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Federal Trade Commission

Staff Report on

ADVERTISING of

OPHTHALMIC GOODS and SERVICES

and Proposed Trade Regulation Rule

(16 CFR Part 456)

Bureau of Consumer Protection

May 1977

UNITED STATES GOVERNMENT

Memorandum

TO : Commission

FROM : Margery Waxman Smith
Acting Director *MWS*
Bureau of Consumer Protection

SUBJECT: Staff Report on the Proposed Trade Regulation
Rule Regarding Advertising of Ophthalmic Goods
and Services

DATE: May 20, 1977

I fully support the recommendations of staff as to the private restraints and release of prescriptions sections of the rule. In my opinion the record supports a finding that it is unfair to consumers for private associations to restrict the advertising of prescription eyeglasses and that the release of prescriptions is necessary to permit consumers to take advantage of a competitive market. I believe the record also supports a finding that government prohibitions on the dissemination of information regarding ophthalmic goods and services are unfair. However, staff would not only eliminate those state laws and regulations that explicitly ban advertising but would also circumscribe state efforts to impose affirmative disclosure requirements on advertising.

Although state disclosure requirements could, if sufficiently costly and burdensome, effectively bar the advertising of ophthalmic goods and services, I believe the record does not support a finding that a significant number of states have already taken such action or will do so in the future. Given the potential benefits to consumers of the elimination of advertising bans and the Supreme Court's recognition of a First Amendment interest in access to truthful commercial information, I do not think the Commission can accurately predict at this time the reaction of the states to the elimination of prohibitions on advertising. To the extent a prediction can be made, we should expect the states to comply with the Commission's rule.

Even assuming staff is correct in anticipating action by some states to contravene the spirit of the Supreme Court and the FTC rule, I am not convinced that staff has identified the only instances in which consumer benefits outweigh the potentially chilling effects of a disclosure requirement. States should be allowed to retain considerable flexibility in prescribing what disclosures would be most in the public interest. Moreover, in determining whether a particular disclosure scheme has the effect of frustrating advertising, the cumulative effect of the imposed disclosures is likely to be more important than the merits of particular requirements.



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It is my recommendation that the Commission act at this time only to eliminate explicit bans on advertising and that it reserve a decision on the effect of state disclosure requirements until it has the opportunity to observe state response to the rule.

ADVERTISING OF
OPHTHALMIC GOODS AND SERVICES

Final Report to the Federal Trade Commission
and Recommended Trade Regulation Rule
(16 CFR Part 456)

BUREAU OF CONSUMER PROTECTION

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

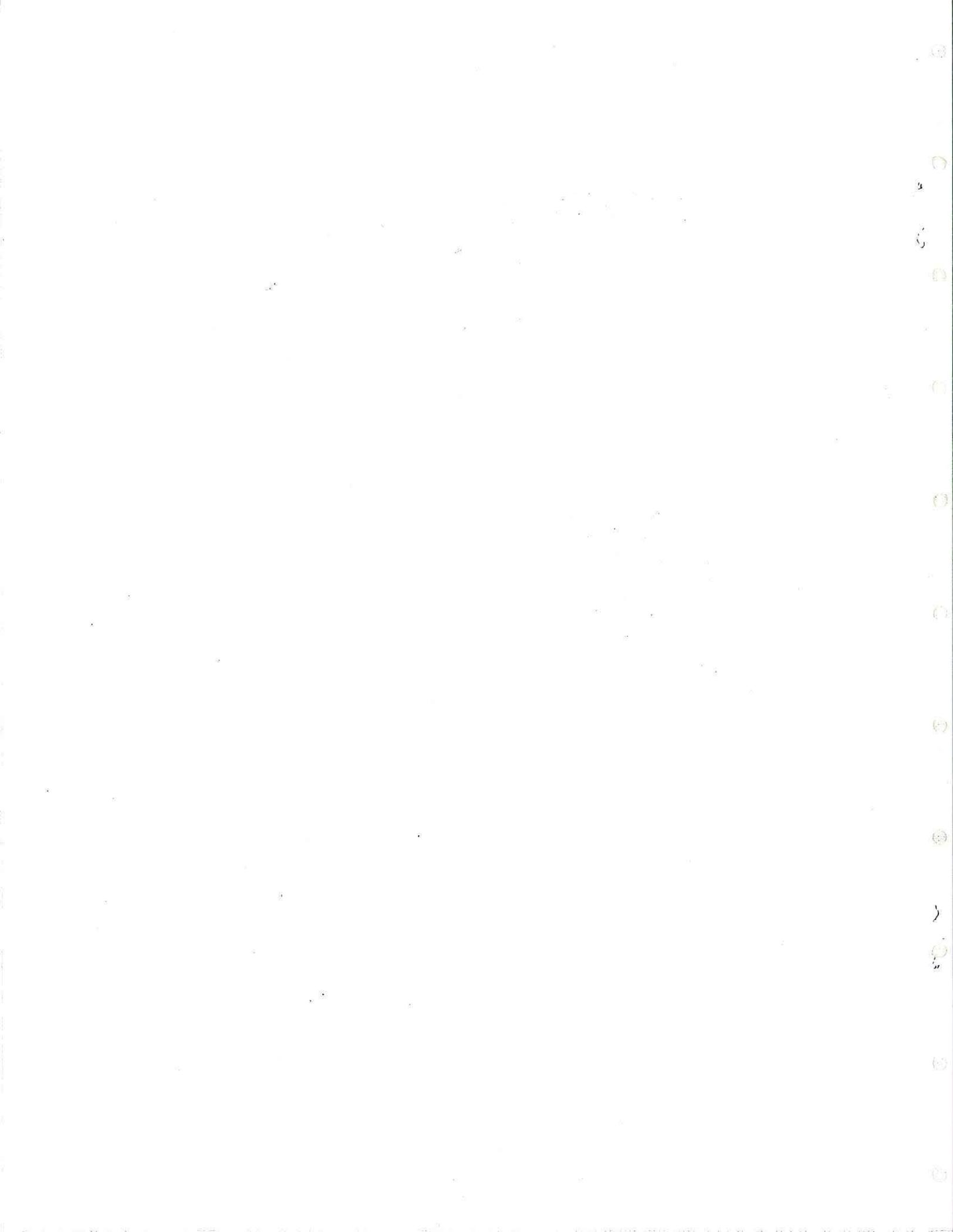


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Introduction

Pursuant to Section 1.13(g) of the Commission's Rules of Practice, the Bureau of Consumer Protection has prepared this Staff Report containing the Bureau's analysis of the evidentiary record and recommendations for a final trade regulation rule.

This proceeding was commenced at the direction of the Commission on September 16, 1975, as an inquiry into the adequacy of information disclosure in the retail ophthalmic market. In the course of its investigation the staff made a comprehensive survey of the state occupational licensing laws, rules and regulations, and private associational codes of practice governing those practitioners who dispense prescription eyeglasses. The staff also solicited information and views from various interested persons: members of the industry, state occupational licensing boards, other state officials, state and national professional associations, and consumer groups.

On January 16, 1976, the Commission issued a proposed trade regulation rule which would eliminate restraints placed by states and private associations on the dissemination of information concerning ophthalmic goods and services, and would permit sellers of prescription eyewear to advertise if they so desired. 1 / In addition, the Commission indicated in the proposed rule that it might require ophthalmologists and optometrists to deliver to their patients copies of the patients' ophthalmic prescriptions, if the evidence indicated that consumers were being prevented from price shopping because of the unavailability of their prescriptions.

A detailed chronology of this proceeding is contained in the report of the Presiding Officer released on January 27, 1977. 2 / Staff will amplify on a few important aspects of this proceeding.

1 / See 41 Fed. Reg. 2399 (Jan. 16, 1976).

2 / See 42 Fed. Reg. 5075 (Jan. 27, 1977).

Federal-State Relations

Because the proposed rule would result in a preemption of state law, special efforts were made to maximize the awareness and participation of state officials in this proceeding. After issuance of the proposed rule, staff mailed individual letters to the governor, attorney general, presiding officials of each chamber of the state legislature, and the appropriate state licensing boards of each of the states. Included in the letter as attachments were the text of the proposed rule and the accompanying staff report. A copy of the letter used to notify these state officials is attached as Appendix A to this report.

After the sites for the public hearings were published in the Federal Register, 3/ each of the aforementioned state officials was mailed a copy of the Federal Register announcement.

A large number of state officials chose to participate in this proceeding. Written comments were received from numerous state officials. Similarly, many appeared at the public hearings held in this matter. Five attorneys general or their representatives, four state legislators, seven representatives of state licensing boards, and 12 other state and local governmental officials appeared at the various public hearings.

Finally, staff mailed copies of the Presiding Officer's report to the governor and attorney general of each state. Similarly, copies of this staff report will be transmitted to the governors and attorneys general, as well as to the appropriate state licensing boards.

Public Hearings

Public hearings were held in five different locations: Washington, D.C. (June 7 - June 10, September 8-9); Cleveland, Ohio (June 21 - June 29); New York City (July 19 - July 23); San Francisco, California (July 26 - August 2); and Dallas, Texas (August 9 - August 18).

3/ See 41 Fed. Reg. 14194 (April 2, 1976).

The public hearings were held on a total of 32 days in the five hearing locations. The transcript of the hearings fills over 6500 pages. Including persons who accompanied scheduled witnesses and responded to questions, more than 190 witnesses were heard. In addition to the 31 state and local governmental spokesmen, each of the retail practitioner groups was also represented. Forty-seven optometrists testified in their personal capacity, or as the representative of a state board or state association. Two of these optometrists are educators on the faculties of colleges of optometry; two are deans of such institutions. Nineteen state optometric associations offered testimony, usually through a member optometrist or their legal counsel. Opticians were also well-represented among those testifying; 24 opticians testified, and eight state optician's associations were represented. Ophthalmology was the least represented profession; four ophthalmologists testified in these proceedings.

Finally, 16 of the witnesses were economists, marketing experts, or other members of the academic community. While 11 consumer groups offered testimony, participation by individual consumers was predominantly through written submissions. Only three individual consumers testified at the public hearings; written comments were received from over 1,000 consumers.

Staff's Recommendations

Based on its analysis of the evidentiary record, staff has recommended that the Commission promulgate a trade regulation rule which would allow the advertising of ophthalmic goods and services. The Rule recommended by the staff contains three major provisions:

- (1) private restraints (e.g. the codes of ethics of professional associations) on the advertising of price and other information concerning the sale of prescription eyewear would be eliminated;
- (2) public restraints (e.g. state and local laws and regulations) on the advertising of accurate information, including price information, concerning the sale of prescription eyewear would be preempted. However, state laws which set standards for all consumer product advertisements or require affirmative disclosures in all advertising would not be preempted. In addition, the states would remain free to impose disclosure requirements on ophthalmic advertising in certain limited areas specified in the Rule; and

(3) ophthalmologists and optometrists would be required to deliver to their patients copies of their ophthalmic prescriptions. The charging of extra fees or the use of waivers or disclaimer forms would be prohibited. In addition, ophthalmologists and optometrists would be prohibited from conditioning the availability of eye examinations on prior agreement by the prospective patient that ophthalmic goods will be purchased from the examining practitioner.

The text of the recommended Rule is found in Section X of this report. A detailed section-by-section analysis of the recommended Rule is contained in Section XI. The recommended Rule contains numerous revisions from the originally proposed rule.

The first major revision concerns the scope of the preemptive effect of the Rule. The recommended Rule would not preempt state or local laws which apply standards for advertising, or require affirmative disclosures in advertising, where those laws apply to the advertising of all consumer products. The recommended Rule would also permit the states to impose certain limited disclosures on the advertising of prescription eyewear.

The second major revision concerns the delivery of prescriptions to consumers. The proposed rule stated that the Commission might require such a provision if the evidence indicated that consumers were being denied their prescriptions, thereby limiting their ability to comparison shop. Staff has recommended a Rule which would require practitioners to deliver to their patients copies of their prescriptions. The Rule would not permit the practitioner to charge an extra fee for releasing the prescription, nor would it permit practitioners to condition the release of those prescriptions on the execution of a waiver or disclaimer of liability form. Finally, this provision would prohibit ophthalmologists and optometrists from conditioning the availability of their examination services on a requirement that the prospective patient agree to purchase ophthalmic goods from the examining practitioner.

In drafting the recommended Rule, staff has endeavored to make the Rule more "readable." The proposed rule contained several long lists of nearly synonymous words, such as "prohibiting, hindering, restricting, reducing, burdening, altering, limiting, changing or impairing." It is staff's belief that the use of such "laundry lists" makes the Rule unnecessarily difficult to read. To that end, staff has deleted those terms which are subsumed by the terms which were

retained. In addition, the definitions in the recommended Rule have been rewritten in complete sentence form to facilitate their understanding.

The Staff Report

The Staff Report contains the staff's analysis of the evidentiary record in this trade regulation rulemaking proceeding. In the report, staff has endeavored to address each major issue which has been raised in this proceeding. As appropriate in each section, staff has taken into account the presiding officer's findings of fact as required by Section 1.13(g) of the Commission's rules.

In section I, staff provides a description of the ophthalmic industry at each of the three levels of distribution. Also included in this section is a description of the roles and functions of the three retail providers of prescription eyewear: ophthalmologists, optometrists and opticians.

In section II, staff discusses the laws, regulations, and private restrictions on ophthalmic advertising. Price advertising of ophthalmic goods and services is totally prohibited in 19 of the states. In 26 others, ophthalmic advertising is restricted to some degree. In the six remaining jurisdictions, there are no legal restraints on advertising, although there are private restraints imposed by state professional associations. Also catalogued in section II are some of the laws and regulations which prohibit other commercial practices in the ophthalmic market.

Section III discusses the economic impact of the prohibitions on ophthalmic advertising. In this section, staff concludes that prices for similar ophthalmic goods vary substantially, often as much as 200% to 300%. Coupled with the finding that consumers are unaware of these price variations because of the dearth of information in the market engendered by the advertising restrictions, staff concludes that significant consumer loss is occurring because consumers are unaware of lower-cost purchase alternatives. The evidence discussed in this section also demonstrates that prices in states which restrict advertising are significantly higher than in non-restrictive jurisdictions.

In section IV, staff elaborates further on the impact of advertising bans on consumers. This section discusses the available evidence on consumer use of prescription eyewear. The evidence shows that in excess of 50% of the United States

population uses corrective eyewear. The evidence also demonstrates that the poor, and those in minority groups, are not able to purchase eyeglasses as frequently as their more affluent or non-minority counterparts.

In this section staff also examines the impact of the advertising bans on the level of consumer awareness. The evidence demonstrates that the lack of information in the ophthalmic market has severely handicapped the public's ability to make rational purchase decisions. Many consumers harbor serious misconceptions about the three practitioner groups; often they are unable to distinguish the different functions performed by each of the three professions. The available evidence indicates that increased advertising will serve to enhance consumers' ability to make ophthalmic purchase decisions.

Section V of the report examines the justifications offered in support of the advertising bans. In the first portion of this section staff discusses the argument that the advertising bans are needed to insure against deceptive advertising. The question of whether there is a need for affirmative disclosures in ophthalmic advertising to protect against deception is also examined. Staff concludes that the existing advertising bans are not necessary to prevent deception. False and deceptive advertising is currently illegal in virtually every jurisdiction. However, staff also concludes that the states should be permitted to impose affirmative disclosure requirements in certain limited circumstances to prevent deception.

In section V(B), the issue of "professionalism" is addressed. Many practitioners contended that advertising bans are necessary to maintain the high professional standards of the professions. Staff concludes in this section that no correlation exists between professional conduct and the existence of advertising restrictions.

Finally, in section V(C) staff addresses the potential for advertising to cause a decline in the quality of ophthalmic goods and services. In this section staff concludes that the evidence does not support such an assumption. The evidence demonstrates that there is no direct correlation between the cost and quality of retail ophthalmic goods. Moreover, to the extent that the states are concerned about maintaining the quality of ophthalmic goods and services, direct remedies such

as mandatory quality standards and minimum examination requirements are available. Staff concludes that advertising bans bear no relationship to the quality of eye care products and services.

In section VI, staff provides a legal analysis of the Commission's authority to promulgate the Rule recommended by the staff. Contained in this section is a discussion of the Commission's "unfairness" authority. In conjunction with the preemption of state law, staff believes that two standards must be satisfied. First, the offending practice, in this instance the failure to disseminate information in order to conform to state law, must be shown to result in substantial injury to the public. Based on the findings that consumers in states which have advertising bans pay considerably higher prices, and are able to purchase necessary eye care less frequently, staff concludes that this test is satisfied. Second, it must be shown that the state law or regulation is not vital to achieve an important state policy goal. Again, staff concludes that this test is satisfied. In previous sections staff noted that the advertising bans do not preserve quality or professional standards. Moreover, the prevention of deception in advertising does not warrant the imposition of total advertising bans.

