller may engage in the dissemination of information concerning ophthalmic goods and services subject to the limitations expressed in Section 456.5 below.~~

~~(b) It is an unfair act or practice for refractionists to fail to disseminate information concerning eye examinations notwithstanding state or local law to the contrary. -- PROVIDED: Violation of this subpart by any refractionist acting alone shall not be deemed to be a violation of Section 5(a)(1) of the Federal Trade Commission Act.~~

~~To prevent this unfair act or practice, any refractionist may engage in the dissemination of information concerning eye examinations. Nothing in this subpart shall excuse a refractionist from compliance with any state or local law which permits the dissemination of information concerning eye examinations, including information on the cost and availability of those examinations, but requires that specified affirmative disclosures also be included.~~

~~Section 456.3 -- Public Restraints~~

~~It is an unfair act or practice under Section 5 of the Federal Trade Commission Act for any state or local government entity or any subdivision thereof, state instrumentality, or state or local governmental official to enforce any:~~

~~(a) prohibition, limitation or burden on the dissemination of information concerning ophthalmic goods and services by any seller or groups of sellers, or~~

~~(b) prohibition, limitation or burden on the dissemination of information concerning eye examinations by any refractionist. -- PROVIDED: Nothing in subpart (b) shall be construed to prohibit the enforcement of a state or local law which permits the dissemination of information concerning eye examinations, including information on the cost and availability of those examinations, but requires that specified affirmative disclosures also be included.~~

~~Violation of subparts (a) and (b) shall not be deemed for purposes of Section 5(m)(1)(A) or Section 19 of the Federal Trade Commission Act to be a~~

violation of Section 5(a)(1) of the Act.

Section 456.4 - Conformance to State Law

It is an unfair act or practice under Section 5 of the Federal Trade Commission Act:

(a) for any seller to reduce, limit, or burden the dissemination of information concerning ophthalmic goods and services in order to comply with any law, rule, regulation or code of conduct of any nonfederal legislative, executive, regulatory or licensing entity or any other entity or person, which would have the effect of prohibiting, limiting, or burdening the dissemination of this information, or

(b) for any refractionist to reduce, limit, or burden the dissemination of information concerning eye examinations in order to comply with any law, rule, regulation or code of conduct of any nonfederal legislative, executive, regulatory or licensing entity or any other entity or person, which would have the effect of prohibiting, limiting, or burdening the dissemination of this information. PROVIDED: To the extent that a state or local law, rule, or regulation permits the dissemination of information concerning eye examinations, including information on the cost and availability of those examinations, compliance with that law or regulation shall not be construed to reduce, limit or burden the dissemination of information concerning eye examinations.

Section 456.5 -- Permissible State Limitations

(a) To the extent that a state or local law, rule, or regulation requires that any or all of the following items be included within any dissemination of information concerning ophthalmic goods and services, such a law, rule, or regulation shall not be considered to prohibit, limit, or burden the dissemination of information:

(1) whether an advertised price includes single vision and/or multifocal lenses;

(2) whether an advertised price for contact lenses refers to soft and/or hard contact lenses;

(3) whether an advertised price for ophthalmic goods includes an eye examination;

(4) whether an advertised price for ophthalmic goods includes all dispensing fees; and

(5) whether an advertised price for eyeglasses includes both frames and lenses.

(b) Where a state or local law, rule or regulation applies to all retail advertisements of consumer goods and services (including a law, rule, or regulation which requires the affirmative disclosure of information or imposes reasonable time, place and manner restrictions), such a law, or regulation shall not be considered to prohibit, limit, or burden the dissemination of information.

~~(c) If, upon application of an appropriate state or local governmental agency, the Commission determines that any additional requirement of any such state or local governmental agency deemed by that agency to be necessary to prevent deception or unfairness is reasonable and does not unduly burden the dissemination of information, then that requirement shall be permitted to the extent specified by the Commission.~~

~~Section 456.6 Private restraints~~

~~(a) It is an unfair act or practice for any person, other than a state or a political subdivision of agency thereof, to prohibit, limit or burden:~~

~~(1) the dissemination of information concerning ophthalmic goods and services by any seller;~~

~~(2) the dissemination of information concerning eye examinations by any refractionist. PROVIDED: Nothing in this subpart shall be construed to prohibit any person from imposing reasonable affirmative disclosure requirements on the dissemination of information concerning eye examinations.~~

~~(b) Any organization or association which is not composed primarily of sellers and/or refractionists, which adopts or enforces self-regulatory guidelines for the dissemination of information which apply to all retail advertisements of consumer goods and services, shall not be deemed to be in violation of this subpart.~~

~~(c) The conditioning of membership in a professional or trade association of sellers or refractionists on a requirement that members or prospective members of that association not engage in the dissemination of information concerning ophthalmic goods and services and eye examinations or a requirement that ophthalmic goods and services be advertised only in a prescribed manner shall be deemed to prohibit, limit or burden the dissemination of that information.~~

Section 456.~~7~~ [2] Separation of Examination and Dispensing

[I]t is an unfair act or practice for ~~a refractionist~~ [an ophthalmologist or optometrist] to:

(a) Fail to give to the ~~buyer~~ [patient] a copy of the ~~buyer's~~ [patient's] prescription immediately after the eye examination is completed. PROVIDED: ~~A refractionist~~ [An ophthalmologist or optometrist] may refuse to give the ~~buyer~~ [patient] a copy of the ~~buyer's~~ [patient's] prescription until the ~~buyer~~ [patient] has paid for the eye examination but only if that ~~refractionist~~ [ophthalmologist or optometrist] would have required immediate payment from that ~~buyer~~ [patient] had the examination revealed that no ophthalmic goods were required;

(b) Condition the availability of an eye examination to any person on a requirement that that person agree to purchase any ophthalmic goods from the ~~refractionist~~ [ophthalmologist or optometrist];

(c) Charge the ~~buyer~~ [patient] any fee in addition to the

~~refractionist's~~ [ophthalmologist's or optometrist's] examination fee as a condition to releasing the prescription to the ~~buyer~~ [patient]. PROVIDED: A ~~refractionist~~ [An ophthalmologist or optometrist] may charge an additional fee for verifying ophthalmic goods dispensed by another seller when the additional fee is imposed at the time the verification is performed; or

(d) Place on the prescription, or require the ~~buyer~~ [patient] to sign, or deliver to the ~~buyer~~ [patient] a form or notice waiving or disclaiming the liability or responsibility of the ~~refractionist~~ [ophthalmologist or optometrist] for the accuracy of the eye examination or the accuracy of the ophthalmic goods and services dispensed by another seller.