Staff also discusses those state laws which permit advertising but require affirmative disclosures. Staff notes that if advertising is burdened with unnecessary disclosures, advertising may be deterred. At the same time, certain limited disclosures may, in fact, deter deception while at the same time not discourage advertising. Accordingly, staff recommends in this section that the Commission preempt state laws which require disclosures other than those permitted by the recommended Rule.

In section VII, the evidence concerning the release of ophthalmic prescriptions is analyzed. The evidence shows that consumers are frequently being denied their prescriptions through a number of devices: the outright refusal by some optometrists and ophthalmologists to release prescriptions; the charging of additional fees for their release; the use of waivers or disclaimers of liability by practitioners as "scare" tactics, and other practices. Both the prevalence and the impact of these practices are discussed in this section.

The potential impact of staff's recommendation on small businesses is noted in section VIII. The recommended Rule may

have conflicting impacts. The requirement that consumers be provided with their prescriptions would increase competition in the ophthalmic dispensing market, and open a portion of the market to small business opticians which has previously been closed to them. With the adoption of this requirement, opticians would be able to compete for the patronage of every eyeglass consumer.

With respect to the impact of advertising on small businesses, there appears to be no clear resolution. In states where advertising is permitted, small businessmen have not been driven from the market by the larger firms. However, the evidence suggests that the ability to advertise may stimulate some increased concentration and vertical integration in the retail ophthalmic market. On the other hand, staff notes in this section that the professional groups in this market exhibit many of the anticompetitive tendencies normally associated with oligopoly control.

In section IX, staff discusses the various suggestions which have been advanced to expand the scope of the rule. The suggested additions include proposals for permitting the advertising of examination fees, mandatory posting of prices, mandatory disclosure of price information over the telephone, and required itemization of vision care bills. While agreeing with the intent behind these suggestions, staff has rejected each of them for the reasons provided in this discussion.

Access to the Record

In addition to releasing this report, the Bureau of Consumer Protection has taken two additional steps to facilitate public comment on the recommended Rule. First, staff will release a topical index of the record. Approximately 200 topic codes were prepared addressing the major issues in this proceeding. The evidence on the record was then indexed according to those topics. Accordingly, the computer printouts of the index will enable the public to ascertain the evidence relevant to any given proposition.

Staff will place on the record a memorandum explaining in detail the uses and limitations of this index. It is important to note that this index is a tool for gaining access to the record; it is not a substitute for the record or the reports of the staff and presiding officer. The Commission

has not reviewed the index and cannot warrant its accuracy or comprehensiveness. Staff will also release two separate indexes of the witnesses who appeared at the public hearings held in this matter. The first of these indexes is chronological, and includes the affiliation of the witness; the second lists the witnesses in alphabetical order.

In addition, the entire public record in this proceeding has been microfilmed. Microfilm copies of the record are available from the Public Reference Branch, Federal Trade Commission, Room 130, 6th Street and Pennsylvania Avenue, N.W., Washington, D.C., 20580, upon payment of the fees specified in Section 4.8 of the Commission's rules.

Brief mention should be made of the citation form used in this report. References to documents in the record include the author, title, publication information, public record exhibit number (e.g. "Exhibit II-1"), and the record page number within the exhibit which supports the text (e.g., "at R. 12345"). Citations to witnesses' testimony at the public hearings in this proceeding include the name and affiliation of the witness, the transcript page at which his testimony begins, and the specific transcript page which supports the text (e.g., "Tr. 2000 at 2020"). Documents cited which are not on the record include all of the relevant bibliographical information, and citation to the document page number (e.g., at pp. 1-2). Finally, references to Hearing Exhibits are identified as HX _____; record page numbers are not included because the hearing exhibits are not paginated. Physical exhibits in the record are also unpaginated.

Conclusion

It is the staff's conclusion and recommendation that the Commission should act to free the channels of communication in the retail ophthalmic market. Consumers are being significantly injured by public and private restraints on the dissemination of accurate information concerning the price and availability of ophthalmic goods and services. The justifications offered in support of these restrictions do not withstand close scrutiny. Staff further recommends that the Commission guarantee consumers

access to their ophthalmic prescriptions. Without the ability to select the seller of their choice, consumers will be unable to effectively use the information provided through advertising.

Respectfully submitted

Terry S. Latanich, Attorney
Ann Stahl Guler, Research Analyst
Rachel Shao, Attorney

APPROVED:

James V. DeLong
Assistant Director
for Special Projects

Margery Waxman Smith*
Acting Director
Bureau of Consumer Protection

The staff wishes to acknowledge the substantial participation in earlier stages of this proceeding of Robert G. Badal, formerly a staff attorney in the Division of Special Projects. In addition, staff wishes to recognize the important contributions of the regional office personnel who organized the regional hearings and served as Commission co-counsel at those hearings: Sharon Devine and Willie Greene in Cleveland, Sandra Bird and Judith Braun in New York, Alfred Lindeman and Jerome Steiner in San Francisco, and John Smith and Joseph Hickman in Dallas. Finally, we wish to thank Jerry Cowden, Christine Latsey, Nancy Martin, Cynthia Hill, Pat Smith, Maurice Schoby, Shirley Jones, and the personnel in the Bureau's Word Processing Center for their assistance in preparing this report.

* See attached cover memorandum.

I. Industry Background

The ophthalmic industry consists of three levels in the production/distribution chain: (1) manufacturers of frames and lenses; (2) wholesale laboratories which distribute the manufactured goods and fabricate completed eyeglasses; and (3) retailers, including ophthalmologists, optometrists, and opticians, who dispense the finished product to the ultimate consumer. Vertical integration within the industry, however, often blurs these sharp functional divisions. Large manufacturers have integrated forward into wholesale distribution and fabrication through numerous branch laboratories, while some retail optical outlets have integrated backward into the ownership of their own laboratories. In this section, we will describe these three components and their respective functions in the delivery of corrective eyewear to the consuming public.

A. Manufacturers

About 46 manufacturing firms produce most of the domestic output of ophthalmic goods, which include eyeglass lenses, contact lenses, frames, and accessories (such as eyeglass cases and cleaning solutions).¹ The six largest firms accounted for approximately 85% of recent annual domestic manufacturer sales of \$550 million.² Two of those firms together account for one-half of total ophthalmic goods sales: American Optical Corporation, a division of Warner-Lambert Company, with a 30% share; and Bausch & Lomb, Inc., with 20%.³

In the manufacture of lenses, American Optical and Bausch & Lomb control about 80% of the domestic market.⁴ The remaining segment is split among approximately 43 other companies.⁵ In

¹ Alternative Reimbursement Approaches for Eyeglasses and Implications for Medicaid Policy, prepared for Medical Services Administration, Social and Rehabilitation Service, U.S. Dept. of Health, Education and Welfare, by National Institute for Advanced Studies (Washington, D.C., May 1977), at p. 14.

² Id. The six major manufacturers are American Optical Corp.; Bausch & Lomb, Inc.; Shuron Continental, a division of Textron, Inc.; Itek Corporation; Titmus Optical, Inc.; and Vision-Ease, a division of Buckbee-Mears Co. Id. at 15.

³ Id. at 14.

⁴ Steve Collins, "Optical Firms Look to Rosier Future," The Commercial and Financial Chronicle, Vol. 219, No. 7445 (Nov. 18, 1974), Exhibit II-6, at R. 230.

⁵ Id.

1975, manufacturers sold an estimated 52.6 million pairs of corrective lenses (excluding contact lenses) for domestic civilian consumption.⁶ The total value of eyeglass and contact lenses sold by domestic manufacturers in 1974 was \$217.4 million.⁷ Imported lenses accounted for approximately 15% of lenses sold in the United States in 1974.⁸

Manufacturers convert glass and plastic raw materials into two categories of lenses: finished and semi-finished. Finished lenses are ground by the manufacturer to specific refractive powers on both the front and back surfaces. They are ready to be dispensed to the ultimate consumer after the edges have been ground by an optical laboratory to fit into specific frames.⁹ To produce semi-finished lenses, the manufacturer grinds the curvature of only one lens surface. The other surface must be custom-ground by the laboratory to produce the required lens power.¹⁰

The majority of lenses produced by manufacturers are finished.¹¹ Most single-vision lenses, or those which are used for seeing at one distance, are manufactured as finished lenses.¹² Multifocal lenses, which include refractive powers for seeing

⁶ 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. 1958.

⁷ U.S. Bureau of the Census, Annual Survey of Manufacturers, 1974: Value of Product Shipments (October 1976), at p. 32.

⁸ Statement of Eugene A. Keeney, Executive Vice President, Optical Manufacturers Association, before International Trade Commission (May 7, 1975), exhibit to letter from Steven John Fellman, Attorney, Optical Manufacturers Association, to FTC (November 1975), Exhibit V-51, at R. 11417.

⁹ Jesse Rosenthal, O.D., and William C. Folsom, Jr., O.D., "Standards of Eyeglasses," Medical Care, Vol. XI, No. 3 (May-June 1973), Exhibit VI-11, at R. 12059. See also testimony of Donald Juhl, President, Jack Eckerd Corp., Tr. 379 at 380.

¹⁰ Id.

¹¹ "Standards of Eyeglasses," supra note 9.

¹² See, e.g., Director of Investigation and Research, Canadian Department of Consumer and Corporate Affairs, Material Collected for Submission to the Restrictive Trade Practices

(Continued)

at two (bifocal) or three (trifocal) distance ranges, are usually manufactured as semi-finished lenses.¹³ In other words, single-vision lenses may be economically finished at the manufacturing level because the prescriptions for them often are relatively simple and fall into predictable and commonly required ranges.¹⁴ Multifocal and other types of lenses, on the other hand, are usually manufactured in the semi-finished form because their greater complexity and the larger number of possible refractive combinations involved make it more economical for optical laboratories to complete the finishing process.¹⁵

Most of the major lens manufacturers also produce eyeglass frames.¹⁶ Although many smaller firms which specialize in frames production share in the market,¹⁷ American Optical and Bausch & Lomb dominate in the frames industry as they do in the lens segment.¹⁸ The value of shipments of frames produced by domestic firms in 1974 was \$168.7 million.¹⁹ Imported frames accounted for 45% of the U.S. market in 1974.²⁰

12 (Continued)

Commission in the course of an Inquiry under Section 47 of the Combines Investigation Act relating to the Production, Supply, Distribution and Sale of Ophthalmic Goods in Canada, Ottawa-Hull (July 1975), Exhibit II-33, at R. 871-72; and Hans S. Hirschhorn, Your Future as an Optician, (New York: Richards Rosen Press, Inc., 1970), at p. 30.

13 Id.

14 Id.; letter from Keith E. West, Executive Vice President, Benson Optical Co., Inc., to FTC (Mar. 18, 1976), Exhibit VI-60, at R. 12588-89; letter from Robert C. Morrow, President, Walman Optical Co., to FTC (Mar. 16, 1976), Exhibit VI-60, at R. 12607.

15 Id.

16 See, e.g., "Foresight Saga," Barron's (June 8, 1970), Exhibit II-3, at R. 214; Steve Collins, supra note 4, at 229.

17 See, e.g., Frames, catalogue published by Zulch and Zulch, Inc., Sylmar, California (June 1975), Exhibit V-15.

18 Steve Collins, supra note 4, at 229.

19 U.S. Bureau of the Census, supra note 7.

20 Statement of Eugene A. Keeney, supra note 8.

B. Wholesale Laboratories

Wholesale laboratories purchase finished and semi-finished lenses and frames from manufacturers for distribution to the three classes of optical retailers. For some retail customers, they perform the usual wholesaling function of supplying finished lenses and frames for final fabrication at the retail level. The major portion of their business, however, consists of filling retailers' orders for fully fabricated eyeglasses. For lenses which are purchased from manufacturers in finished form, the laboratories need only to grind the edges of the lenses and place them in the frames according to the retail practitioner's specifications. Semi-finished lenses are ground on the blank sides to specific refractive powers by the laboratories.²¹

The grinding of prescription powers is highly automated in modern laboratories, where machinery has eliminated subjective judgment and hand craftsmanship.²² The "benchwork" during which completed eyeglasses are fabricated, however, consists of both automated and manual processes.²³ While the shaping and cutting of lenses to conform to frame specifications may be done by machines,²⁴ the measuring and centering of the lenses in the frame in accordance with prescription specifications is done by skilled technicians who exercise some degree of subjective judgment.²⁵

There are about 500 optical wholesale firms, many of which operate laboratories at numerous separate locations.²⁶ American

21 See, e.g., letter from Irby N. Hollans, Jr., Executive Director, Optical Wholesalers Association, to FTC (Oct. 21, 1975), Exhibit V-52, at R. 11492; and Hans S. Hirschhorn, supra note 12, at 30-32.

22 See, e.g., testimony of Roy Marks, Executive Director, California Optical Laboratory Association, Tr. 3778 at 3809-10.

23 Id.

24 Hans S. Hirschhorn, supra note 12, at 31-32.

25 Id.; testimony of Roy Marks, supra note 22; letter from Robert C. Morrow, President, Walman Optical Co., to FTC (Mar. 16, 1976), Exhibit VI-60, which contains a detailed description of laboratory functions at R. 12608-10.

26 Alternative Reimbursement Approaches for Eyeglasses, supra note 1, at 19.

Optical and Bausch & Lomb are major laboratory owners,²⁷ and 10 other large diversified firms account for approximately 500 separate laboratories.²⁸ Additionally, eight independent wholesalers each have five or more separate locations.²⁹ Many retail opticians have integrated backward into the laboratory business; 300 own their own laboratories.³⁰

C. Retailers

The delivery of eye care goods and services to the ultimate consumer is divided among the three classes of practitioners: ophthalmologists, optometrists, and opticians. Ophthalmologists and optometrists examine the eyes and prescribe and dispense eyeglasses; opticians engage only in the dispensing of eyeglasses.

1. Ophthalmologists

Ophthalmology is a medical specialty practiced by licensed physicians and osteopaths.³¹ Ophthalmologists diagnose and treat all conditions relating to the eyes, including diseases and visual anomalies.³² They may perform surgery, prescribe

27 Id. American Optical operates 229 laboratories; Bausch & Lomb owns 149.

28 Id.

29 Id.

30 Id.

31 Approximately 2% of ophthalmologists are Doctors of Osteopathy. U.S. Dept. of Health, Education and Welfare, Ophthalmology Manpower: A General Profile, United States - 1968, Publication No. (HSM) 73-1800, Series 14, #5 (December 1972), Exhibit II-11, at R. 276.

32 In addition to eye diseases, ophthalmologists also examine the eyes for symptoms of diseases elsewhere in the body. Diseases whose symptoms may appear in the eyes include diabetes, high blood pressure, arteriosclerosis, brain tumor, multiple sclerosis, and kidney disease. American Association of Ophthalmology, "What Is An Ophthalmologist?" (1965), HX 281, Attachment 5.

drugs or lenses, or employ other medical treatments to remedy these pathological or visual conditions.³³ The educational requirements for ophthalmologists include the basic training of all physicians (four years of undergraduate study, plus four years of medical school and one year of general medical internship). In order to be certified by the American Board of Ophthalmology as a specialist in that field, physicians must complete an additional three years of hospital residency training in ophthalmology, for a total of 12 years of study after high school.³⁴

33 National Center for Health Statistics, Health Resources Statistics, U.S. Dept. of Health, Education and Welfare (1974), Exhibit II-18, at R. 636. The American Association of Ophthalmology's definition of the specialty reads, in part, as follows:

An ophthalmologist (eye physician, oculist, eye doctor) is a medical doctor who specializes in the total care of the eyes. He is the only practitioner medically trained and qualified to diagnose and treat all eye and visual system problems as well as general diseases of the body.

The eye is affected by disease and general health of the rest of the body; hence the ophthalmologist diagnoses and treats eye problems as part of total medical and health care. His treatment may consist of eye-glasses or contact lenses, when necessary, orthoptic training, medications, surgery, or any other required scientific therapy.

Reprinted in Better Vision Institute, Inc., "Facts You Should Know About Your Vision," Advertising Supplement to The New York Times (Jan. 9, 1977), at p. 2

34 American Association of Ophthalmology, supra note 32. According to a 1973 report, 75% of ophthalmologists were board-certified. Robert J. Havighurst, Study Director, Optometry: Education for the Profession, National Commission on Accrediting (Washington, D.C., 1973), Exhibit II-20, at R. 682.

Approximately 10,820 ophthalmologists were in active practice in 1975.³⁵ They performed an estimated 22.5 million eye examinations in that year, or about 43% of all eye examinations.³⁶ According to a recent study, ophthalmologists dispense, either directly or through employees, approximately 10% of all corrective lenses purchased by consumers.³⁷ Estimates of the proportion of ophthalmologists who dispense eyeglasses range from 40%³⁸ to 50%.³⁹ Consumers spent an estimated \$1.25 billion in 1975 for services and ophthalmic goods furnished by ophthalmologists.⁴⁰

2. Optometrists

Optometrists are state-licensed practitioners who specialize in problems of human vision.⁴¹ They examine the eyes to determine the presence of visual, muscular, neurological, or other abnormalities which affect the patient's ability to see.⁴²

³⁵ Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1965.

³⁶ Id. at 1967.

³⁷ Id. Of a total of 44.9 million corrective lens pairs sold at retail in 1975, 4.2 million pairs of eyeglass lenses and 0.4 million pairs of contact lenses were dispensed in ophthalmologists' offices by ophthalmologists themselves and by optometrists, opticians, and technicians in their employ. These figures do not include an indeterminate number of lenses dispensed by opticians whose outlets are owned or controlled by ophthalmologists.

³⁸ See, e.g., letter from Lawrence A. Zupan, Executive Secretary, American Association of Ophthalmology, to FTC (Oct. 21, 1975), Exhibit IV-52, at R. 2494; Dispensing of Eyeglasses by Physicians: Hearings Before the Subcommittee on Antitrust and Monopoly of the Senate Committee on the Judiciary, 89th Cong., 1st Sess. (1965) (statement of Dr. Ralph W. Ryan, National Medical Foundation for Eye Care), Exhibit II-26, at R. 763-64.

³⁹ See, e.g., testimony of J. Harold Bailey, Executive Director, American Optometric Association, Tr. 5905 at 5916.

⁴⁰ Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1950.

⁴¹ Health Resources Statistics, supra note 33.

⁴² Id.

Optometrists prescribe and adapt lenses or other optical aids and may use visual training aids to preserve or restore maximum visual efficiency.⁴³ Optometrists are also trained and qualified under state law to detect certain diseases of the eye;⁴⁴ they do not, however, make definitive diagnoses of or treat eye diseases, perform surgery, or prescribe drugs for patient use.⁴⁵ When evidence of eye disease is detected, optometrists refer patients to ophthalmologists or other medical specialists for diagnosis and treatment. Optometrists in 11 states are permitted by state law to use drugs for diagnostic purposes; in one state, they may employ drugs for therapeutic uses as well.⁴⁶ The American Optometric

43 Id.

44: According to the Association of Schools and Colleges of Optometrists, optometrists may, for example, "detect diabetes, hypertension, arteriosclerosis and other diseases of the body as well as primary ocular conditions such as glaucoma and cataract, that require referral to other health care practitioners for treatment." Synopsis of Education for the Health Professions, Committee of Presidents of the Health Professions Educational Associations of the Association for Academic Health Centers (Washington, D.C.), at p. 26.

45 Health Resources Statistics, supra note 33.

46 The following states, as of April 1, 1977, had laws specifically authorizing the use of pharmaceutical agents by optometrists for diagnostic purposes: California, Delaware, Louisiana, Maine, New Mexico, Oregon, Pennsylvania, Rhode Island, Tennessee, West Virginia, and Wyoming. West Virginia permits optometrists to use drugs for both diagnostic and therapeutic purposes. American Optometric Association News, Vol. 16, No. 7 (April 1, 1977), at p. 7.

In six additional states, either no explicit prohibitions on the use of drugs by optometrists exist, or attorneys general have issued opinions indicating that drugs may be used: Florida, Idaho, Indiana, Kansas, Minnesota, and New Jersey. American Optometric Association, Bulletin from Office of Counsel, Vol. XXXV, Bulletin No. 52 (Jan. 31, 1977), at p. 8.

Association has defined the functions and qualifications of the profession as follows:

A Doctor of Optometry (O.D.) is a primary provider of vital health care services who examines, diagnoses and prescribes specific treatment for conditions of the vision system. He or she examines eyes and related structures to determine the presence of vision problems, diseases or other abnormalities, utilizing drugs for diagnostic purposes when permitted by state law. By thoroughly evaluating the internal and external structure of the eyes, the optometrist can detect systemic and eye diseases that require referral of the patient to other health care practitioners.

The optometrist treats by prescribing and adapting spectacle lenses, contact lenses or other optical aids and uses visual training/vision therapy to preserve or restore maximum efficiency of vision.⁴⁷

Optometrists' educational background consists of two to four years of college undergraduate work, and four additional years of specialized training at one of the nation's 12 accredited colleges of optometry.⁴⁸

Optometrists outnumber ophthalmologists almost two-to-one; an estimated 20,025 optometrists were in active practice in 1975.⁴⁹ Nearly 85% are self-employed or in professional corporation practice.⁵⁰ Three-quarters of those are sole proprietors, with the remainder in partnership, group, or professional corporation practice.⁵¹ The 15% of optometrists who are employed by others work primarily for other optometrists.⁵² Most of the others are employed by ophthalmologists and other medical doctors,

47 Better Vision Institute, Inc., supra note 33.

48 Id.

49 Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1964.

50 Id.

51 Id.

52 Id.

firms such as retail optical outlets, the military and civilian government agencies, and non-profit organizations.⁵³

Optometrists are the major retail providers of eye care goods and services in the United States. They performed approximately 29 million eye examinations in 1975, or 57% of the total performed by ophthalmologists and optometrists combined.⁵⁴ Optometrists and their employees dispensed 20.4 million pairs of eyeglass lenses and 1.7 million pairs of contact lenses, or 49% of the total corrective lenses sold at retail in 1975.⁵⁵ Approximately 75% of all optometrists dispense eyeglasses, and 65% provide contact lenses.⁵⁶

Consumers paid optometrists an estimated \$1.75 billion in 1975 for eye examinations, lenses, and frames.⁵⁷ A majority of optometrists charge their patients the laboratory cost of ophthalmic goods, without a markup; they derive their income from fees for examination and dispensing services.⁵⁸ Although the average

53 Id.

54 Id. at 1967.

55 Id. The totals represent the numbers of lens pairs dispensed in optometrists' offices by optometrists themselves and by opticians and others in their employ. Not included are 0.6 million lens pairs dispensed by optometrists in noncommercial establishments such as hospitals, clinics, and military installations.

56 David V. Shaver, "Opticianry, Optometry, and Ophthalmology: An Overview," Medical Care, Vol. XII, No. 9 (September 1974), Exhibit II-21, at R. 708.

57 Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1949.

58 See, e.g., "1st Annual Practice Management Survey," Optical Journal and Review of Optometry, Vol. 113, No. 2 (Feb. 15, 1976), Exhibit VI-44, at R. 12547; testimony of James W. Clark, Jr., Executive Director, Kansas Optometric Association, Tr. 4272 at 4294; testimony of Donald Juhl, President, Jack Eckerd Corp., Tr. 379 at 396-97; letter from J. Harold Bailey, Executive Director, American Optometric Association, to FTC (Nov. 15, 1975), Exhibit IV-53, at R. 2553; letter from Joseph W. Jenkins, Executive Director, South Carolina Optometric Association, to FTC (Oct. 22, 1975), Exhibit IV-60, at R. 3186.

optometrist presents his patients with a total, unitemized bill for the complete package of examination and eyeglasses,⁵⁹ optometrists routinely include in the total two separate professional fees: one for the examination, and one for the dispensing service.⁶⁰ The dispensing service includes taking facial and pupillary distance measurements, ordering eyeglasses from the laboratory, verifying that the prescription was properly filled by the wholesaler (for which most optometrists use a machine called a lensometer), and fitting and adjusting the spectacles to the patient's face.

59 See, e.g., "1st Annual Practice Management Survey," supra note 58, at 12547; Manual of Professional Practice for the American Optometrist, American Optometric Association (revised 1966), Exhibit IV-117, at R. 5575. The Manual advises optometrists that while there is a

need for distinction between charges for professional services and charges for ophthalmic materials in the optometrist's own mind and in his records . . . [for tax purposes], it is by no means necessary, nor in most cases desirable, to make such distinction in statements rendered to patients. (Emphasis in original.)

Although the AOA's Executive Director indicated in his testimony at the hearings that the Association has since repudiated this advice as official AOA policy (testimony of J. Harold Bailey, Tr. 5905 at 5938-42), the Practice Management Survey referred to herein demonstrates that more than half of all optometrists still adhere to the Manual's advice. Further, the record contains no indication that optometrists separate charges for examination services from those for dispensing services in statements rendered to patients. See Section VII, infra.

60 See, e.g., Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (March 1976), Exhibit II-65, at R. 1601; testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3640; testimony of James Bing, O.D., Tr. 1679 at 1732; testimony of James W. Clark, Executive Director, Kansas Optometric Association, Tr. 4272 at 4289; testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1036-38; testimony of George L. Haffner, O.D., Florida Optometric Association, Tr. 201 at 235; testimony of Eugene McCrary, O.D., Maryland Optometric Association, Tr. 432 at 450; testimony of Richard C. Reed, Oregon Committee of Concerned Optometrists, Tr. 3227 at 3269; testimony of Myron Shofner, O.D., Tr. 4842 at 4860.

A recent survey of a representative sample of optometrists found that the average optometric fee charged to patients for eye examinations was \$23; for dispensing eyeglasses, \$25; and for dispensing contact lenses, \$163.⁶¹ Although laboratory charges for lenses and frames vary with the prescription complexity and the frame style chosen, the survey showed that the overall average charge to patients for lenses was \$15, and for frames was \$11.⁶² Contact lenses cost the average patient \$50.⁶³ Thus, the average complete cost of eyeglasses purchased from optometrists, including examination and dispensing services, was \$74; for contact lenses, it was \$213. The survey also revealed that optometrists derived 52% of their gross professional fee income from dispensing services, and 45% from eye examinations.⁶⁴

3. Opticians

Opticians⁶⁵ at the retail level supply eyeglasses to consumers on the written prescriptions of ophthalmologists and optometrists. The optician's functions have been summarized by the Opticians Association of America to include the following:

[P]rescription analysis and interpretation;
the taking of measurements to determine the
size, shape, and specifications of the lenses,
frames, contact lenses, or lens forms best
suited to the wearer's needs; the preparation
and delivery of work orders to laboratory

⁶¹ Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1996.

⁶² Id.

⁶³ Id.

⁶⁴ Id. at 1991. The remaining 3% was derived from vision therapy and other treatment services.

⁶⁵ The term "optician," as used in this report, refers to the specific occupational category of "dispensing optician," or "ophthalmic dispenser." Two other vocational categories are often included in the generic designation of "optician": the laboratory or wholesale optician, who prepares and assembles eyeglasses at the wholesale level; and the manufacturing optician, who is an optical technician at the lens manufacturing level. H. W. Hofstetter, Optometry: Professional, Economic and Legal Aspects (St. Louis: C. V. Mosby Co., 1948), at p. 348.

technicians engaged in grinding lenses and fabricating eyewear; the verification of the quality of finished ophthalmic products; the adjustment of lenses or frames to the intended wearer's face or eyes; and the adjustment, replacement, repair and reproduction of previously prepared ophthalmic lenses, frames, or other specially fabricated ophthalmic devices.⁶⁶

Opticians do not examine or treat the eyes, perform refractions, or prescribe lenses. They constitute the third source of eyeglasses sold at retail, specializing in the dispensing function which is shared by optometrists and ophthalmologists who supply eyeglasses to their patients. Since most optometrists dispense eyeglasses to their patients, opticians' primary source of customers consists of nondispensing ophthalmologists' patients.⁶⁷

Most opticians, like optometrists and ophthalmologists, order fully fabricated eyeglasses from wholesale laboratories. Some opticians maintain their own facilities for edging and assembling of lenses and frames.⁶⁸ Others own their own laboratories, as was discussed in Part B of this section. The training

66 Better Vision Institute, Inc., supra note 33. See also Opticians Association of America, "A Task Analysis of the Dispensing Optician," HX 309, for a more detailed description of the optician's functions.

67 The Opticians Association of America (OAA) has estimated that:

Perhaps as many as 75% of eyewear purchasers never receive a written prescription inasmuch as the eye examination and the purchasing of glasses or contact lenses are treated as one inseparable operation. . . . Here is a situation where it is the independent dispensing optician, who provides the competitive base for the nation's eyewear delivery system and yet he has little or no chance of competing for 75% of the market.

Letter from J. A. Miller, Executive Director, OAA, to FTC (Oct. 17, 1975), Exhibit IV-55, at R. 2912. See also subsection (C)(4), infra; and Section VII, infra.

68 See, e.g., "The ABC's of Optical Retailing," Chain Store Age/Drug Edition (November 1976), at p. 57.

and licensing requirements for opticians are generally less formal and universally applicable than are those pertaining to the other two types of ophthalmic practitioners. Of the 19 states which license opticians,⁶⁹ six specify high school graduation as one prerequisite to licensure.⁷⁰ Most of the licensing states require either several years of apprenticeship training, or completion of a one- to two-year formal program in ophthalmic dispensing at a community college, or in a military or technical school.⁷¹ In addition, applicants for licensure in 18 of the states⁷² must pass a state-administered examination.⁷³

Although in the nonlicensing states anyone may legally practice opticianry, as a practical matter most opticians learn the trade in apprenticeships before establishing their own optical outlets.⁷⁴ As a supplement to state licensure, the National Academy of Opticianry administers a voluntary certification program through which opticians may demonstrate their competency by successfully completing an examination and meeting specified educational and experience prerequisites.⁷⁵

⁶⁹ See Section II(A), infra.

⁷⁰ Health Resources Statistics, supra note 33, at 632.

⁷¹ Id.

⁷² California does not give an examination; its optician licensing program covers only optical firms and their active principals and managers. Hans S. Hirschhorn, Your Future as an Optician (New York: Richards Rosen Press, Inc., 1970), Exhibit II-16, at R. 597.

⁷³ Id.

⁷⁴ See, e.g., David V. Shaver, supra note 56, at 705.

⁷⁵ Hans S. Hirschhorn, supra note 72, at 596. Another national effort to promote uniform standards of competency in the optician sector has been undertaken by the Opticians Association of America (OAA). The OAA has revised its membership requirements so that all optician employees of the member firms must meet one of three standards: (1) hold a valid state license; (2) be certified by the National Academy of Opticianry; or (3) pass an OAA examination independently administered by the Educational Testing Service. Additionally, member firms must ensure that employees participate in the Association's mandatory continuing education program. Testimony of Robert C. Odom, President, OAA, Tr. 4312 at 4322.

There were an estimated 10,500 active opticians in 1975.⁷⁶ Nearly 70% of them worked in retail optical outlets, either as proprietors or as employees.⁷⁷ Opticians' businesses vary considerably in size, ranging from small independent establishments to major interstate chains having numerous outlets. Some opticians locate their outlets in department stores where permitted by state law;⁷⁸ 369 opticians, or 3.5% of the total, worked in such outlets in 1975.⁷⁹ The remaining 27% were employed primarily by ophthalmologists and other physicians, optometrists, hospitals and clinics, and the military.⁸⁰

Opticians and their employees dispensed an estimated 17.8 million pairs of eyeglass lenses and 0.4 million pairs of contact lenses sold at retail in 1975.⁸¹ They accounted for approximately 41% of the total number of corrective lenses dispensed by the three practitioner groups in that year.⁸² An estimated \$920 million was spent by consumers in optician establishments in 1975.⁸³

The survey of optometric fees for ophthalmic goods and services which was described above also included a sample of opticians' charges. It found that the average cost to consumers for all types of corrective eyeglass lenses obtained from opticians was \$36, and for frames was \$26.⁸⁴ Thus, the average cost of eyeglasses purchased from opticians in the sample was \$62. The

76 Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1962.

77 Id. at 1966.

78 See Section II(A)(3), infra.

79 Gordon R. Trapnell Consulting Actuaries, supra note 6, at 1966.

80 Id.

81 Id. at 1967. The totals represent the numbers of lens pairs dispensed in opticians' establishments--including large chains and department stores--by opticians themselves and by optometrists and others in their employ. Not included are 3.5 million lens pairs dispensed by opticians in noncommercial establishments such as hospitals, clinics, and military installations.

82 Id.

83 Id. at 1950.

84 Id. at 1998.

authors of the report noted, however, that the survey of opticians contained a disproportionate ratio of independent optical outlets, so that large discount chains were under-represented in the calculation of average prices. For this and other reasons, they cautioned against using the data to compare consumer costs of obtaining eyeglasses from one or another of the practitioner groups.⁸⁵

4. Professional Interrelationships

Because of the degree of overlap in the functions performed by the three types of practitioners, the retail level of the ophthalmic goods and services industry historically has been characterized by controversy over each group's proper role. The major areas of conflict are between ophthalmologists and optometrists on the one hand, and between optometrists and opticians on the other. Although some evidence in the record suggests a growing tension between ophthalmologists and opticians because of an increasing trend among the former to dispense eyewear themselves rather than refer patients to opticians,⁸⁶ this discussion will focus on the aforementioned traditional sources of conflict. It is staff's view that the relationships between practitioner groups bear directly on the competitive situation at the retail level, and that an understanding of them is important in assessing the dynamics of this industry.⁸⁷

The dispute between ophthalmologists and optometrists centers mainly on the question of which functions each profession is qualified to perform. Optometry as a distinct profession evolved

⁸⁵ Id. at 1994-95.