[Section 456.3 Release of Prescription after Dispensing

It is an unfair act or practice for an ophthalmologist, optometrist or any other seller to:

(a) Fail to return to a patient who has purchased eyeglasses from that provider his or her prescription immediately after those eyeglasses are dispensed; and

(b) Fail to provide a patient who has purchased contact lenses a complete set of specifications for those lenses sufficient to enable that patient to obtain replacement or duplicate lenses from any other ophthalmologist, optometrist or other seller permitted under state law to sell contact lenses. These specifications shall be provided immediately after the fitting and adaption process is completed or after the purchase of replacement or duplicate lenses.

The requirements imposed by subparts (a) and (b) extend to all subsequent purchases of eyeglasses or contact lenses.]

Section 456.~~8~~ [4] Federal or State Employees

~~Nothing in this part shall be construed to prohibit any federal, state or local governmental entity from adopting and enforcing standards or requirements concerning the dissemination of information and release of prescriptions by sellers or refractionists employed by those governmental entities.~~

[The requirements of Sections 456.2 and 456.3 of this rule do not apply to ophthalmologists, optometrists or sellers in the employ of any federal, state or local governmental entity.]

[Section 456.5 State Bans on Commercial Practice

(a) It is an unfair act or practice for any state or local governmental entity to enforce any law, rule or regulation which:

(1) Prohibits the employment of optometrists or sellers by persons other than ophthalmologists or optometrists;

(2) Limits the number of offices which an optometrist, seller, or any other person may own or operate;

(3) Prohibits an optometrist or seller from locating any office in a

pharmacy, department store, shopping center or other mercantile location;

(4) Imposes a trade name ban.

(b) This subpart is intended to prevent states from enforcing the total prohibitions on commercial ophthalmic practice described in paragraphs (a)(1) through (a)(4) above. Nothing in this subpart is intended to prevent states from enforcing any law, rule or regulation pertaining to subparagraphs (a)(1) through (a)(4) above, so long as the law, rule or regulation does not directly or indirectly proscribe those activities. Examples of such laws might be requirements that:

(1) unlicensed persons not interfere in the professional judgment of licensed ophthalmologists, optometrists or sellers;

(2) the ophthalmic goods, services, or eye examinations provided at any office be supplied by persons qualified to do so under state law;

(3) control the permissible compensation schemes used to pay employed optometrists or sellers; or

(4) the identity of an optometrist or seller be disclosed to a patient at the time an eye examination is performed or ophthalmic goods or services are dispensed.

(c) If any state or local governmental entity or officer violates any of the provisions of Section 456.5(a)(1)-(4), that person will not be subject to any liability under Sections 5(m)(1)(A) or 19 of the Federal Trade Commission Act.]

Section 456.9[6] Declaration of Commission Intent

~~(a) It is the purpose of this part to allow retail sellers of ophthalmic goods and services to disseminate information concerning those goods and services in a fair and nondeceptive manner to prospective purchasers. This part is intended to eliminate certain restraints, burdens, and controls imposed by state and local governmental action as well as by private action on the dissemination of information, including advertising, concerning ophthalmic goods and services.~~

~~It is the intent of the Commission that this part shall preempt all state and local laws, rules, or regulations that are repugnant to this part, and that would in any way prevent or burden the dissemination of information by retail sellers of ophthalmic goods andservices to prospective purchasers, except to the extent specifically permitted by this part. All state or local laws, rules,or regulations which burden the dissemination of information by requiring affirmative disclosure specifically addressed to ophthalmic goods and services are preempted, except for those specifically permitted by this part. State and local laws, rules, or regulations which apply to advertising of all consumer goods and services, including those that require affirmative disclosure of information, are not preempted.~~

~~(b) It is the Commission's intent that state laws which do not permit refractionists to disseminate information concerning eye examinations, including information concerning the cost and availability of those examinations, be preempted. State and local laws, rules or regulations which~~

~~require affirmative disclosure of information in all disseminations of information concerning eye examinations are not preempted.~~

~~(c) The Commission intends this part to be as self-enforcing as possible. To that end, it is the Commission's intent that this part may be used, among other ways, as a defense to any proceeding of any kind which may be brought against any retail seller of ophthalmic goods and services or refractionist who advertises in a nondeceptive and fair manner.~~

~~(d) It is not the Commission's intent to compel any seller or refractionist to disseminate information by virtue of this part. On the contrary, the provisions of this part are intended solely for the protection of those sellers and refractionists who want to disseminate information but have been restrained or prevented from advertising due to the prohibitions and restrictions of state and local laws and regulations, or by private action.~~

~~(e)~~ [a] In prohibiting the use of waivers and disclaimers of liability in ~~Section 456.7(d)~~ [456.2(d)], it is not the Commission's intent to impose liability on a ~~refractionist~~ [an ophthalmologist or optometrist] for the ophthalmic goods and services dispensed by another seller pursuant to that ~~refractionist's~~ [ophthalmologist's or optometrist's] prescription.

~~(f)~~ [b] In this part, the Rule, each subpart, and the Declaration of Commission Intent and their application are separate and severable.

[(c) It is the purpose of this Rule to allow commercial ophthalmic practice. The Rule is intended to permit optometrists and sellers of ophthalmic goods and services to work for non-professsional corporations or for unlicensed persons; to eliminate restrictions on both the number and location of offices which optometrists or sellers may operate; and to permit optometrists and sellers to practice under trade names.