⁸⁶ See, e.g., Dispensing of Eyeglasses by Physicians, supra note 38; letter from Richard L. Heilman, President, Heilman Optical Co., to FTC (Mar. 15, 1976), Exhibit VI-60, at R. 12603; testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2009-12; testimony of Billie J. Odom, Vice President, Opticians Association of Northern Virginia, Tr. 55 at 62-63.

⁸⁷ In addition to the disputes between practitioner groups, a substantial degree of controversy exists within the professions, and particularly among optometrists, over "professional" vs. "commercial" practices in the provision of eye care goods and services. See Section II(A)(1)(e), infra.

in the late 19th century from opticianry, as opticians began performing refractions in addition to selling spectacles.⁸⁸ Ophthalmologists had concurrently begun refracting and providing prescriptions for eyeglasses, and opposed the optometrists' initial attempts to obtain state licensure and a distinct professional identity.⁸⁹ Subsequent efforts by optometrists to expand their scope of practice beyond refractions, to include such traditionally medical functions as examining for pathology and using drugs, have also met with opposition from ophthalmologists.⁹⁰

In particular, the dispute revolves around the distinction between the "detection" of eye disease, for which optometrists claim to be qualified, and the "diagnosis" of pathology, for which ophthalmologists assert their medical training is essential. Ophthalmologists insist that the difference--far from being merely a semantic distinction--is crucial to the public's health and welfare. They emphasize that the general public is not aware of the differences between the two professions in terms of their respective functions and qualifications,⁹¹ so that individuals may mistakenly rely on optometrists to attend to all of their

88 See, e.g., statement of Judith Tiffin, HX 264, at p. 6.

89 Id. at 6-7.

90 For example, a Michigan attorney warned ophthalmologists in a speech before the Michigan Ophthalmological Society that:

[T]here are a lot of optometrists in this country who think they're ready to practice medicine. . . . From the ophthalmological point of view, the political drive upon which the optometrists have embarked seeks to erase the legislative distinction between the two professions. It is perfectly possible for your specialty to become extinct.

Robert W. Wilmoth, A Statement on the Future of Ophthalmology (Aug. 1, 1975), Exhibit II-28, at R. 792. See also David V. Shaver, supra note 56, at 711-13; Moseley H. Winkler, M.D., "We're Surrendering Our Patients to Nonphysicians," Medical Economics (Aug. 23, 1976), at pp. 74-79.

91 This contention has been borne out by a study of consumer knowledge and attitudes conducted by Paul Fine Associates. See testimony of Paul A. Fine, Tr. 3648. See also Section IV(B), infra, which discusses in detail the problem of consumer confusion about the various sources of eye care.

eye care needs.⁹² Aside from the public's welfare, the economic well-being of ophthalmologists may be threatened by what some view as encroachment on their professional scope of practice.⁹³

Optometrists counter that they provide a valuable public service by offering a "point of entry" into the health care system, through which patients with problems other than those affecting vision can be referred to medical practitioners.⁹⁴ Thus, optometrists contend that they can detect eye disease or other pathological conditions whose symptoms are manifested in the eye, and can refer patients--who might otherwise go untreated--to the appropriate medical specialists. It is apparent, in any event, that the expansion of their role to the provision of "primary" eye care services has inured to the increased professional stature of optometrists.

92 See, e.g., statement of Frank W. Newell, M.D., Chairman, Department of Ophthalmology, University of Chicago, HX 115.

93 For example, an ophthalmologist advised his colleagues in other specialties of "incursions" into the medical field by nonphysicians:

If this drive [by optometrists] succeeds everywhere, physicians could be relegated to secondary and tertiary eye care. Optometrists could do just about everything ophthalmologists do except for the most complex procedures, such as corneal transplants and retinal-detachment surgery.

Moseley H. Winkler, supra note 90, at 76. See also David V. Shaver, supra note 56, at 711; Robert H. Wilmoth, supra note 90, at 795. Wilmoth warned the ophthalmologists in his audience that if they "accept the status of being a secondary provider of eye care . . . a large number of you in this room had better find another specialty, and quickly, before you are left to 5% of your present patients."

94 See, e.g., testimony of Ron G. Fair, President, American Optometric Association, Tr. 4638 at 4669-73. In addition to contending that they can screen for eye diseases which were formerly the exclusive province of physicians, some optometrists believe that they should be the sole providers of refraction services. Optometrists who were interviewed in connection with the SFCA study (supra note 60), charged that ophthalmologists are not as well qualified as optometrists to perform refractions, and should limit their practices to medical diagnosis and treatment. The study quoted one optometrist

(Continued)

The optometry-opticianry dispute is similar to that described above in that it revolves around a definition of the proper functions of each group and derives in part from economic competition between the two. Optometrists and opticians are in direct competition in the retail eyeglass market. Optometrists, as was noted above, have a distinct competitive edge because of their ability to offer customers a "one-stop" examination-plus-eyeglasses package. Since most optometrists dispense the eyeglasses they prescribe, patients are rarely given a prescription and advised to obtain their eyeglasses from the provider of their choice. Rather, in most optometrists' offices, they are led from the examining room to the dispensing area to choose their frames and have a laboratory order prepared for the completed eyeglasses. Thus, the typical optometric patient never sees a copy of his prescription, and is therefore not likely to seek the services of a second practitioner--i.e., an optician--to fill that prescription.⁹⁵ For this reason, opticians rely for most of their business on the patients of nondispensing ophthalmologists, as was noted above.

Optometrists have consistently resisted attempts by opticians to expand their professional role, just as ophthalmologists opposed similar perceived incursions by optometry. Some optometrists who testified at the hearings in this proceeding expressed the view that opticians are treading on optometric territory when they determine the proper form or design of a patient's eyeglass lenses.⁹⁶ They further dispute the competence of opticians to dispense contact lenses, and have frequently brought court challenges against

94 (Continued)

as saying that ophthalmologists "are spending fifty to sixty percent of their time refracting eyes for glasses--that is, practicing optometry--a job they do especially poorly because their education does not emphasize optics as does ours." Id. at 1565.

95 See Section VII, infra, for a fuller discussion of this process.

96 See, e.g., testimony of Ron G. Fair, President, American Optometric Association, Tr. 4638 at 4747; testimony of Robert N. Kleinstein, O.D., M.P.H., Ph.D., School of Optometry, University of Alabama Medical Center, Tr. 6057 at 6095.

such opticians on the ground that contact lens fitting constitutes the practice of optometry.⁹⁷

Opticians counter that, in the first instance, they are qualified by training and experience to make professional judgments as to lens design, so long as the refracting powers conform to the doctor's prescription.⁹⁸ As to contact lens dispensing, they claim that in spite of the fact that many state laws prohibit the practice by opticians, they can and do fit such lenses for the patients of ophthalmologists where permitted by law.⁹⁹ Further, opticians complain that while on the one hand optometrists justify

97 See, e.g., Florida State Board of Optometry v. Miami-Dade Optical Dispensary, No. 74-24358 (Fla. Cir. Ct., Dade Co., June 3, 1976); Kentucky Board of Optometric Examiners v. Economy Optical, No. C105238 (Ky. Cir. Ct., Jef. Co., Aug. 1975); Attorney General v. Kenco Optics, Inc., 340 N.E.2d 868 (Mass., 1976); State ex rel: Delaware State Board of Examiners in Optometry v. Edwin P. J. Kuhwald, Civil Action No. 4074 (Court of Chancery, New Castle Co., Feb. 22, 1977). See also letter from J. A. Miller, Executive Director, Opticians Association of America, to FTC (Oct. 30, 1975), Exhibit IV-55, at R. 2913-14.

98 See, e.g., statement of California Association of Dispensing Opticians, HX 286; testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6190-91; testimony of John H. Burns, Optician, Tr. 5582 at 5583; testimony of Berry C. Lofland, Professional Eyewear, Tr. 5510 at 5529; rebuttal submission of Opticians Association of America, Exhibit IX-180, at R. 17366.

99 See, e.g., comment of Al Schleuter, Warson Optics, Exhibit VIII-126, at R. 14536; testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6192-93; testimony of Stephen Lee Adams, Optician, Tr. 6035 at 6052-53; testimony of Jack S. Folline, member, South Carolina Board of Examiners in Optometry and Opticianry, Tr. 574 at 586; testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5571; testimony of Robert C. Odom, Executive Director, Opticians Association of America, Tr. 4312 at 4344; rebuttal submission of Opticians Association of America, Exhibit IX-180, at R. 17367-68. See also testimony of Frank W. Newell, M.D., Chairman, Department of Ophthalmology, University of Chicago, Tr. 1167 at 1196. Dr. Newell testified that opticians not only are qualified to fit contact lenses, but also "are responsible for many of the advances in contact lenses." Id.

their disparagement of the optician's role on the ground that his qualifications are not uniformly assured by state licensure, on the other hand organized optometry thwarts attempts by opticians to gain such licensure at every opportunity.¹⁰⁰ For their part, some opticians would like to see optometrists and ophthalmologists limit their practices to examining and prescribing,¹⁰¹ with the result that opticians would control the entire retail ophthalmic goods market.

It might be assumed from the foregoing discussion that such interprofessional rivalries would enhance competition among providers of eye care and thereby benefit consumers. However, widespread restrictions on advertising by those groups severely hamper their ability to inform consumers of their respective qualifications, services, and prices. Thus, the potentially beneficial effects of such interprofessional competition are substantially diminished by the fact that consumers in many jurisdictions lack the basic informational tools to discern the various marketplace alternatives. In the next section, we will describe the restraints on advertising, and in subsequent sections their effects on competition¹⁰² and consumer awareness.¹⁰³

¹⁰⁰ See, e.g., testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4344-45; rebuttal submission of Opticians Association of America, Exhibit IX-180, at R. 17368. See also Section II(A), infra.

¹⁰¹ See, e.g., testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2012-13; Optical Illusion, supra note 60, at 1568.

¹⁰² See Section III, infra.

¹⁰³ See Section IV, infra.

II. Public and Private Restraints on Advertising

In this section we will describe the statutory, regulatory, and private restraints which are the reason for the dearth of information in the retail prescription eyeglass market. The restrictions on advertising emanate from a complex web of state and private regulation of the providers of eye care: ophthalmologists, optometrists,¹ and opticians.

The legal restrictions flow from the states' licensing function and concomitant regulatory control over the three professions. The evidence which shows that some practitioner groups exert considerable influence over the legislative and regulatory control of their own professions will be discussed as a partial explanation of why the state-sanctioned competitive restraints have come to exist. A description of other restrictions on practitioners' business practices as they relate to the advertising restraints will follow.

The final part of this section describes the private pacts against advertising which state and national professional associations have drawn up to reinforce existing legal restraints and to suppress advertising where the state has failed to do so. We will discuss the evidence which shows that professional associations, through their codes of ethics, rules of practice, membership requirements, and informal persuasion, have succeeded in preventing the disclosure of price information even where it is legally permitted.

A. State Laws and Regulations

1. Overview of Regulatory Structure

Since the legal restrictions on advertising of eye care goods and services stem from the states' professional licensing framework, we will preface the discussion of those restrictions with an overview of the regulatory structure.

¹ Throughout this section, the public and private restraints on advertising by optometrists will be discussed in greater detail and with more emphasis than those affecting ophthalmologists and opticians for two reasons. First, optometrists control the major share of the retail eye care goods and services market. (See Section I(C), supra.) Second, the evidence in the record indicates that optometrists are considerably more organized, active in, and concerned with efforts to suppress price advertising than are either of the other two practitioner groups.

Ophthalmologists are universally licensed by the states as members of the medical profession. Each of the states has laws governing physicians and surgeons, and boards which carry out the state's licensing and regulatory functions. The majority of members on every state's medical board are licensed physicians, although at least 14 states require that one or more lay persons be included in board appointments.²

Optometrists also are licensed in all 50 states and the District of Columbia. The state licensing statutes define the functions of the optometric profession and limit the performance of those functions to licensed persons.³ Each state's law also delineates the basic requirements for obtaining a license, and provides for the establishment of a board to perform the licensing and regulatory functions.

The state legislatures have generally taken one of two approaches to the regulation of optometry: (1) direct control through statutory proscription of specific practices; or (2) indirect regulation through the delegation of extensive powers to the licensing boards. States which have followed the first course have included in the licensing statutes delineations of unlawful acts and the criminal penalties for their commission,⁴ or enumeration of the specific grounds for license suspension and revocation.⁵ The regulatory powers of the boards in those states are limited to enforcement of the statutory provisions.

2 Arizona, Connecticut, Delaware, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, New Jersey, Ohio, Pennsylvania, Vermont, and Wisconsin.

3 The state statutes, board regulations, and association codes of ethics pertaining to optometrists and opticians are contained in Exhibits IV-1 through IV-51 of the record, except for recently enacted laws and rules which were promulgated after the written record was closed. Many of those new statutes and regulations were submitted as exhibits to witnesses' testimony, and may be found in the record under category XII.

4 See, e.g., 1941 Ark. Acts, Act 94, § 12, as amended by Act 102 (1957), Exhibit IV-4.

5 See, e.g., TENN. CODE ANN. §§ 63-123, 822, Exhibit IV-43.

In the second instance, the statutes provide only that licenses shall be withdrawn for conduct which is deemed by the state optometry board to be "unprofessional" or "unethical."⁶ Authority is thus delegated to the boards in those states to interpret and define the nature of such conduct.

The boards of optometry of 37 states are composed entirely of optometrists.⁷ Eight states require one lay member on the board,⁸ four state boards have two lay members,⁹ and California recently enacted a law requiring that three of the nine board members be non-optometrists. In spite of a recent trend to include some board members who are not part of the regulated profession, the boards of all 50 states are still dominated by optometrists by virtue of their majority status.

Board members in 46 states are appointed by the state governors¹⁰ from rosters of optometrists who have practiced optometry in the state for a specified period of time--typically three to five years. In 16 states, the optometry laws either specify membership in the state optometric association as a prerequisite to appointment, or require the governor to make

6 See, e.g., ALASKA STAT. § 08.72.030, 240, Exhibit IV-2. The Alaska statute states simply that "The Board may define professional conduct and adopt rules of professional conduct," the violation of which is cause for license revocation.

7 Of the remaining states, South Carolina is unique in that it has one board governing both optometry and opticianry. The board membership consists of five optometrists and two opticians.

8 The states with one lay board member are Colorado, Kansas, Kentucky, Maine, Massachusetts, Rhode Island, South Dakota and Wisconsin.

9 States with two lay board members are Alaska, Iowa, Minnesota and New Jersey.

10 In four states (District of Columbia, Illinois, Nebraska and New York), board members are appointed by state agencies. In North Carolina, the statute specifies that board members shall be elected by the North Carolina State Optometric Society, and then "commissioned" by the governor.

his appointments from lists submitted by the state association.¹¹ Although not required by state law to do so, the governors of most other states rely on their respective state optometric associations to provide them with rosters of optometrists eligible for board membership.¹²

The functions of the state boards can be divided into two general categories: the licensing of optometrists and the regulation of the professional and business practices of the licensees. In fulfilling the first function, the boards establish minimum standards for licensure by defining educational requirements and designating accredited optometric schools; design, administer, and set passing scores for licensing examinations; and establish conditions for license renewal such as continuing education requirements.

The regulatory functions of the boards are determined by the nature of the respective optometry licensing statutes. As was noted above, the optometry boards of many states are granted considerable latitude by the governing statutes to specify permissible modes of business conduct, to proscribe practices which in the board's opinion are inimical to the public welfare, and to frame elaborate definitions of broad statutory phrases such

¹¹ States where membership in the state association is a prerequisite to board appointment or where the governor appoints members from an association list: Alabama, Connecticut, Delaware, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, South Carolina and South Dakota (which requires that not only board members but all licensed optometrists must be members of the South Dakota Optometric Association). Several other states' laws specify that a certain proportion of the appointments must be made from association rosters, or that the governor should take into consideration the association's views on prospective nominees.

¹² See, e.g., Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (1976), Exhibit II-65, at R. 1706.

as "unprofessional" and "unethical" conduct.¹³ In those states where the legislatures have reserved the power to enumerate grounds for disciplinary action, the boards' regulatory duties are limited to enforcing the statutory standards.

The boards' enforcement powers derive primarily from their ability to suspend and revoke the licenses they grant. The statutes generally specify the administrative procedures to be followed in cases where a licensee is charged with violating either the law or the board regulations, including provisions for hearings, due process rights of the accused violator, and appeals procedures.¹⁴

In contrast to the universal state regulation of the other ophthalmic professions, opticians are licensed in only 19 states.¹⁵ The licensing laws and regulatory structures governing

¹³ The Georgia optometry statute, for example, states simply that the license of any person shall be revoked "who is not of good moral character, or who commits an act involving moral turpitude or who is guilty of unprofessional conduct" (GA. CODE § 84-1110, Exhibit IV-11), and then gives the State Board of Examiners in Optometry the power "to regulate the practice of optometry as a profession in conformity with and in compliance with accepted professional standards." Id., § 84-1110.1. The Board has adopted 26 rules defining and proscribing "unprofessional conduct." Rules of Georgia State Board of Examiners in Optometry, Chapter 430-4.01.

¹⁴ See, e.g., WIS. STAT. § 449.09, Exhibit IV-50.

¹⁵ States which license opticians: Alaska, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Kentucky, Massachusetts, Nevada, New Jersey, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, and Washington.

Opticians in virtually all of the remaining states have attempted to obtain licensure, but contend that their lack of success has been due in large part to strong opposition from organized optometry. According to an Opticians Association of America survey, opticians have made 125 separate attempts to obtain licensure in the past 15 years, in some states introducing licensure bills on as many as six occasions. The survey found that in 87.5 % of those attempts, the bills were opposed by state optometric associations. Testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4321-22. Opticians point to an American Optometric Association (AOA) resolution adopted

(Continued)

opticians parallel those pertaining to optometrists. The state board members are appointed either by the governor or an agency of the state, usually from lists submitted by the state optician associations.¹⁶

Most of the boards are composed solely of opticians who meet certain experience and residence criteria, although in some states members of the other ophthalmic professions are given minority representation on the boards.¹⁷ Two states have granted majority representation to the other classes of ophthalmic practitioners, so that the regulatory bodies governing opticians in those states are dominated by their competitors. Virginia's Board of Opticians comprises two ophthalmologists,

15 (Continued)

in 1954, and later rescinded (testimony of J. Harold Bailey, Executive Director, AOA, Tr. 5909 at 5919):

Where there is an increasing tendency for groups which are presently unlicensed to seek licensure; now therefore be it resolved that the American Optometric Association is opposed to the licensing of any new groups in the visual care field.

Adopted at Annual Congress of American Optometric Association, Seattle, Washington, 1954 (quoted in testimony of Sen. Phil Watson, Tr. 4570 at 4580). See also testimony of E. Logan Goar, Vice-President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5557; testimony of Charles I. Hughes, O.D., Arkansas Optometric Association, Tr. 4795 at 4819; testimony of Doug Matthews, Optician, Tr. 4460 at 4464, 4476.

16 See, e.g., 1951 N.C. Sess. Laws ch. 1089, § 5, Exhibit IV-34.

17 Kentucky's Board of Ophthalmic Dispensers includes one optometrist and one medical doctor or osteopath in addition to three opticians; New Jersey's six-member board includes one optometrist; New York's board, which is called "advisory" because its functions are limited to preparing and administering the license examination, consists of three opticians, one optometrist, and one ophthalmologist. A few states, such as Massachusetts, New Jersey and Vermont, require a public member to be included on the board.

one optometrist, and two opticians.¹⁸ South Carolina's optometrists and opticians are governed by one board whose membership ratio is five optometrists to two opticians.¹⁹ The functions and powers of the state opticianry boards are also similar to those of the optometry boards.²⁰

2. Price Advertising Restrictions

(a) Ophthalmologists

As mentioned above, ophthalmologists are governed by the state laws pertaining generally to physicians and surgeons. Legal restrictions on advertising by medical doctors are not as widespread nor as explicit as they are for optometrists and

18 VA. CODE § 54 - 398.4 (1950), Exhibit IV-47.

19 A South Carolina optician who testified at the hearings characterized this imbalance in board representation as one where, "[p]lainly stated, optometry ... completely controls opticianry.... Optometry has created a utopic situation of controlling competition, thereby fostering the higher cost of glasses." Testimony of Kenneth R. Davenport, President, Opticians Association of South Carolina, Tr. 6182 at 6185. (Although the examination and licensing of opticians is done by a subcommittee of the board composed of two opticians and one optometrist, the promulgation and enforcement of regulations affecting opticianry is in the hands of the full, optometry-dominated board.)

20 Some state opticianry boards are--like the optometry boards noted above--empowered by the licensing statutes to delineate the grounds for license revocation. One researcher who studied Connecticut's opticianry board concluded that:

The grounds for revocation of an optician's license in Connecticut are so detailed and so comprehensive that they are worth repeating in full for what they suggest about the restrictive nature of the licensing law.

[The author proceeds to quote the 17 grounds for license revocation enumerated in the regulations, which fill two pages of his report.]

Elton Rayack, An Economic Analysis of Occupational Licensure (completed under U.S. Dept. of Labor Grant No. 98-02-6851), Exhibit IV-96, at R. 5044. See also Benjamin Shimberg, Barbara F. Esser, and Daniel H. Kruger, Occupational Licensing (Washington, D.C.: Public Affairs Press, 1972), Exhibit II-25, at R. 729.

opticians. One possible reason for this is the fact that most classes of physicians do not dispense or sell the medical appliances attendant to the treatments they prescribe, and thus do not enter the products marketplace to the same degree that non-medical practitioners such as optometrists do.²¹ Since the likelihood of doctors attempting to compete for segments of the medical goods marketplace is thus a remote one, the legislatures and the medical lobbies of many states apparently saw no reason to specifically proscribe price advertising. By the same token, legislation to curb advertising of doctors' services was apparently also deemed unnecessary by many jurisdictions in light of the old and deeply-ingrained tradition among all of the "learned professions" which held solicitation of clients to be unseemly.²²

Explicit bans on advertising by doctors are found in the laws of 13 states.²³ Several other states proscribe advertising of a vaguely defined nature, such as that which is done in an "unethical or unprofessional manner."²⁴ It is unclear whether price advertising would be included in such proscriptions, or in the general

21 Although an estimated 40%-50% of ophthalmologists dispense eyeglasses or contact lenses (see Section I(C)(1), supra), only 3% of all physicians are ophthalmologists. Center for Health Services Research and Development, American Medical Association, Physician Distribution and Medical Licensure in the U.S., 1974 (Chicago, 1975), at p. 37.

22 As the Counsel for the South Dakota State Board of Examiners in Optometry explained the absence of legislation to ban advertising by ophthalmologists in his state,

The medical profession in South Dakota is long past the point where any member thereof would consider price advertising and therefore it does not take a statute to keep the ophthalmologists of South Dakota from any kind of advertising whatever. Many states have let their archaic law [prohibiting price advertising by physicians] ... stand.

Comment of Alan L. Austin, Exhibit IX-59, at R. 15236.

23 Alaska, Arizona, Arkansas, Illinois, Kansas, Maryland, Michigan, Missouri, Nebraska, Oklahoma, Tennessee, Utah, and Virginia.

24 GA. CODE § 84-916(11), Exhibit IV-11. Similar language is found in the laws of states such as Delaware, Idaho, Maine, Nevada, North Dakota, Rhode Island, South Carolina, and Wyoming.

interdictions against unprofessional conduct contained in numerous other state laws which do not specifically mention advertising.

(b) Optometrists

Of the three ophthalmic practitioners, the advertising practices of optometrists are by far the most widely and stringently regulated. Twenty-five states prohibit the use of any form of advertising by optometrists, except for narrowly delineated institutional notices announcing a new practice or a change in location.²⁵ Moreover, 37 states explicitly ban price advertising, either by statute or regulation.²⁶ The total bans on price advertising take several forms: definitions in optometry laws or state board regulations of "unprofessional" or "unethical" conduct for which licenses may be suspended or revoked (12 states); inclusion in other statutory enumerations of grounds for license revocation (8 states); or provisions deeming price advertising an "unlawful" practice (17 states), which is punishable in some jurisdictions by fines of up to \$500, imprisonment for a maximum of one year, or both.²⁷ With the threat of \$500 fines, "one year

²⁵ See chart at p. 78, infra.

²⁶ States which prohibit price advertising by optometrists by statute (S) or state board regulation (R):

Alabama (S)	Missouri (S)
Alaska (R)	Montana (S)
Arkansas (S)	Nebraska (S)
Connecticut (R)	Nevada (S)
Delaware (S)	New Hampshire (S)
Florida (S)	New Jersey (S)
Georgia (R)	New Mexico (S)
Hawaii (S)	North Carolina (S)
Idaho (R)	North Dakota (S)
Illinois (S)	Oklahoma (S)
Indiana (S)	Oregon (S)
Kansas (R)	Pennsylvania (S)
Kentucky (S)	Rhode Island (S)
Louisiana (S)	South Carolina (S)
Maine (S)	South Dakota (S)
Michigan (S)	Tennessee (S)
Minnesota (S)	Vermont (R)
Mississippi (R)	Wisconsin (S)
	Wyoming (S)

²⁷ E.g., WYO. STAT. § 33-304 (1957), Exhibit IV-51. The Wyoming law provides that violators "shall be deemed guilty of a misdemeanor and upon conviction shall be fined not more than five hundred dollars or imprisoned not more than one year in the county jail."

in the county jail,"²⁸ or the even more punitive removal of one's license to earn a living in his profession, it may be assumed that optometrists in those 37 states are effectively constrained from price advertising.

Eight of the remaining 14 states restrict price advertising by optometrists to some degree. Two states prohibit the advertising of professional services, but permit optometrists to publish either prices of frames and mountings (but not lenses),²⁹ or of complete eyeglasses if the prices of component parts are itemized.³⁰ Four states require that various disclosures must accompany price advertisements.³¹

The disclosures range from relatively simple clarifying statements to complex and burdensome descriptive requirements. A recently enacted Massachusetts statute, for example, requires simply that price advertisements describe: (1) whether the price includes lenses as well as frames, and if so, the type of lens (single-vision, bifocal, or trifocal) and the refractive power (low, medium or high); and (2) that the price does not include eye examinations.³² A new Virginia law, on the other hand, mandates several categories of disclosures--many of which are of dubious informational value to the consumer, such as the name and country of the manufacturer--and then authorizes the state board to further refine the disclosure requirements.³³ The state board hastened to delineate a panoply of technically detailed disclosures which seem likely to discourage optometrists from taking advantage of the new law ostensibly enacted to permit price advertising.³⁴

28 Id.

29 Washington.

30 West Virginia.

31 Massachusetts, New York, Utah, and Virginia.

32 MASS. GEN. LAWS. ANN. ch. 112, § 73A, as amended by 1976 Mass. Acts ch. 91, Exhibit IV-22.

33 VA. CODE § 54-396(9) as amended, Exhibit IV-47.

34 The following is a paraphrase of the Virginia State Board of Examiners in Optometry's Regulation 3:

The following disclosures must be included in at least 10 point type: as to frames, (1) name of manufacturer; (2) manufacturer's

(Continued)

Ohio has no state-wide statutory ban on advertising by optometrists, but at least 14 cities--including such large municipalities as Dayton and Cincinnati--have enacted ordinances prohibiting price advertising of eyeglasses.³⁵ Finally, Texas, which has often been cited as a "non-restrictive" state, allows an optometrist to price advertise only in the name of any dispensing opticianry which he may own or operate, and then only after several filing and disclosure requirements are met.³⁶

34 (Continued)

name or number of frame; (3) country of manufacture; (4) material (plastic, metal, or combination, unless frame is illustrated); as to lenses, name and country of manufacturer and name or number of lens, and whether (1) clear, tinted, or photochromatic; (2) glass or plastic; (3) single vision, bifocal (including segment size, except for executive/dualens types), trifocal (including segment size, except for executive/dualens and variable focus), occupational (including whether double bifocal or quadrifocal), aphakic (including whether lenticular aspheric, full-field aspheric, or full-field non-aspheric); as to contact lenses, (1) name of manufacturer, (2) country of manufacturer, and (3) whether hard or soft lenses. Additionally, artificial eyes must be identified as either "stock," "modified stock," or "custom"; price advertisements must state that an eye examination is not included; discount advertisements must include regular price of item to be discounted; and advertisements for lenses which (a) are not purchased from a manufacturer who warrants that they meet ANSI specifications or (b) which in fact do not meet ANSI specifications, must contain the statement, "Does Not Meet ANSI Standards."

35 Testimony of Anthony O. Calabrese, Ohio State Senator and Chairman, Ohio State Health and Retirement Committee, Tr. 1537 at 1538.

36 (1) An "advertising permit" must be obtained from the Texas Optometry Board; (2) before commencing advertising or making any price changes, a list of the contemplated prices to be charged for nine categories of lenses (e.g., single-vision, bifocal, contact lenses) must be filed with the Board; and (3) when the price of one category of lens is advertised,

(Continued)

The six remaining states--Arizona, California,³⁷ Colorado, Iowa, Maryland, and the District of Columbia--impose no legal barriers to price advertising. Restraints imposed by the optometric associations of those and other states will be described below at part B of this section.

In addition to the aforementioned prohibitions on advertising, most of the states restrict in some way the use of other means of informing potential customers of the availability of an optometrist's services. For example, 25 states strictly limit the form and content of yellow-page listings, and 26 states limit the use of store signs or window displays which would attract customers.³⁸ Thirty-five states prohibit the publishing of discount offers or of general policies of underselling competitors.³⁹

(c) Opticians

Opticians in 20 states are prevented by law from advertising prices. The prohibitions are contained in the laws of seven of

36 (Continued)

the prices for the other categories must also be displayed with equal prominence, or combined into one general category of "up to \$ _____" (the highest priced lens). TEX. CODE. ANN. § 5.10(c)-(f), Exhibit IV-44.

³⁷ Although the California statute prohibiting price advertising is still on the books, the Director of the California Department of Consumer Affairs, the umbrella agency which administers all state boards, announced on July 28, 1976 that the state boards of optometrists and of opticians would thenceforth permit their licensees to advertise prices. The Department said that in light of the Virginia Pharmacy decision and the developments in a related California case (Terminal-Hudson Electronics, Inc. v. Dep't of Consumer Affairs, No. CV 74-2321 (AAH) FW (D.C. Cal. Jan. 6, 1976), Exhibit IV-89, at R. 4938), "the Board of Optometry and ... [the opticianry board] will no longer initiate disciplinary or injunctive proceedings against licensees who advertise the price of eyeglasses." California Department of Consumer Affairs Press Release, HX 290. A bill has been introduced in the current state legislature to repeal the statutory price advertising bans. Assembly Bill No. 52, California Legislature--1977-78 Regular Session, introduced by Assemblyman Terry Goggin, Dec. 14, 1976.

³⁸ See chart at p. 78, infra.

³⁹ Id.

the 19 states which license opticians,⁴⁰ and in the optometry laws of 13 other states which extend the bans to "all persons" or other all-inclusive designations.⁴¹ The statutory advertising bans resemble those employed to restrict optometrists. The Washington State law, for example, stipulates that an optician's license may be suspended or revoked if he has "displayed or published, directly or indirectly by any means, price, terms of payment, or a discount."⁴² North Carolina includes price advertising in a list of prohibited "unethical methods of practice."⁴³ Nevada typifies those states which declare price advertising a misdemeanor, punishable in that state by a fine of up to \$500, or imprisonment for not less than 10 days, or both.⁴⁴

Five additional states require that opticians' price advertisements include disclosures like those required for optometrists'.⁴⁵ Ohio's municipal ordinances banning eyeglass advertisements apply to opticians as well as optometrists. The remaining 25 states allow unrestricted price advertising by opticians.

Several other types of advertising restrictions appear in the opticianry statutes and regulations, although they are considerably less widespread than those applicable to optometrists. For example, bans on advertising of discounts by opticians are in effect in five states.⁴⁶ South Carolina prohibits outright the giving of any discounts, thereby dispensing with the question of whether or not they should be advertised.⁴⁷

40 Alaska
Hawaii
Nevada
New Jersey

North Carolina
South Carolina
Washington

41 Illinois
Indiana
Kentucky
Louisiana
Maine

New Mexico
North Dakota
Oklahoma
Oregon
Pennsylvania

Rhode Island
Wisconsin
Wyoming

42 WASH. REV. CODE § 18.34.090(6), Exhibit IV-48.

43 N.C. GEN. STAT. § 90-249(16), Exhibit IV-34.

44 NEV. REV. STAT. § 637-200, Exhibit IV-29.

45 Connecticut, Massachusetts, New York, Texas, and Virginia.

46 Georgia, New Jersey, North Carolina, Tennessee, and Washington.

47 S.C. CODE § 56-1074, Exhibit IV-41.

(d) Net Effect of Restrictions: Where Eyeglasses Can Be Advertised

Since the restrictions on eyeglass price advertising stem from the licensing laws of the three separate ophthalmic professions, the degree of legal restraints on such advertising varies considerably from state to state. The extent to which prices can be advertised in a state depends on two variables: (1) which, if any, practitioners can advertise; and (2) whether advertising is freely allowed, or is restricted to some degree by disclosure or other requirements. The states can be ranked in order of relative overall restrictiveness, according to those two variables. Staff's ranking of the states in this manner excludes the ophthalmologists, since as a practical matter they do not advertise even in those states where they are not legally constrained from so doing, as was noted above.