The Commission intends the Rule to be as self-enforcing as possible. To that end, it is the Commission's intent that this Rule may be used, among other ways, as a defense to any proceeding of any kind which may be brought against any seller or optometrist for practicing under a trade name, working for a non-professional corporation, operating branch offices or practicing in a mercantile location.]

VIII. Section-by-Section Analysis of the Proposed Rule

In this section we present a detailed analysis of our recommended proposed rule. As we explained earlier in our report, we have drafted the rule on the assumption that the new provisions will be integrated into the existing Eyeglasses I Rule and that the remanded portions of the Eyeglasses I Rule will not be repromulgated in the near future.

This analysis includes both an explanation of the changes necessitated in the Eyeglasses I Rule as a result of our Eyeglasses II proposal, as well as an explanation of the Eyeglasses II provisions. The sections of the Eyeglasses I Rule which remain unchanged and which were explained in the Statement of Basis and Purpose of the Eyeglasses I Rule will not be described here.

Section 456.1 -- Definitions

Paragraph (a) - The term "patient" has been substituted for the term "buyer". There is no substantive change from the Eyeglasses I Rule. The change to the term "patient" is a technical revision to conform more closely to industry usage.

Paragraphs (b), (c) and (d) - The definitions of the terms "eye examination," (section 456.1(c) of the Eyeglasses I Rule), "ophthalmic goods," (section 456.1(d) of the Eyeglasses I Rule), and "ophthalmic services," (section 456.1(e) of the Eyeglasses I Rule), remain unchanged from the original rule definitions.

Paragraphs (e) and (f) replace section 456.1(h) of the original rule, which used the term "refractionist" to define those categories of providers-- namely Doctors of Medicine, Optometry and

Osteopathy-- who are qualified under state law to perform eye examinations. We have deleted the word "refractionist" and substituted the terms "optometrist" and "ophthalmologist" for two reasons. First, because the term "refractionist" is not generally used by consumers or the industry, its use in the original rule has caused confusion. Second, parts of the proposed rule, specifically the provisions permitting commercial practice, do not now apply to ophthalmologists (although we have raised a question about whether they should be covered by these provisions in the Federal Register notice). We have eliminated the term "refractionist" so that this distinction is made clear.

Paragraph (g) - The term "person" (section 456.1 (f) of the Eyeglasses I Rule) remains unchanged from the original definition.

Paragraph (h) - The term "prescription" is defined as those specifications necessary to obtain spectacle lenses. Thus, the prescription which is released to the patient must at a minimum contain the data on the refractive status of the patient's eyes. Where state law requires that a prescription contain the date or signature of the examining optometrist or ophthalmologist in order for an optician to be legally permitted to fill it, the prescription must also contain those elements.

The definition has been amended to eliminate all references to contact lenses. This change will end the confusion that was generated by the original definition concerning the obligation of optometrists and ophthalmologists to place the wording "OK for contact lenses" on prescriptions. The new definition eliminates

any requirement that an optometrist or ophthalmologist include on the prescription the wording "OK for contact lenses" or similar language. This change will clarify the fact that the prescription release requirement does not affect state law concerning who is legally permitted to fit contact lenses.

Paragraph (i) - The term "seller," (section 456.1(i) of the original rule), remains unchanged from the original definition.

Paragraph (j) - The term "trade name ban" is a new definition. It is intended to cover any state law or regulation which prohibits an optometrist or seller from practicing under an assumed or corporate name. An explanation of how states may regulate the use of trade names is found below in our explanation of section 456.5.

Section 456.2 - Separation of Examination and Dispensing (section 456.7 of the Eyeglasses I Rule)

Section 456.2 of the Eyeglasses I Rule was upheld by the D.C. Circuit, and the provision's release of prescription requirement remains in effect. No substantive changes have been made in the proposed rule. We have, however, altered the language to conform to the proposed rule's revised definitions so that "refractionist" has been replaced by "ophthalmologist" and "optometrist", and "buyer" by "patient". In addition, the provision has been renumbered so it now appears as section 456.2 of the proposed rule.

Section 456.3 -- Release of Prescription after Dispensing

Paragraph (a)- New section 456.3(a) requires that after the purchase of eyeglasses, all providers return to their patients a spectacle prescription which may be filled by any other pro-

vider. This requirement will provide consumers with copies of their prescriptions so that they may purchase replacement or duplicate eyeglasses at a later date, even in those states where duplication of lenses through the "neutralization" process is prohibited. If consumers have a prescription, they will not run the risk of having their existing pair of eyeglasses duplicated inaccurately. They will also not be forced to obtain a new eye examination unless they desire one.

Although the prescription release requirement of the Eyeglass I Rule (renumbered as section 456.2), applies only to ophthalmologists and optometrists, the requirement of section 456.3(a) applies to all providers who dispense eyeglasses, including dispensing ophthalmologists, dispensing optometrists, and all opticians. Examiners who do not dispense eyeglasses would not, of course, be covered by section 456.3(a).

The purpose of this provision is to provide consumers with a prescription which may be used at a later date to obtain a new pair of eyeglasses. All dispensing providers must return to their patients either the original prescription or a copy that contains all the information necessary for it to be filled by any provider. Thus, if state law requires that a prescription include the signature of an ophthalmologist or optometrist, this provision would mandate that dispensing providers return a prescription which has the required signature.

Several other factors about this provision should be noted. First, unlike the release of prescription at the time of examination, dispensing providers may withhold the return of the pre-

scription after purchase until the consumer has paid all fees. The possibility of a discriminatory requirement of prepayment which is an issue in release of prescriptions after examination (as a means to induce or coerce the patient to purchase from the examiner) ceases to be an issue after the patient has purchased eyeglasses. Second, the rule provision explicitly states that the prescription must be returned not only after the initial purchase, but after every subsequent purchase. Finally, it must be emphasized that this provision does not change the obligation of ophthalmolgists and optometrists under the Eyeglasses I Rule to release an eyeglasses prescription immediately after an eye examination.