The net effect of the advertising restrictions pertaining to optometrists and opticians is as follows:

In 19 states, no price advertising of eyeglasses is permitted, by virtue of the legal restraints pertaining to both optometrists and opticians:

Alaska	North Carolina
Hawaii	North Dakota
Illinois	Oklahoma
Indiana	Oregon
Kentucky	Pennsylvania
Louisiana	Rhode Island
Maine	South Carolina
Nevada	Wisconsin
New Jersey	Wyoming
New Mexico	

In 17 states, price advertising by opticians is permitted, but is prohibited for optometrists:

Alabama	Mississippi
Arkansas	Missouri
Delaware	Montana
Florida	Nebraska
Georgia	New Hampshire
Idaho	South Dakota
Kansas	Tennessee
Michigan	Vermont
Minnesota	

In 5 states, price advertising by both optometrists and opticians is partially restricted:

Massachusetts	Texas
New York	Virginia
Ohio	

In 2 states, price advertising by one practitioner group is prohibited (by optometrists in Connecticut; by opticians in Washington), and by the other group is partially restricted (by opticians in Connecticut; by optometrists in Washington):

Connecticut
Washington

In 2 states, price advertising by opticians is permitted, but by optometrists is partially restricted:

Utah
West Virginia

In 6 states, unrestricted price advertising by both optometrists and opticians is legally permitted:

Arizona	District of Columbia
California	Iowa
Colorado	Maryland

The above categorization into six groups of states, based on the practitioners covered by and the extent of the legal advertising restraints, can be seen as a ranking of the states along a continuum from the most restrictive (the first 19 states) to the least restrictive (the last six states). Thus, the net effect of the states' various restrictions on price advertising by optometrists and opticians is that no one can advertise eyeglass prices in 19 states, any one can do so without limitations in six states, and one or the other class of ophthalmic dispenser can advertise--frequently with some degree of limitation such as disclosure requirements--in the 26 remaining states.

(e) Origins of Legal Restraints
on Advertising

Several of the witnesses and others whose views were made part of the record in this proceeding focused on the question of how and why the legislative and regulatory advertising bans came into being. Representatives of optometry boards and associations who addressed the issue generally contended that the advertising prohibitions were passed--admittedly at the urging

of the industry itself--48 to protect the public from unscrupulous practitioners and the "commercialization" of eye care goods and services.⁴⁹ The Massachusetts Board of Optometry, for example, opposed the repeal of that state's advertising ban on the following bases:

48 From all indications in the record, the professions themselves were responsible for passage of the advertising bans. This contention was not disputed by industry representatives. As Presiding Officer Cabell stated, "[t]hat these restraints were enacted into state laws and regulations... at the insistence of optometrists cannot be challenged." Report of the Presiding Officer, Exhibit XIII-1, at p. 59.

Some evidence shows that even where public sentiment has been overwhelmingly in favor of allowing price advertising, industry lobbies have succeeded in quelling legislative attempts to loosen the restrictions. An Oklahoma senator testified that a bill he sponsored to allow price advertising was ultimately defeated by the optometry lobby, despite the fact that the "general public favored [it] overwhelmingly." He cited surveys taken by two of his senate colleagues which showed that their constituents favored the bill by 96% and 92%, respectively. Testimony of Senator Phil Watson, Tr. 4570, at 4572, 4578-79.

According to a Florida consumer, a bill to allow price advertising in his state

wasn't killed in committee because the public didn't want it, but died in committee because of the very powerful lobby put on by the optical interests. Many letters appeared in area papers supporting the bill and thousands of people signed petitions asking that it be passed, but the State Legislature paid no attention.

Letter from Charles A. Johnson, Pinellas Park, Fla., to Florida State Sen. Richard Stone (Sept. 8, 1975), Exhibit III-6, at R. 2421. See also, in connection with defeat of Florida bill, Florida Association of Dispensing Opticians News Bulletins heralding their "victory" in that "hard fought battle," Exhibit IV-101, at R. 5238.

49 See, e.g., letter from Norman G. Goss, O.D., Executive Secretary, Oregon Board of Optometry, to FTC (undated), Exhibit IV-59, at R. 3036; letter from Joseph W. Jenkins, Executive Director, South Carolina Optometric Association, to FTC (October 22, 1975), Exhibit IV-60, at R. 3187; testimony of Jerry Burger, O.D., Tr. 1056 at 1074; testimony of Alden N. (Continued)

This state has a long history of prohibiting the commercialization of health care professions. Without this protection the consumer becomes easy prey for the unscrupulous practitioner who may be a good salesman but a haphazard optometrist or optician.⁵⁰

Representatives of consumer groups, economists, and others who commented on the origins of the advertising bans agreed that the legislatures and boards acted to quell commercialism in the eye care field, but argued that the ultimate objective of such action was the protection not of the public's welfare, but rather of the practitioners' economic well-being.⁵¹ Elton Rayack, who conducted an in-depth study of occupational licensure in three Northeastern states, found that Connecticut's regulations governing opticians which were "supposedly drawn to protect the consumer against false or misleading advertising were used to restrict competition and prevent a reduction in price to the consumer."⁵² A San Francisco Consumer Action study of the eye care industry in California avers that "many of the so-called

49 (Continued)

Haffner, O.D., Dean, State College of Optometry, State University of New York, Tr. 2035 at 2040-41; testimony of Bernard A. Morewitz, O.D., President, Virginia Optometric Association, Tr. 160 at 162, 164-65, 169; testimony of George L. Haffner, O.D., President, Florida Optometric Association, Tr. 201 at 202-3.

50 Attachment to letter from Francis A. Murdy, O.D., Secretary, Massachusetts Board of Registration in Optometry, to FTC (Nov. 6, 1975), Exhibit IV-59, at R. 2996. M. F. Keller, Chairman, Legislative Committee, Montana Optometric Association, expressed a similar view when he testified that the Montana legislature's purpose in enacting advertising prohibitions was to protect the consumer, who otherwise would be "easy prey for the practitioner with more advertising acumen than professional ability." Tr. 3469 at 3470.

51 Presiding Officer Cabell agreed with these parties, finding that "[t]here is little or no evidence that these restraints are in the public interest or that they serve any purpose other than that of protecting optometrists from competition." Report of the President Officer, Exhibit XIII-1, at p. 59.

52 Elton Rayack, supra note 20, at 5153.

protective laws on the books, including those prohibiting price advertising, were themselves industry inspired and industry drafted, often with their own interests in mind."⁵³ Several witnesses testified at the hearings in this proceeding that, as one economist stated, "the profit motive is what dictates the desire to ban advertising because that reduces competition."⁵⁴ Elton Rayack testified that:

Economic theory and empirical investigations indicate that the fundamental effect of restrictions on informational advertising is to protect the various professions from competitive pressures at the expense of the general public.⁵⁵

Economist Lee Benham observed in his study of the relationship between professional control and eyeglass prices that:

From the point of view of the profession, restricting information may be one of the most effective politically acceptable methods available for constraining the behavior of suppliers and consumers in the desired direction.⁵⁶

Aside from the question of whether the professional groups who were largely responsible for the advertising bans were motivated by a desire to protect the public or to protect themselves from competition, there is ample evidence that the bans were indeed part of an attempt by organized optometry to eliminate "commercialism" in the sale of eyewear. One aspect of commercialism, in the

⁵³ Optical Illusion, supra note 12, at 1712.

⁵⁴ Testimony of Roger D. Blair, Associate Professor of Economics, University of Florida, Tr. 547 at 559. Optician Doug Matthews testified that in his opinion, "deep down under the surface... [the optometrists' opposition to price advertising is] a conspiracy to eliminate the competition." Tr. 4460 at 4465.

⁵⁵ Testimony of Elton Rayack, Professor of Economics, University of Rhode Island, Tr. 2275 at 2276. Professor Rayack went on to say that the goal of those who are responsible for the restrictions "is to raise the income of the particular profession through the restrictive practices." Id. at 2300.

⁵⁶ Lee Benham and Alexandra Benham, "Regulating Through the Professions: A Perspective on Information Control," 18 J. LAW & ECON. 421 (1975), Exhibit V-2, at R. 6232.

view of organized optometry, is the "corporate" practice of optometrists, or the employment of optometrists by large optical retailers and other commercial establishments such as department stores.⁵⁷ The fear of commercialism has been a dominant theme throughout the history of organized optometry. The following statement, which appeared in a 1966 optometry journal, illustrates both the antipathy felt by the "professionals" toward the "commercialists" and the underlying dread of competitive pressures posed by the latter group:

Professional optometry has been travelling a rocky road ever since its inception ... our chief enemies are optometrists who succumb to the blandishments of the 'chains' and other heavyweights and sell us down the river.

The store-offices of the commercial brethren are prominently located, handsomely furnished, carry large selections of the newest frames and possess examination rooms equipped with a battery of flashy instruments. Barkers on the radio never miss a trick. Spread-eagle ads proclaim skillful professional services with stylish glasses at around \$12.50, contacts at around \$75.00, everything guaranteed, budget terms if desired, registered doctors of optometry in attendance. And the public comes piling in.

This is slashing into the practices of individual optometrists to an alarming degree.... how long can ethical men survive such strangling competition? (Emphasis added.)⁵⁸

The use of advertising prohibitions to limit corporate practice was suggested in 1934 by the president of a prominent optometry college:

⁵⁷ See subsection A(3), infra.

⁵⁸ George T. Warren, O.D., Optical Journal-Review (Oct. 15, 1966) (now the Optical Journal and Review of Optometry), quoted in comment of National Association of Optometrists and Opticians, Exhibit VIII-187, at R. 14334.

As I see it there is one direct way to whip the corporate practice menace in optometry, and that is to make price advertising illegal.⁵⁹

The South Carolina Optometric Association has published an historical "Profile" of its organization in which the association is described as being "preoccupied throughout the twenties with the elimination of 'commercialism.'"⁶⁰ In its efforts to eliminate commercial practice, the Association

worked successfully with other groups to get the General Assembly to pass an anti-advertising act. Thus, unable to advertise and without referrals from any vision health care specialists the stores quickly went out of business. "Commercialism" has not been a problem in South Carolina since.⁶¹

A 1937 letter to all South Carolina optometrists, urging attendance at a meeting concerning the imminent dangers posed by commercialists, contained the following warning:

This is not a fake cry of "wolf-wolf" but an authentic call to every Optometrist to come to the aid of Optometry to save it from the fraudulent vultures who are invading our State at this time ... only the concentrated efforts of our entire State group, standing together as one fearless warrior, can make our own South Carolina safe for optometry ... [signed], Yours for the safety of Optometry ... (emphasis added).⁶²

⁵⁹ W. B. Needles, President, Northern Illinois College of Optometry, The Optometric Weekly, Vol. XXV, No. 2 (March 1, 1934), p. 36, quoted in statement of Judith Tiffen, California Citizen Action Group, HX 264, at p. 21.

⁶⁰ "Profile of an Association, 1903-1975," Practice Reference Manual, 1975-1976, South Carolina Optometric Association, Exhibit IV-109, at R. 5283.

⁶¹ Id. at 5284.

⁶² Quoted in The Delineator: The Newsletter of the South Carolina Optometric Association (Jan. 15, 1975), Exhibit IV-110, at R. 5411.

The president of the South Carolina Opticians Association testified at the hearings that although the opticians in that state were at odds with the optometrists over virtually every issue affecting the two professions, they had joined forces in fighting commercialism. When asked why his organization objected to commercial firms, the witness answered:

A. I imagine, to be honest with you, they don't want the competition.

Q. Do you think that's the same reason the optometrists don't want them in the state?

A. No question. Economics.⁶³

Rhode Island optometrists also found that the prohibition of advertising was an effective means to expel the commercialists. Elton Rayack quoted the chairman of that state's Board of Examiners in Optometry as saying that the advertising ban was "effective in driving department stores out of the field... it was unprofitable because they could not advertise... that is why there is so little commercial practice in Rhode Island."⁶⁴ A similar situation was said to exist in California by a witness who had studied the history of such regulations in her state: "It appears that the primary incentive for the campaign against price advertising was to avoid competition from corporations."⁶⁵

If indeed the advertising strictures arose from a desire by industry members to insulate themselves from competition, there is considerable evidence that their self-regulatory environment affords them ample opportunity to do so. First, the impetus for regulation uniformly has come from the industry itself. In a history of the optometric profession, Maurice Cox recounts the "generation of struggle"--beginning with the first optometry licensing law in Minnesota in 1901 and culminating with the District of Columbia's in 1923--through which optometrists undertook "legislative campaign[s]" in every state

⁶³ Testimony of Kenneth R. Davenport, Tr. 6182 at 6207-p.

⁶⁴ Quoted in testimony of Elton Rayack, supra note 55, at 2281.

⁶⁵ Testimony of Judith Tiffen, California Citizen Action Group, Tr. 3453 at 3459.

to achieve licensure.⁶⁶ Second, the optometrists' almost universal control of the licensing boards ensured their ability to perpetuate a guild-like regulatory structure.⁶⁷

Much of the general literature on occupational licensing emphasizes the ramifications inherent in self-regulation by the professions. Economist Milton Friedman, who has described licensure as "essentially the medieval guild kind of regulation in which the state assigns power to the members of the profession," believes that it "almost inevitably becomes a tool in the hands of a special producer group to obtain a monopoly position at the expense of the rest of the public."⁶⁸ The natural tendency of state boards composed entirely of members of the profession they are charged with regulating to protect the profession's self-interests has been frequently examined. As one student of professional regulation commented:

66 Maurice Cox, Optometry, The Profession: Its Antecedents, Birth, and Development (Philadelphia: The Chilton Co., 1947), at p. 27. See also James R. Gregg, The Story of Optometry (New York: The Ronald Press Co., 1965), excerpts, Exhibit II-31, at R. 883.

67 Statement of Judith Tiffen, supra note 59. Presiding Officer Cabell concluded that the boards do indeed act primarily in the interests of the profession:

[I]t appears that the state optometry regulatory boards are controlled and operated by members of the optometric association for the benefit and protection of individual practicing optometrists rather than for the benefit of the public or the vision care industry as a whole.

Report of the Presiding Officer, Exhibit XIII-1, at p. 59.

68 Milton Friedman, Capitalism and Freedom (Chicago: University of Chicago Press, 1962), at pp. 141, 148. It is interesting to note Adam Smith's recognition, over 200 years ago, of the propensities of state-sanctioned guilds:

People of the same trade seldom meet together, even for merriment and diversion, but the conversation ends in a conspiracy against the public, or in some contrivance to raise prices. It is impossible indeed to prevent such meetings, by any law which either could be executed, or would be consistent with liberty and justice. But though the law cannot hinder people of the same trade from sometimes assembling together,

(Continued)

When sellers are given the power to decide what is "good" for buyers, the question that arises is whether they will administer this power in a benevolent fashion. When situations arise in which sellers' and buyers' interests do not coincide, will the seller decide at his own expense in the buyer's favor? There is evidence to indicate that many boards exercise their power in ways that are not in the interest of buyers.⁶⁹

The author points out that since board members "are members of the profession they govern, ... they cannot help but be influenced, if only subconsciously, by the fact that their actions will affect their own and their colleagues' well being."⁷⁰ Elton Rayack found that:

68 Continued

it ought to do nothing to facilitate such assemblies; much less to render them necessary.

The Wealth of Nations (Modern Library Ed., Random House, Inc., 1937), at p. 128. See also Walter Gellhorn, Individual Freedom and Governmental Restraints (Baton Rouge: Louisiana State University Press, 1956); Note, Due Process Limitations on Occupational Licensure, 59 VA. L. REV. 1097 (1973); Thomas G. Moore, "The Purpose of Licensing," 4 J. LAW & ECON. 93 (1961).

69 J. F. Barron, Business and Professional Licensing in California, A Representative Example, 18 STAN. L. REV. 650 (1966). A Texas State Senator testified at the hearings that his experience in that state confirmed the problems inherent in self-regulatory systems:

My general approach is to oppose any licensing bill, because as I say unfortunately in Texas we've acquired a history of letting the fox guard the chicken coop, and it's used primarily in many instances as a vehicle to prevent competition through lawyers, doctors, and everybody else in this state.

Testimony of Sen. Oscar Mauzy, Tr. 5536 at 5541.

70 J. F. Barron, supra note 69.

[T]he key dilemma of present systems of licensure ... [is] that the delegation of power to set standards, to protect the consuming public, is a concomitant grant of power to protect those licensed from competition at the expense of both the unlicensed and of the consuming public.⁷¹

That the state boards have used their regulatory powers to restrict the advertising practices of their colleagues and competitors is evident from the fact that virtually every optometry board which has been statutorily empowered to promulgate such restrictions has done so.⁷² The evidence in the record suggests that the boards have vigorously enforced the advertising bans, in some cases devoting the majority of their enforcement resources to policing advertising infractions. A study of the California Board of Optometry's activities between 1972 and 1975, for example, revealed that 72 of the 86 disciplinary actions taken by the Board concerned improper telephone Yellow Pages advertisements of licensees.⁷³ Moreover, the complaints to state boards regarding advertising practices are usually lodged not by consumers, but by competing practitioners.⁷⁴

71 Elton Rayack, supra note 20, at 5181. Professor Rayack quotes from a study by the Massachusetts Special Commission on Government Operations, which concluded that:

The power to limit entry into a profession and the power to establish rules of conduct for them is essentially the same as the powers held by a cartel or a private monopoly The phenomenon of all-professional board membership converts public regulation for practical purposes into trade self-restraint. Id. at 5183.

72 See subsection A(2)(b).

73 Optical Illusion, supra note 12, at 1709. See also Elton Rayack, supra note 20, at 5196; Focal Point, Tennessee Dispensing Opticians Association (Dec.-Jan., 1975-76), Exhibit IV-76, at R. 4668; testimony of Conrad Donner, Bay Area Union Professional Center, Tr. 3389 at 3389-90; testimony of Jack Perry, Perry Optical Centers, Tr. 2328 at 2329-34; Official Minutes of the [Wisconsin] Optometry Examining Board (Jan. 28, 1975), Exhibit IV-121, at R. 5643; Memorandum from South Carolina Board of Examiners in Optometry and Opticianry, Exhibit IV-111, at R. 5444.

74 See, e.g., Elton Rayack, supra note 20, at 5175; Optical Illusion, supra note 12, at 1709.

Arizona, apparently recognizing the proclivity of self-regulatory agencies to attempt to circumscribe their constituents' competitive activities, included in its optometry statute a specific limitation on the board's power in this regard:

[N]o rule shall be promulgated by the board which shall prohibit advertising by a registered optometrist.⁷⁵

Wisconsin's statute contains a similar curb on the optometry board's powers to regulate other business practices.⁷⁶

(f) Current Legislative Trends

Since the initial Staff Report was published in January, 1976, the state legislatures have shown a marked interest in the price advertising issue. Particularly in the wake of the U.S. Supreme Court Virginia Pharmacy decision striking down prescription drug price advertising bans on first amendment grounds,⁷⁷ several states have moved to repeal similar laws relating to eyeglasses. Some 45 bills pertaining to price advertising were introduced in 23 states during 1975-76.⁷⁸ Only three of those states--Florida, Massachusetts and Virginia--enacted the proposed legislation to repeal eyeglass advertising bans.⁷⁹ Several

⁷⁵ ARIZ. REV. STAT. § 32-1705(A), Exhibit IV-3.

⁷⁶ WIS. STAT. § 449.03(1), Exhibit IV-50, states:

No rule made by the examining board shall expand the practice of optometry or affect the practice of dispensing opticians nor shall the examining board enact rules which forbid the employment of an optometrist or declare such employment unprofessional conduct, or prohibit the operation of an optometric department by optometrists in a mercantile establishment.

⁷⁷ Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, 96 S. Ct. 1817 (1976).

⁷⁸ Office of Counsel, American Optometric Association, State Legislation (September 1976).

⁷⁹ In Florida, a bill to remove restrictions on price advertising by opticians which had failed in the previous legislature was passed by unanimous vote in 1976. Testimony of Donald Juhl, President Jack Eckerd Corp., Tr. 379 at 413. A similar bill to allow Florida optometrists to advertise failed. The Massachusetts and Virginia amendments apply to both optometrists and opticians; both require advertisements to be accompanied by disclosures. See notes 32-34, supra.

of the bills which failed in the last legislature are being reintroduced in current sessions.⁸⁰

As was noted above,⁸¹ strong opposition from optometric lobbies was responsible for the defeat of many of those bills. Several witnesses testified that pressure from industry associations had dissuaded legislators in their states from passing price advertising bills.⁸² Other evidence in the record demonstrates the considerable political clout of many of the state associations.⁸³ It was the opinion of some witnesses that the proposed trade regulation rule is necessary in order to free practitioners from advertising restraints on a nationwide basis, since state legislatures have been more responsive to the views of the professional association lobbies than to the often less organized and influential proponents of price advertising.⁸⁴

80 In California and Illinois, for example.

81 At note 48, supra.

82 See, e.g., testimony of Doug Matthews, supra note 15, at 4463-64, 4476; testimony of Senator Phil Watson, supra note 48, at 4571-72; testimony of Edward L. Petrini, Legal Director, Public Interest Research Group in Michigan, Tr. 831 at 834-35; testimony of Donald L. Heyden, O.D., Wisconsin Optometric Association, Tr. 5852 at 5874-76.

83 See, e.g., Wisconsin Optometric Association, Legislative Bulletins (Oct. 31, 1975 and Jan. 27, 1976), HX 359 and HX 360; Florida Association of Dispensing Opticians, News Bulletin, Exhibit IV-101, at R. 5229; letter from Oklahoma Student Optometric Association, Southern College of Optometry, to Oklahoma state senators (April 21, 1975), HX 321; letter from David C. Hendershot, Executive Director, Ohio Optometric Association, to FTC (June 29, 1976), HX 196; letter from Charles A. Johnson, supra note 48; Robert W. Wilmoth, "A Statement on the Future of Ophthalmology" (Aug. 1, 1975), Exhibit II-28, at R. 792. See also Moseley H. Winkler, M.D., "We're Surrendering our Patients to Nonphysicians," Medical Economics (Aug. 23, 1976), at pp. 74-79; American Optometric Association, A Legislative Manual (September 1966).

84 According to Optician Doug Matthews, for example, "[t]his is all the more reason for the Federal Trade Commission ruling, since it is apparent that the state governments are so heavily influenced by these associations." Supra note 15, at 4464. Edward Petrini, a Michigan Public Interest Research Group

(Continued)

(g) Past and Current Judicial Trends

The courts traditionally have upheld the states' authority to restrict advertising by ophthalmic practitioners and other professions as "a reasonable and valid exercise of the police power"⁸⁵ of the states. The constitutionality of statutory prohibitions on price advertising by optometrists and opticians has been upheld in virtually every reported case.⁸⁶ The state board rules prohibiting price advertising as unethical or unprofessional conduct have proven similarly immune in most judicial challenges.⁸⁷

84 Continued

member who was active in an unsuccessful attempt to repeal his state's price advertising prohibition, concluded that "[t]here is no reason to believe that the legislative climate will change." Supra note 82, at 835.

85 *Springfield v. Hurst*, 144 Ohio St. 49, 56 N.E.2d 185, 188 (1943).

86 *Melton v. Carter*, 204 Ark. 595, 16 S.W.2d 453 (1942); *Economy Optical Co. v. Kentucky Board of Optometric Examiners*, 310 S.W.2d 783 (Kent. 1958); *Michon v. Louisiana Board of Optometry Examiners*, 121 So.2d 565 (La. App. 1960); *Akin v. Louisiana Board of Optometry Examiners*, 150 So.2d 807 (La. App. 1963) aff'd, 158 So.2d 833 (1963); *Commonwealth v. Ferris*, 305 Mass. 233, 25 N.E.2d 378 (1940); *Seifert v. Buhl Optical Co.*, 2766 Mich. 692, 268 N.W. 784 (1936); *New Mexico Board of Examiners in Optometry v. Roberts*, 70 N.M. 90, 370 P.2d 811 (1962) aff'd sub nom. *Head v. New Mexico Board of Examiners in Optometry*, 374 U.S. 424 (1963); *Kelley v. Duling Enterprises, Inc.*, 84 S.D. 427, 172 N.W.2d 727 (1969); *Tennessee Board of Dispensing Opticians v. Eyear Corp.*, 218 Tenn. 60, 400 S.W.2d 734 (1966); *Ullom v. Boehm*, 392 Pa. 643, 142 A.2d 19 (1958); *Texas Optometry Board v. Lee Vision Center, Inc.*, 515 S.W.2d 380 (Tex. Civ. App. 1974); *Ritholz v. Commonwealth*, 184 Va. 339, 35 S.E.2d 210 (1945); *Bedno v. Fast*, 6 Wis.2d 471, 94 N.W.2d 396 (1959). See also Motion of American Optometric Association to Dismiss Rulemaking Proceeding Concerning Advertising of Ophthalmic Goods and Services (May 7, 1976), Exhibit I-7.

87 See, e.g., *Finlay Strauss, Inc. v. University of State of New York*, 270 A.D. 2060, 62 N.Y.S.2d 892 (1946); *Dubin v. Board of Regents of State of New York*, 286 A.D.9, 133 N.E.2d 697, 141 N.Y.S.2d 54 (1955); but see *Bresler v. Tietjen*, 424 S.W.2d 64 (Mo. 1968) (held Board of Optometry lacked power to control advertising by opticians).

The courts have generally emphasized the need to maintain professional decorum among licensed optometrists and opticians and have concurred in the industry view that advertising bans are a reasonable means to that end. The decision in Dubin v. Board of Regents of State of New York⁸⁸ upholding the board's rule declaring price advertising unprofessional conduct is illustrative:

The rule here in question does not forbid advertising in toto ... It only forbids a type of advertising which, by the standards accepted by, and prevailing in, the profession, constitutes professional misconduct. It was amply proved upon the trial in the Finlay Straus case that any advertisement of professional optometric services and any offering of free examinations or discounts as an inducement are, according to the consensus of the profession, improper and unprofessional.⁸⁹

These cases also point to legislative findings that consumers of eye care services may need the protections ostensibly embodied in the advertising restraints. The statement of the court in Springfield v. Hurst⁹⁰ is typical:

Quality of material and skill in workmanship are prime essentials in producing the finished lenses. Poor quality and poor grinding will naturally result from the desire to sell spectacles in quantity at a low advertised price, with the purpose of underselling the optometrist and other opticians who do not indulge in such advertising. Poor and improperly ground lenses will impair the eyesight of the person to whom they are sold as properly fitted. Thus, legislation prohibiting such bait advertising has a real and substantial relationship to the public health whatever vendor employs the injurious method. The result of forbidding the professional practitioner to resort to such advertising and permitting the optician (or even the retail vendor) to indulge in the harmful practice does not eradicate the evil. The whole field must be covered if protection is to be afforded the public.

⁸⁸ 286 A.D.9, 133 N.E.2d 697, 141 N.Y.S.2d 54 (1955).

⁸⁹ Id. at 60.

⁹⁰ 144 Ohio St. 49, 56 N.E.2d 185 (1943).

Therefore, an ordinance which prohibits advertising the price of lenses or complete eyeglasses is a reasonable and valid exercise of the police power.⁹¹

Thus, the courts have consistently endorsed the states' discretionary judgment in employing advertising bans as a means to ensure professionalism and thereby protect the public's health and welfare; in some decisions they have explicitly affirmed the states' contention that the means and the ends were indeed reasonably related. The courts have not, however, traditionally inquired into whether there are other public welfare issues to be taken into consideration in balancing the gains against the losses associated with advertising bans--such as the informational benefits to the public which flow from advertising.

The landmark U. S. Supreme Court decision in Virginia Pharmacy,⁹² which extended first amendment protection to commercial speech, appears to have rekindled the dispute over the validity of eyeglass advertising bans in the judicial arena. The Court's holding that the first amendment applies to the recipient of information -- that "the protection afforded is to the communication, to its source and to its recipients both"⁹³ -- has led opponents of eyeglass advertising bans in current suits to ask the courts to consider whether, in light of Virginia Pharmacy, the public's interest in receiving price information may now be the controlling interest. Numerous pending cases⁹⁴ brought by consumer groups and others challenging both statutory and regulatory advertising restraints will show whether the past judicial trends affirming the bans will now be reversed.

⁹¹ Id. at 188.

⁹² 96 S.Ct 1817 (1976).

⁹³ Id. at 1823.

⁹⁴ See, e.g., Complaint in Wall & Ochs, Inc. v. State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Superior Court of New Jersey, Chancery Division, Camden County, Exhibit IV-90; Complaint, Sidney Fried v. Hugh Sticksel, Jr., U.S. District Court for the Northern District of Texas, Dallas Division, No. CA 3-76-0377-G, Exhibit IV-143; Complaint and related documents in Arkansas Community Organizations for Reform Now v. Arkansas State Board of Optometry, Arkansas Optometric Association, U.S. District Court, Eastern District of Arkansas, Western Division, Exhibit IV-91; Amicus
(Continued)

In at least two jurisdictions, Florida⁹⁵ and Tennessee,⁹⁶ courts have held eyeglass advertising bans to be violative of the first amendment. In the Tennessee decision the court noted:

We think that Virginia [Pharmacy] is controlling in the case at bar. For purposes of the Supreme Court's reasoning in that case, there is no meaningful distinction between pharmacists and dispensing opticians. There is an aspect of professionalism and skill in both, but there is also a large element of mere retail selling of a standardized product. As was the case with the state's interest in pharmacy in Virginia [Pharmacy], the state's interest in the quality of service and professionalism of dispensing opticians here seems protected by other provisions of the regulatory scheme that more directly affect those qualities than does the ban on advertising ... (citations omitted). It is clear, that by prohibiting advertising by dispensing opticians, Tennessee is seeking to protect its citizens in a manner that has now been declared violative of the first amendment.⁹⁷

Two factors make it difficult to predict the extent to which the Virginia Pharmacy precedent might obviate the need for Commission action. First, the Court specifically noted in that decision that 95% of all prescription drugs are pre-packaged at the manufacturing level.⁹⁸ Thus, many ophthalmic practitioners have argued

94 (Continued)

Curiae of the Consumers' Council of the Commonwealth, Meyer Finkelstein, O.D. v. John E. Quinn, Massachusetts Supreme Judicial Court, No. 446 (Feb. 2, 1976), and Supplemental Brief of Amicus Curiae (March 2, 1976), Exhibit IV-118; Amended Complaint and Plaintiff's Memorandum of Law in Support of Preliminary Injunction, Consumers' Council v. Board of Registration in Optometry, Superior Court, Commonwealth of Massachusetts, No. 20715 (April 2, 1976), Exhibit IV-122.

- 95 Final Judgment in Eckerd Optical Centers, Inc. v. Florida State Board of Dispensing Opticians, No. 75-368, Second Circuit, Leon County, Fla. (Jan. 12, 1976), Exhibit IV-95.
- 96 Horner-Rausch Optical Co. v. Ashley (Davidson Law) (Tenn. Co. App., Oct. 29, 1976).
- 97 Id. at 6.
- 98 Supra note 77, at 1821.

that eyeglasses should be differentiated from prescription drugs because eyeglasses are individualized products. There is little doubt that prescription eyeglasses are not as standardized as are prescription drugs; however, most retailers purchase prescription eyewear which is fully fabricated at the wholesale and manufacturing levels.⁹⁹ Accordingly, it is unclear whether all courts will choose to apply the Virginia Pharmacy precedent to prescription eyeglass advertising bans.

Secondly, many persons testified that a greater amount of professional service is involved in the dispensing of prescription eyewear than is present in the retail drug analogy.¹⁰⁰ Of particular importance in this regard is a footnote in the Court's decision:

We stress that we have considered in this case the regulation of commercial advertising by pharmacists. Although we express no opinion as to other professions, the distinctions, historical and functional, between professions, may require consideration of quite different factors. Physicians and lawyers, for example, do not dispense standardized products; they render professional services of almost infinite variety and nature, with the consequent enhanced possibility for confusion and deception if they were to undertake certain kinds of advertising.¹⁰¹

Thus, staff agrees with the finding of the Presiding Officer in this proceeding that the full impact of Virginia Pharmacy remains to be determined.¹⁰² We do not believe, however, that this Court decision should deter the Commission from acting to free the flow of information in the ophthalmic market. The need for the recommended Rule, and particularly the provisions relating to the release of prescriptions, exists independently of Virginia Pharmacy.

⁹⁹ See Section V(c), infra.

¹⁰⁰ See Report of the Presiding Officer, Exhibit XIII-1, at p. 174, note 5.

¹⁰¹ Virginia Pharmacy, supra note 77, at 1831.

¹⁰² Report of the Presiding Officer, Exhibit XIII-1, at pp. 176-77.