Paragraph (b)- New Section 456.3(b) requires all ophthalmologists, optometrists and sellers who dispense contact lenses to give the patient a complete contact lens prescription that will permit the patient to purchase a replacement or duplicate pair of contact lenses without undergoing a new fitting procedure. This requirement does not in any way affect who may fit contact lenses under state law. It merely permits consumers to obtain contact lenses from anyone who is permitted to sell them under state law. If opticians in a particular state are not permitted to sell contact lenses, then consumers will still not be able to purchase lenses from opticians in that state, even though the provision requires the release of a complete contact lens prescription.

This requirement, like its companion in section 456.3(a), applies to both the initial purchase and to all later purchases

of contact lenses. While it is clear that the specifications must be returned immediately after the purchase of replacement or duplicate contact lenses, there may be some question concerning the timing of the release after the original purchase. We have not set a specific time requirement for the release of prescription on the initial purchase of contact lenses because often there is a trial fitting period during which the fitter adjusts the lens specifications as the patient adapts to the lenses. The rule requires the return of the contact lens prescription only after the fitter has, in his or her professional judgment, made a determination of the final prescription. The rule states that the prescription must be returned "after the fitting and adaptation process is completed." In some cases this determination may be made relatively quickly, but in other instances it may take several months for the fit and adaptation to be completed. We have raised a question in the draft Federal Register notice concerning the precision of the term "completion of the adaptation process." We believe that this term is understood within the industry, but we would like comments on whether a more specific term or an actual time period should be substituted for the phrase.

One argument against re-release of prescriptions is that it will enable consumers to by-pass eye examinations. We recognize this concern and have drafted section 456.3 so that it does not limit the ability of a state to impose expiration dates on either eyeglasses or contact lens prescriptions. In addition, even if the state has acted, ophthalmologists and optometrists may place

expiration dates on the initially released spectacle prescription, and all three provider classes may place an expiration date on the original contact lens prescription unless the state has forbidden providers from placing expiration dates on either or both types of prescriptions. This date may be for a shorter time period than that set by the state (if any) since the rule in no way interferes with the professional judgment of the providers. If an expiration date selected by a provider is unreasonably short and appears designed only to circumvent the rule's requirements, we would have to consider on a case-by-case basis whether that is equivalent to an actual refusal to return the prescription.

Section 456.4 -- Federal or State Employees (section 456.8 of the Eyeglasses I Rule)

We have redrafted the language of this provision to delete references to the remanded portions of the Eyeglasses I Rule and to clarify its meaning. This provision exempts practitioners who work for any federal, state or local government from the rule's release of prescription requirements irrespective of whether those governmental entities have regulations which would otherwise conflict with the rule. If practitioners work only part-time for the government, the exemption only applies when they are engaged in their governmental duties.

Section 456.5 -- State Bans on Commercial Practice

This section prohibits state or local governments from enforcing certain commercial ophthalmic practice bans. The purpose of this section is to preempt total prohibitions on commercial ophthalmic practice. The rule does not interfere with

the state's ability to control specific abusive practices as long as the state does not directly or indirectly proscribe totally the commercial practices protected by this section. (Since section 465.5(b) serves primarily to explain the effects of 456.5(a), the discussion of its provisions appear with the discussion of the corresponding provisions of section 456.5(a) rather than appearing separately.)

Paragraph (a)(1) - Section 456.5(a)(1) prevents state and local governments from prohibiting the employment of optometrists or sellers by persons other than ophthalmologists or optometrists. Specifically, this section is directed at state restrictions which prevent optometrists and sellers from working for non-professional corporations or lay individuals.

As indicated in section 456.5(b)(1), the rule will allow states to prevent unlicensed persons from interfering in the professional judgments of optometrists and sellers. And section 456.5(b)(3) of the proposed rule makes clear that states may restrict permissible compensation schemes used to pay optometrists or sellers who are employed by corporations or lay individuals, as long as any restriction on compensation schemes does not rise to the level of a total ban on corporate or commercial employment. Thus, a state could choose to prohibit commission payments as a form of compensation for optometrists or sellers. Similarly, the rule will leave to the states the discretion to regulate leasing arrangements between optometrists or sellers and corporations or lay individuals, as long as the restrictions do not operate as a total prohibition on commercial ophthalmic

practice. Thus, to the extent that states determine that the health and safety of their citizens may be threatened by certain compensation schemes or leasing arrangements, the rule would allow the states to take action.

Paragraph (a)(2) - Section 456.5(a)(2) prohibits state or local restrictions on the number of offices which an optometrist, seller or any other person may operate. The purpose of this provision is to allow any person, (including any corporation) who provides eye examinations or ophthalmic goods and services to own or operate any number of offices. Under this section, a state could not require that an office be open only when the optometrist who owns it is in personal attendance. The rule does not, however, prevent states from regulating the services provided at each office, as long as states do not directly or indirectly prohibit the number of offices which an optometrist, optician or any other person may operate. As provided in Section 456.5(b)(2), the rule would not prevent states from requiring that ophthalmic goods, services or eye examinations provided at each office be supplied by a person qualified under state law to do so.

Paragraph (a)(3) - Section 456.5(a)(3) preempts state and local restrictions which prohibit an optometrist or seller from locating any office in a pharmacy, department store, shopping center or other mercantile location. The purpose of this section is to allow optometrists and sellers to set up offices in high consumer-traffic areas such as drug stores and shopping centers. Mercantile location has not been specifically defined at this

time since we believe its meaning is commonly understood and further clarified by the rest of the section. However, we are raising a question in the Federal Register notice to determine if a more precise definition is necessary.

Paragraph (a)(4) - Section 456.5(a)(4) prohibits all state or local trade name bans on ophthalmic practice. This section is designed to allow optometrists or sellers to practice or hold themselves out to the public under commercial or corporate names. The provision will not prevent states from controlling specific deceptive practices which may occur as long as the state restrictions do not operate as a total prohibition on the use of trade names. Thus, under section 456.5(b)(4), if states want to ensure full professional identification, they may require that the identity of the optometist or seller be disclosed to the patient at the time the eye examination is performed or ophthalmic goods and services are dispensed.

We have raised two questions in the Federal Register notice concerning this trade name ban provision. The first question is whether the states should be allowed to require that all offices under common ownership operate under the same name. Such a requirement may be necessary in order to prevent certain forms of deception, and may not unduly restrict the use of trade names. The rule as currently drafted does not preclude state regulation of this practice.

We also ask whether states should be allowed to regulate trade names in advertising. For example, should states be able to require that any use of trade names, including advertisements

using trade names, be accompanied by the name of every individual who operates under that trade name? Should states be able to require that any use of trade names in advertisements for a specific office or location also include the names of the individual sellers or optometrists practicing at that office or location? As drafted, our rule would not preclude state regulation of the use of trade names in advertisements, unless those restrictions effectively banned trade name practice. We need to determine whether these types of restrictions, and other restrictions on trade names in advertising, are necessary to prevent deception, and second, whether they unduly encumber the use of trade names.

Finally, with respect to sections 456.5(a)(1) through 456.5(a)(4), in the Federal Register notice will ask whether the rule should cover ophthalmologists as well as optometrists and sellers. We have not included ophthalmologists in this section at this time for two reasons. First, the evidence that we have is almost totally limited to optometrists and opticians, both in terms of the existence of commercial practice bans and in terms of the effect of these commercial practice limitations on cost and quality of care. Second, the evidence that we have, particularly the Bureau of Economics (BE) study, focused on a limited type of optometric practice-- visual diagnostic eye examinations and dispensing services. We believe that although these tasks may cover the average optometric practice, the practice of the vast majority of ophthalmologists goes beyond the limited practice that was covered by the BE study and includes

the treatment of eye disease and eye surgery.

We do, however, recognize that often optometrists perform tasks other than visual diagnostic eye examinations and dispensing services, such as low vision testing. Because of this, we are specifically raising a question in the Federal Register notice concerning whether to exclude from the commercial practice section of the proposed rule those optometrists who perform these broader functions. In addition, we are raising a question as to whether to include in the commercial practice section those ophthalmologists who limit their practice to only those activities covered by the rule.

Paragraph(c) -- Section 456.(c) is simply a restatement of the last paragraph of Section 456.3 of the Eyeglass I Rule. No substantive change has been made in that language.

Section 456.6 -- Declaration of Commission Intent (section 456.9 of the Eyeglasses I Rule)

This section has been modified to conform with substantive changes in the rule. The provision continues to make clear that an optometrist or ophthalmologist who performs an eye examination and writes a prescription for ophthalmic goods following the eye examination is not made responsible for the ophthalmic goods and services dispensed by other sellers pursuant to that prescription by the rule. Rather, in such a situation the optometrist or ophthalmologist would be responsible only for the eye examination he or she performs and the prescription he or she writes.

In addition, each of the rule requirements and the Declaration of Intent are declared to be separate and severable, so that if any provision or the application of any provision is held

invalid the remaining provisions will not be affected.

This section also makes it clear that the proposed rule is intended to allow commercial ophthalmic practice, specifically by preempting employment, location and branch office restrictions, and trade name bans. The section of the proposed rule which removes commercial practice restraints is intended solely for the protection of optometrists and sellers who wish to operate branch offices, practice in mercantile locations, be employed by non-professional corporations, or practice under trade names, but have been prevented from doing so by these state restrictions.

Finally, this section makes it apparent that the Commission intends that the proposed rule may be used as a defense in legal or administrative proceedings, or affirmatively for declaratory, injunctive, or other relief.

Section 456.2-456.6 -- The Advertising Provisions of the Eyeglasses I Rule

Sections 456.2 - 456.6 of the Eyeglasses I rule have been remanded by the Court of Appeals in American Optometric Association v. FTC , No. 78-1461 (D.C. Cir.) (slip op. Feb. 6, 1980). We have drafted the proposed rule on the assumption that these provisions will not be repromulgated in the near future, although no final Commission decision has yet been made. The provisions have therefore been deleted from the proposed rule.

APPENDIX A

Summary of Comments by State and Local Governmental Officials on Notice of Staff Intent to Recommend Rulemaking

In June, 1979, the Commission's Office of Federal-State and Consumer Relations sent to state and local governments a notice prepared by the Bureau of Consumer Protection Staff notifying state officials and agencies that we intended to recommend to the Commission that a rulemaking proceeding be used to explore the issues in the Eyeglasses II investigation and inviting them to comment on that investigation. This notice described our investigation of commercial practice restraints and scope of practice restrictions on opticians and also discussed the various alternative remedies that might be pursued should the Commission decide to take action in these areas.

We have received approximately 98 responses to this notice of intent. These responses have been segregated into four categories by type of respondent: optician boards, optometric boards, medical boards, and other state and local government units.[1] Many of the responses merely acknowledged receipt of our notice.[2] A number of comments were general in nature and indicated a concern that removal of the various restrictions

---

1 The responses in this last category come from various sources. Many are from the state attorney general. Some were sent from the state governor, the speaker of the state house of representatives or some other elected official. A few were from state or local agencies such as the office of consumer affairs.

2 See, e.g., A1 (p. 1); B10 (p.1); C6 (p. 1); D1 (p. 1); D4 (p. 1); D53 (p. 1).

under investigation would adversely affect the quality of vision care without citing any substantial evidence in support.[3] However, many responses addressed substantive issues raised by the notice of intent. These substantive comments break down into three major categories: commercial practice restraints, scope of practice restrictions, and the Commission's authority to act in the area of vision care.

For the purposes of the footnotes in this summary, the four categories of respondents have been labeled A, B, C, and D. Category A is for the optician boards; category B is for the optometric boards; category C is for the medical boards; and category D is for other state entities and state officials. The responses within each category have been provided with a number. For example, the response from the Arizona opticians board is A1 while the response from the Georgia medical board is C1. The responses have been listed with their corresponding numbers at the end of the summary.

Commercial Practice Restraints

While some responses supported commercial practice,[4] and particularly corporate employment,[5] practice on the premises

---

3 A1 (p. 1); B2 (p. 2); B3 (p. 1); B8 (p. 1); B9 (p. 1); D15 (p. 1); D33 (p. 1).

4 A5 (pp. 1,2); A9 (p. 2). One state governor noted that commercial practice restraints are difficult to justify on the basis of maintaining the quality of care. D48 (p. 1).

5 A9 (p. 2).

of a mercantile establishment,[6] and the use of trade names,[7] the vast majority of responses that addressed this area opposed the elimination of commercial practice restraints.

General comments include one state governor's assertion that corporate employment is not in the best interests of the public.[8] The secretary of human resources from another state claimed that commercial optometric practice would not allow states to protect consumers from mercantile establishments in which unhealthful and dangerous practices occur.[9] Neither comment, however, offered any evidentiary support for those assertions.

The more specific responses, however, focused on the issue of quality. In particular, some state boards of optometry felt that commercial establishments are solely interested in profit[10] generated by high-volume practice.[11] They stated that commercial establishments are less likely to conduct complete eye examinations[12] and that they will not protect the visual welfare

---

6 A9 (p. 2).

7 A9 (p. 2).

8 D28 (p. 1).

9 D39 (p. 1).

10 B2 (p. 1); B23 (p. 2).

11 B2 (p. 1); B14 (p. 2); B15 (p. 2); B23 (p. 2).

12 B2 (p. 1); B15 (p. 2).

of the public.[13] Other similar comments were that commercialism lowers the quality of professional service,[14] that high volume and low prices generally reduce quality,[15] and that removing limitations on commercial practice could seriously affect quality.[16] One state board of opticians noted that commercial practice restraints are "all tools of the optometric boards to assure a higher quality of examination that is not affected by an employer-employee relationship."[17]

Two state optometric groups addressed the issue of prices. One response asserted that commercial optometry would not reduce prices and that removing commercial practice restrictions would increase the cost of eye care,[18] while another stated that when quality is considered, the cost to consumers is higher in commercial practices.[19]

Some respondents were concerned about the impact of commercial practice on the doctor/patient relationship. They contended that commercial practice may jeopardize this rela-

---

13 B1 (p. 1); B2 (p. 1); B14 (p. 2); B15 (p. 2).

14 B1 (p. 1); B13 (p. 2); B15 (p. 1).

15 B16 (pp. 1,2).

16 B15 (p. 2); see also D25 (p. 1); D39 (p. 1).

17 A7 (p. 1).

18 B15 (p. 2).

19 B14 (p. 2).

tionship[20] and that it is important to have this relationship free from third party influence.[21] One of these respondents asserted that corporate practice results in the unnecessary prescribing of eyeglasses.[22]

Two responses discussed the issue of trade name bans. One optometric board asserted that a professional should not be shielded by trade names but should be highly visible and individually responsible.[23] Another optometric board felt that trade names should be allowed but only under board regulation so as to limit the use of names that might tend to deceive the public.[24]

Scope of Practice Restrictions

The comments on the proposed investigation of scope of practice restrictions focus on two major areas: allowing opticians to fit contact lenses and allowing opticians to duplicate eyeglasses without a prescription.

Most of the responses dealing with the contact lens issue were opposed to allowing opticians to fit.[25] The reason most

---

20 B6 (p. 1).

21 A9 (p. 2); B15 (p. 1); B19 (p. 1); D39 (p. 1).

22 B15 (pp. 1,2).

23 B15 (p. 3).

24 B6 (p. 2).

25 A3 (pp. 1,2); B1 (p. 1); B4 (p. 1); B5 (p. 1); B11 (p.2); B14 (p. 2); B15 (p. 3); B16 (p. 1); D5 (p. 1); D50 (pp. 1,2).

frequently cited for this opposition was that opticians do not have sufficient training to fit contact lenses.[26] One other reason cited in opposition to contact lens fitting by opticians is that they will divest business from others (optometrists and ophthalmologists) thereby creating a shortage of these providers.[27]

One optometric association took issue with the statement in the notice of intent that one reason for a trade regulation rule in this area would be to allow the consumer to obtain the most economic buy. This association stated that one reason opticians may charge less is that they do not incur the time and expense of follow-up care nor do they have the expertise to perform follow-up care.[28]

Some respondents felt that if opticians were allowed to fit, they should be permitted to do so only under the supervision or direction of an ophthalmoloigst or an optometrist.[29]

Most of the responses from state boards of opticians that discussed contact lens fitting supported the right of opticians

---

26 B5 (pp. 1,2); B11 (p. 2); D5 (p. 1); D15 (p. 1); B16 (p. 2); B14 (p. 2); B15 (p. 3); B20 (p. 1); B4 (p. 1); B1 (p. 1); A3 (p. 1).

27 B11 (p. 2).

28 B20 (p. 1).

29 B16 (p. 2); B5 (p. 2). One optician's group felt that opticians should be allowed to fit contacts under the "direction" of a refractionist where "direction" was interpreted to mean that the patient, at a minimum, see a refractionist for appropriate follow-up review of the fitting. A9 (p. 2).

to fit contact lenses.[30] Two reasons given for this support were that it would enhance consumers' purchase alternatives and lower prices.[31]

More than half of these responses, however, stated that opticians should be required to pass certain competency exams in order to fit contact lenses.[32] One state board of opticians indicated that it was not opposed to requiring some further qualifications for opticians to fit, but it did not specify exactly what type of qualifications it thought appropriate.[33]

One state board of opticians felt that opticians should be allowed to fit contact lenses but only from a prescription, not from duplication.[34]

One of the alternative remedies suggested in the notice of intent was a proposal to require ophthalmologists and optometrists to release to their patients contact lens prescriptions with all of the specifications necessary to manufacture the finished lenses included. Several responses were addressed

---

30 A2 (p. 3); A4 (p. 1); A5 (p. 2); A8 (p. 1); A9 (p. 1); A10 (p. 1); A11 (p. 1).

31 A8 (p. 1).

32 A8 (p. 1); A9 (p. 1); A10 (p. 1); A11 (p. 1). One board of opticians thought that opticians also should be licensed by the state or certified by the American Board of Opticianry in order to fit contacts. A11 (p. 1).

33 A4 (p. 1).

34 A9 (p. 2).

to this proposal, most of them in opposition to it.[35] One state board of optometry said that release of contact lens prescriptions with all the specifications would do a disservice to the consumer because the prescriber needs to observe the lens in the consumer's eye.[36] A board of medical examiners said that harm to the cornea is possible if the keratometer readings are not followed accurately and therefore release of prescriptions with keratometer readings should not be required.[37]

On the other hand, two optician boards stated that contact lens prescribers should be required to include all the contact lens specifications in prescriptions.[38] One of these boards said that release of all prescriptions, contact lens, as well as eyeglasses, allows the consumer to shop for price, quality and service.[39]

Finally, in the area of contact lenses, one opticians group suggested that the Commission should formulate a uniform definition of the services that constitute contact lens dispensing as well as a more precise definition of a contact lens prescription and a definition, in the form of a uniform national standard, of

---

35 A4 (p. 1); B14 (p. 3); B16 (p. 2); C1 (p. 1).

36 B14 (p. 3).

37 C1 (p. 1).

38 A3 (p. 2); A7 (p. 2).

39 A7 (p. 2).

what constitutes contact lens specifications.[40]

Many responses, primarily those from state boards of opticians, supported the idea of allowing opticians to duplicate existing eyeglasses without a prescription.[41] Various boards of opticians felt that opticians are competent to duplicate,[42] that laws restricting duplication restrict consumers from effectively shopping,[43] increase costs,[44] inconvenience consumers,[45] that the right to duplicate helps to keep costs at a reasonable level,[46] that duplication avoids the necessity of obtaining duplicate prescriptions, possibly at a cost,[47] and that the ANSI standards for lens quality are sufficient guidelines to ensure that minimum tolerances are adhered to while duplicating without a prescription.[48]

Some of these responses qualified their support for duplication without a prescription. One state board of opticians said that opticians should be allowed to duplicate as long as

---

40 A12 (p. 1).

41 A9 (p. 1); B15 (p. 3); A5 (p. 2); A8 (p. 1); B5 (p. 1); D15 (p. 1); A10 (p.1); A7 (p. 2); A2 (p. 2); A4 (p. 2).

42 A5 (p. 2); A10 (p. 1).

43 A7 (p. 2).

44 A4 (p. 2).

45 A4 (p. 2); A8 (p. 2).

46 A10 (p. 1).

47 A8 (p. 1); A10 (p. 1).

48 A2 (p. 2).

there is no change in refractive value.[49] Another said that rules for duplication should be relative to qualifications and accuracy of the practitioner and his equipment.[50] Finally, one board of examiners in optometry indicated that while a qualified optician could duplicate without a prescription, a time limit should be set on prescriptions.[51]

On the other hand, some respondents opposed the right of opticians to duplicate.[52] The stated reasons were that opticians are not competent to duplicate,[53] and that allowing duplication without a prescription raises a problem of compounding the errors introduced in examination and fabrication of eyeglasses and thus may put the duplicated lens out of tolerance.[54] One respondent asserted that restraints on duplication do not increase costs.[55]

One of the alternative remedies to allowing lens duplication, which was suggested in the notice of intent, would be to require that prescriptions be returned to consumers after they are filled or to give consumers the right to obtain copies of their prescriptions from the refractionist within a reasonable time after

---

49 A11 (p. 1).

50 A2 (p. 2).

51 B15 (p. 3).

52 B5 (p. 2); B14 (p. 2); D5 (p. 1).

53 D5 (p. 1).

54 B5 (p. 2); B14 (p. 2).

55 B14 (p. 3).

an eye examination. A few responses supported these proposals,[56] though one board of opticians did note that it would be hard to enforce this release of the prescription to the patient after it was filled since it has been almost impossible to enforce the release of the prescription on completion of the eye exam.[57] Moreover, at least one state consumer affairs office stated that while it believed duplication should be allowed, these proposed alternative remedies would solve the problem.[58]

FTC Authority

A number of comments addressed the Commission's authority to act in this area. Some respondents expressed the belief that FTC regulations do not preempt state laws.[59] One commenter specifically stated that the FTC has no statutory or constitutional right to preempt state laws.[60] Several comments stressed that this area should be left to the states to regulate.[61]

---

56 A4 (p. 2); A12 (p. 1); B16 (p. 2).

57 A7 (p. 2).

58 D15 (p. 1).

59 B2 (p. 2); B7 (p. 1); D27 (p. 1); D35 (p. 1); D43 (p. 1). The Speaker of the Michigan House of Representatives stated that he supported a cooperative attitude on the part of state and federal authorities but that federal preemption in areas that are primarily state economic activities would not meet this cooperation test. D47 (p. 1).

60 B1 (p. 1).

61 B9 (p. 2); B14 (p. 1); B20 (p. 1); B23 (p. 2); C9 (p. 1); D13 (p. 1); D17 (p. 1); D27 (p. 1); D52 (p. 1). One state governor supported the FTC investigation of commercial restraints but thought the area of scope of practice restrictions should be left to the state to regulate. D48 (p. 1).

Other reasons cited in opposition to the Commission's presence in this area were that it is the inherent right of the state to regulate the conduct of professionals,[62] that this area is primarily of state and local concern,[63] that the investigation is an unwarranted intrusion into state affairs,[64] and that the responsibility of promulgating and enforcing a regulation is at the state level since the burden of enforcing an FTC rule could be costly and ineffective and judicial review could be lengthy, prolonged and recriminatory.[65]

Other Comments

The comment from one state assemblyman made a number of suggestions as to Commission action. He suggested the adoption of model legislation for the licensing and certification of professions; consumer representation of at least 40% on all licensing, regulatory and professional boards; and holding owners of professional services responsible to the consumer.[66]

---

62 B8 (p. 1); D50 (p. 1).

63 D13 (p. 1).

64 B8 (p. 1); B9 (p. 1); B14 (p. 1).

65 A2 (p. 2).

66 D46 (pp. 1,2).

Category A -- State Optician Boards

1. Arizona State Board of Dispensing Opticians (June 22, 1979)
2. Connecticut Commission of Opticians
3. President, Georgia State Board of Dispensing Opticians
4. Georgia State Board of Dispensing Opticians
5. Hawaii Board of Dispensing Opticians
6. Ohio Board of Dispensing Opticians
7. Tennessee Board of Dispensing Opticians
8. President, Vermont Opticians Licensing Board
9. Virginia Department of Commerce on behalf of Virginia State Board of Opticians
10. New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians
11. Arizona State Board of Dispensing Opticians (July 16, 1979)
12. South Carolina Board of Examiners in Opticianry

Category B -- State Optometric Boards

1. Neil Cummings, O.D., State Health Council
2. Arizona State Board of Optometry
3. Arkansas State Board of Examiners in Optometry
4. President, Georgia State Board of Examiners in Optometry
5. Society of Professional Optometrists, Inc., Atlanta, Georgia
6. Hawaii Board of Examiners in Optometry
7. Indiana State Board of Optometry
8. Kansas Optometric Association, Inc.
9. Kansas State Board of Examiners in Optometry
10. Maryland Board of Examiners in Optometry
11. Missouri State Board of Optometry
12. New York State Board of Optometry
13. Thomas Wold, Special Assistant Attorney General, representing the North Dakota State Board of Optometry
14. Oregon Board of Optometry
15. Rhode Island Division of Professional Regulation for the Rhode Island Board of Examiners in Optometry
16. Utah Department of Business Regulation for the Utah State Optometric Committee and the Department of Registration
17. Washington Department of Licensing on behalf of the Washington State Board of Optometry
18. Wisconsin Optometry Examining Board
19. California Board of Optometry
20. Wyoming Optometric Association
21. Virginia State Board of Examiners in Optometry

22. Rhode Island Department of Health, for the Rhode Island Board of Examiners in Optometry

23. Maryland Board of Examiners in Optometry

Category C -- State Medical Boards

1. Georgia Composite State Board of Medical Examiners
2. Medical Licensing Board of Indiana
3. State of Ohio, the State Medical Board (June 20, 1979)
4. State of Ohio, the State Medical Board (June 25, 1979)
5. Utah Department of Business Regulation
6. Virginia State Board of Medicine
7. Washington Department of Licensing
8. California Board of Medical Quality Assurance
9. Michigan Department of Licensing and Regulation
10. Joint Commission on Allied Health Personnel in Ophthalmology

Category D -- Other State Entities and State Officials

1. National Association of Attorneys General
2. Alabama Office of the Attorney General
3. Alabama Office of Consumer Protection
4. Alaska Office of the Attorney General
5. Arkansas Office of the Attorney General
6. City of Long Beach Department of Human Resources
7. Cleveland Office of Consumer Affairs
8. Ella Grasso, Governor of Connecticut
9. Delaware Department of Justice
10. Marion Barry, Mayor of the District of Columbia
11. Committee of Regulatory Reform, Florida House of Representatives
12. George Ariyoshi, Governor of Hawaii
13. Hawaii Department of the Attorney General
14. Hawaii Office of Consumer Protection
15. Illinois Acting Special Assistant to the Governor on Consumer Affairs, Ellen Craig
16. Edwin Edwards, Governor of Louisiana
17. James Clark, Jr., President, Senate of Maryland
18. Massachusetts Executive Office of Consumer Affairs
19. C.B. Newman, Speaker, Mississippi House of Representatives
20. William Milliken, Governor of Michigan
21. Charles Thone, Governor of Nebraska (July 13, 1979)
22. Missouri Department of Consumer Affairs, Regulations and Licensing
23. New Hampshire Department of Health and Welfare
24. New Mexico Office of the Attorney General

25. Citizens Action Bureau, Office of the Supervisor, East Islip, N.Y.
26. James Hunt, Jr., Governor of North Carolina
27. George Nigh, Governor of Oklahoma
28. Victor Atiyeh, Governor of Oregon
29. Consumer and Corporate Affairs Canada, Marketing Practices Branch, Ottawa, Ontario
30. Kansas Office of the Attorney General
31. American Samoa Government Office of the Attorney General
32. William Janklow, Governor of South Dakota
33. South Dakota Department of Commerce and Consumer Affairs
34. Office of the Speaker of the Tennessee House of Representatives
35. Texas Office of the Attorney General
36. Utah Department of Business Regulation, Consumer Affairs Division
37. Juan Luis, Governor of the Virgin Islands
38. Florida Department of Professional and Occupational Regulation
39. Virginia Secretary of Human Resources
40. Dixy Lee Ray, Governor of Washington
41. John Rockefeller, IV, Governor of West Virginia
42. Fred Risser, President Pro Tempore, Wisconsin State Senate
43. North Carolina Department of Justice
44. Pasco County, Florida, Public Service Department
45. Samuel Bogley, Lt. Governor of Maryland
46. Jose E. Serrano, Assemblyman, South Bronx, N.Y.
47. Bobby Crim, Speaker of the House of Representatives, Michigan
48. James Thompson, Governor of Illinois

49. Maryland Department of Health and Mental Hygiene

50. Wyoming Office of the Attorney General

51. Texas Office of the Government, Budget Planning Office

52. Charles Thone, Governor of Nebraska (September 17, 1979)

53. George Deukmejian, Attorney General of California

*U.S. GOVERNMENT PRINTING OFFICE : 1980 0-629-757/6008