3. Related Business Restraints

The Notice of Proceeding and Proposed Trade Regulation Rule which was published in the Federal Register on January 16, 1976,¹⁰³ was accompanied by 12 questions designed to elicit public comment on certain areas in which the Commission was particularly interested. Questions 9 and 10 asked whether several business practice restraints other than advertising had an impact on the cost and availability of eye care services. The Commission's interest in the restrictions stemmed from staff's finding during the investigation preceding publication of the proposed rule that the advertising prohibitions were only part of a comprehensive network of public and private restrictions extending to virtually all business aspects of the practitioner's practice.¹⁰⁴

The implication that restrictions on the mode and location of a practitioner's practice might contribute to the observed price dispersions attributed to advertising restrictions gave rise to a separate, concurrent Commission investigation into the possible effects of those restraints.¹⁰⁵ Although that investigation is a continuing, non-public matter, it is pertinent to note in the context of this proceeding both the existence of these other anticompetitive restrictions and their perceived relationship to the subject advertising bans. A discussion of the evidence presented during the trade regulation rule proceeding relating to the alleged economic impact of other business restraints vis-a-vis that of the advertising bans appears elsewhere in this report.¹⁰⁶

Business practice restrictions are aimed primarily at optometrists, and are found in their various forms and degrees in the licensing statutes, board regulations, and professional association codes in a majority of states. The most pervasive forms restrict the modes of commercial practice in the following ways:

103 41 Fed. Reg. 2399.

104 See Advertising of Ophthalmic Goods and Services: Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule (January 1976), Exhibit II-1, at pp. 19-20, 23-24.

105 See "FTC Announces Investigation of Commercial Restrictions in Prescription Eyeglass Industry," FTC News Release (Jan. 20, 1976).

106 See Section III(D), infra.

(1) prohibit the employment of optometrists by lay persons or firms; (2) forbid optometrists from practicing on the premises of mercantile establishments; (3) dictate the number of offices the practitioner may operate; and (4) ban the use of trade names.

Thirty states prohibit by statute or board regulation the employment of optometrists by lay persons or firms.¹⁰⁷ Lay employment restrictions are designed to prevent optometrists from working for individual opticians, retail optical chains, and department stores. Their ultimate effect on the retail competitive environment is to prevent such other retailers of optical goods from offering the "one-stop service" reserved to dispensing optometrists.¹⁰⁸ In states where opticianries and department stores can employ an optometrist to perform refractions and write prescriptions, the independent dispensing optometrist is obviously deprived of a segment of the potential market which he would otherwise enjoy.¹⁰⁹

107 See chart at p. 78, *infra*. The codes of ethics of at least four state optometric associations contain a similar restriction.

108 See, e.g., testimony of Kenneth Boyer, Ph.D., Assistant Professor of Economics, Michigan State University, Tr. 1281 at 1289; testimony of Michael Magura, Ph.D., Professor of Economics, University of Toledo, Tr. 1261 at 1263; testimony of John Collins, Chairman, Health Care Task Force, North Jersey Federation of Senior Citizens, Tr. 2430 at 2434; testimony of R. Burr Porter, Ph.D., Southern Methodist University Graduate School of Business, for National Association of Optometrists and Opticians (NAOO), Tr. 6264-D at 6264-F; Ralph Nader Study Group, The Closed Enterprise System (1972), quoted in testimony of James J. Ryan, NAOO and New York State Optical Retailers Association, Inc., Tr. 2360 at 2366; comment of Nancy Chasen, Consumers Union, Exhibit VII-1007, at R. 14015; letter from Franklin D. Rozak, Vice President, Cole National Corp., to FTC (Nov. 26, 1975), Exhibit V-42, at R. 9980; comment of NAOO, Exhibit VIII-187, at R. 14930, and exhibits.

109 A committee of the Illinois Optometric Association clearly stated its objectives in attempting to eliminate competition from "commercialists" in the following account of its advice to "professional" optometrists:

We tell them, look, here's a commercial outfit operating in your area taking 'x' number of dollars out of your practice. If it can be closed these dollars will be sifted back to you.

Quoted in Exhibit No. 2, comment of NAOO, *supra* note 108, at p. 16.

The legal bans on practicing on mercantile premises, which are in effect in 27 states,¹¹⁰ serve essentially the same purposes as lay employment restraints. Although they are aimed more specifically at preventing department stores such as Sears, Roebuck from providing refraction services, they also have the effect of precluding a potentially vigorous form of competition from encroaching on the independent practitioner's market segment.¹¹¹

Eighteen states limit the number of branch offices an optometrist can operate--usually to one outlet in addition to his original establishment.¹¹² Optometrists in 39 states are prohibited from using trade names,¹¹³ which means that the practitioner cannot call his outlet "Discount Optical," or use any appellation other than the one on his license to practice. The branch office and trade name restrictions differ in effect from the aforementioned prohibitions in that they--like the advertising bans directed at optometrists--limit competition among optometrists

¹¹⁰ See chart at p. 78, infra. The codes of ethics of at least 19 state optometric associations prohibit mercantile location practice.

¹¹¹ For example, Virginia Long, Director of New Jersey's Division of Consumer Affairs, testified that:

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. Tr. 1843 at 1856.

See also testimony of Michael Magura, Ph.D., supra note 108, at 1263; testimony of John Collins, supra note at 108, at 2434; letter from Deputy Attorney General Kleindienst to Chairman, Committee on the District of Columbia (Nov. 12, 1970), quoted in testimony of James J. Ryan, supra note 108, at 2367-68; letter from Franklin D. Rozak, supra note 108; comment of NAOO, supra note 108; testimony of R. Burr Porter, supra note 108.

¹¹² See chart at p. 78, infra.

¹¹³ See chart at p. 78, infra.

themselves, rather than insulating them from certain forms of competition from other types of ophthalmic retailers.¹¹⁴

Statutory business restraints on opticians, although imposed less widely than on optometrists, also augment the advertising restraints in limiting competition both among opticians and between opticians and other purveyors of eyeglasses.¹¹⁵ The restrictions in most cases are similar to those pertaining to optometrists.

One restriction unique to opticianry is that prohibiting, in 19 states, the duplication of lenses without a prescription.¹¹⁶ That prohibition prevents the consumer from having an extra pair of eyeglasses made or a damaged lens replaced by an optician unless the consumer happens to possess a copy of his original prescription. The restriction not only inconveniences eyeglass wearers who need repairs or lens replacements,¹¹⁷ but precludes

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- 114 See, e.g., branch office restrictions: testimony of Kenneth Davenport, supra note 19, at 6186; testimony of Kenneth Boyer, Ph.D., supra note 108, at 1289; testimony of Michael Magura, Ph.D., supra note 108, at 1263; testimony of John Collins, supra note 108, at 2434; testimony of James J. Ryan, supra note 108, at 2361; testimony of R. Burr Porter, Ph.D., supra note 108, at 6264-F; comment of NAOO, supra note 108. Trade name restrictions: testimony of Kenneth Davenport, supra note 19, at 6195-96; Complaint in the Intervention of Texas Senior Citizens Association, *Rogers v. Friedman*, No. B-75-277-CA (E.D.Tex), Exhibit IV-142, at R. 6125; letter from Franklin D. Rozak to FTC, supra note 108, at 9985; testimony of Robert Odom, President, Opticians Association of America, Tr. 4312 at 4318; rebuttal submission of Stanley C. Pearle, O.D., Chairman, Opticks, Exhibit IX-161, at R. 16381.
- 115 See, e.g., testimony of Kenneth Davenport, supra note 19, at 6197; rebuttal submission of Stanley C. Pearle, O.D., supra note 114, at 16381-82; rebuttal submission of J. A. Miller, Executive Director, Opticians Association of America, Exhibit IX-180, at R. 17377; letter from Franklin D. Rozak, supra note 108.
- 116 Alabama, California, Idaho, Illinois, Indiana, Iowa, Kansas, Maine, Montana, Nevada, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Virginia, Washington, West Virginia, and Wyoming.
- 117 See, e.g., testimony of Robert Odom, supra note 114, at 4317-18; testimony of Donald Juhl, supra note 79, at 386; comment of NAOO, supra note 108, at 14941-42.

opticians from performing a service for which they are mechanically and educationally equipped.¹¹⁸ One justification proffered for this restriction is that consumers will fail to obtain eye examinations as frequently as they should if they are not required to return to their refractionist each time they desire new eyeglasses.

The importance of the foregoing business practice restrictions in the context of this proceeding is their place in the larger picture of anticompetitive laws, rules, regulations and ethical codes which unmistakably emerges from the record. They have, perhaps even more directly than the advertising bans, evolved from the efforts of organized optometry to eradicate commercialism and to ensure the "professionalization" of optometry. The same public health and welfare justifications which have been proffered in support of the advertising restraints¹¹⁹ are found in even greater abundance and intensity in the industry arguments for business practice restrictions.¹²⁰

118 See, e.g., testimony of Robert Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2011, 2029; testimony of Stephen LaVerdiere, LaVerdiere's Super Drug Stores, Tr. 2573 at 2575; testimony of James E. Washington, O.D., Tr. 2591 at 2618; testimony of Donald Juhl, supra note 79, at 409; testimony of Robert Odom, supra note 114, at 4339-41; rebuttal submission of J. A. Miller, supra note 115, at 17366-69; letter from Richard D. Myrick, Certified Optician, Topeka, Kansas, to FTC (March 10, 1976), Exhibit IV-119, at R. 5628.

119 See, e.g., Section V, infra.

120 Virginia Long, Director of the New Jersey Division of Consumer Affairs, testified that the section of a bill which would have allowed commercial practice by optometrists was even less palatable to the industry than was the section pertaining to price advertising:

In New Jersey very honestly we finally had to drop the section of our law which would have allowed optometrists to practice in a commercial establishment because that, frankly, was the part of the law that we were proposing which met with the most vituperative response from the particular professions that were involved. Tr. 1843 at 1854-55.

See, for examples of industry arguments for business practice restraints: testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1040; testimony of James Elless,
(Continued)

The validity of those justifications is not at issue here, and, at this juncture, staff questions neither the intent of nor the rationality of the means employed by the states to eliminate the alleged evils of "commercialism" from the delivery of eye care goods and services. That these commercial restrictions do have the possibly not altogether coincidental effect of limiting competition among providers of those goods and services and of restricting the sources of eye care available to consumers is relevant to this proceeding. The evidence in the record suggests that the advertising bans are one component in a larger structure of anticompetitive restraints which inhibits natural market forces and preserves the guild nature of the ophthalmic professions. As the Presiding Officer concluded in his Report, the business restrictions serve as a reinforcement of the advertising bans in that they are

protective barriers which keep potentially highly competitive providers from the marketplace in some states and leave it to the domination of those who do not wish to engage in price competition.¹²¹

B. Private Associational Restraints

In addition to the legal strictures on advertising, the private associations of ophthalmic practitioners employ a variety of formal and informal means to discourage advertising by their members. The associations have as a major objective the increased

120 (Continued)

O.D., Tr. 5363 at 5365; testimony of Alden Haffner, O.D., supra note 49, at 2046; testimony of Bernard Morewitz, O.D., supra note 49, at 182; testimony of Robert N. Kleinstein, O.D., M.P.H., Ph.D., School of Optometry, University of Alabama Medical School, Tr. 6057 at 6081, 6101; testimony of Ron G. Fair, O.D., President, American Optometric Association, Tr. 4638 at 4640; testimony of Herman Gould, O.D., Tr. 4749 at 4753; testimony of Edward Stein, O.D., Tr. 926 at 929; testimony of Sylvester Bradford, O.D., Tr. 5401 at 5409; testimony of Eugene V. McCrary, O.D., Maryland Optometric Association, Tr. 432 at 438; letter from Paul W. Lycette, O.D., Secretary, Mississippi State Board of Optometry, to FTC (Oct. 13, 1975), Exhibit IV-59, at R. 3018; letter from Brian S. Klinger, O.D., President, New Hampshire Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3143; Ralph Barstow, How to Succeed in Optometry (Chicago: Illinois College of Optometry Press, 1948), Exhibit II-23, at R. 721.

121 Report of the Presiding Officer, Exhibit XIII-1, at p. 125.

"professionalization" of their respective vocations, and price advertising is generally held to be inimical to that goal. Thus, the state and national associations exert varying degrees of pressure on their memberships to refrain from advertising, both through explicit directives such as codes of ethics and through more subtle indoctrination in the credos of "professionalism." The associational restraints affecting each of the three practitioner groups vary considerably, and will be described separately below.

1. Ophthalmologists

Ophthalmologists, as physicians, may belong to the American Medical Association (AMA). They also have an organization of practitioners in their own specialty, called the American Association of Ophthalmology (AAO).

The American Association of Ophthalmology has approximately 3,500 members,¹²² who constitute about one-third of U.S. ophthalmologists.¹²³ The AAO is affiliated with ophthalmology societies in every state.¹²⁴ The AAO differs from other professional associations in that it apparently has no codes or rules binding its members to particular modes of conduct. Its stated objectives are:

to promote the conservation of vision and prevention of blindness through more effective utilization of the scientific knowledge of ophthalmology and of the various supporting skills in all aspects of eye care.¹²⁵

Its functions are primarily research- and education-oriented, with some emphasis on public relations in the area of delineating the qualifications and functions of the three types of ophthalmic practitioners.¹²⁶

The AAO¹²⁷ took a general position against advertising of ophthalmic services and of contact lenses in a comment on the Federal

122 Letter from Lawrence Zupan, Executive Secretary, AAO, to FTC (Oct. 21, 1975), Exhibit IV-52, at R. 2493.

123 See Section I(C)(1), supra.

124 Letter from Lawrence Zupan (Exhibit A), supra note 122, at 2499.

125 Id. at 2497.

126 Id.

127 Then named the National Medical Foundation for Eye Care.

Trade Commission's proposed Trade Practice Rules for the Optical Products Industry in 1962.¹²⁸ In its comment, the Association also pointed out that "[a]ll physicians are already governed by the ethical code of the medical profession,"¹²⁹ and specifically cited the AMA's Principles of Medical Ethics as governing ophthalmologists.¹³⁰

Section Five of the AMA's Principles of Medical Ethics states simply that "[a physician] should not solicit patients." The Judicial Council of the AMA has elaborated on that principle in 13 interpretative Opinions directly related to advertising practices.¹³¹ The Opinions make clear that advertising is considered a form of solicitation, which is condemned as an affront to the dignity and honor of the profession.¹³² The following excerpt from one Opinion exemplifies the Association's views on advertising as it relates to professionalism:

The refraining from or the employment of advertising is the clearly defined difference between a reputable physician and a quack-- the physician, one who quietly, through his professional work and attainments seeks by daily honorable dealing to spread the truth among his patients, the quack, one who endeavors to obtain his livelihood by playing on the credulity of the ignorant and timid, imposing on the public statements known to be false, stopping at nothing in his effort to enhance his notoriety or fill his pocket.¹³³

128 Letter from Lawrence Zupan (Exhibit E), supra note 122, at 2526.

129 Id. at 2530 (emphasis in original).

130 Id.

131 Section Five: Opinions 6, 7, 8, 9, 11, 14, 16, 17, 18, 20, 22, and 23; Section 10: Opinion 4, American Medical Association, Opinions and Reports of the Judicial Council (1971).

132 Id.

133 Id. at Section 10, Opinion 4.

The approved information a physician may disseminate concerning his availability include his name, type of practice, office location and hours.¹³⁴ "[A]cceptable media of making factual information available to the public" include telephone listings, office signs, professional cards, and "dignified announcements."¹³⁵ The advertising of prices or fees is not specifically mentioned in the Principles or the Opinions--apparently either because such advertising is implicitly banned in the proscriptions regarding solicitation, or because the hoary medical tradition against advertising is so universally adhered to that the AMA tribunal was never called upon to rule on the issue. The Commission has filed a still-pending complaint in a separate proceeding charging the American Medical Association and two state and county affiliates with using the Principles of Medical Ethics to hinder competition and deprive consumers of pertinent information.¹³⁶

2. Optometrists

The American Optometric Association is the major national association of optometrists. Approximately 75% of the nation's 20,000 optometrists are members of the AOA.¹³⁷ The AOA has affiliated associations in every state, and membership in a state association is a prerequisite of and automatically confers membership in the national organization.¹³⁸ Yet, according to AOA submissions to the Commission and the testimony of its executive director, the state associations are entirely autonomous and receive no direction from the national body as to policies, membership requirements, or ethical standards.¹³⁹

Until recently, the AOA had a clear national policy against price advertising by its members. The organization's position was enunciated in the Supplements to its Code of Ethics, which

134 Id. at Section 5, Opinion 11.

135 Id.

136 Complaint in the Matter of The American Medical Association, The Connecticut State Medical Society, the New Haven County Medical Association, Inc., Docket No. 9064 (Dec. 22, 1975).

137 Testimony of J. Harold Bailey, Executive Director, AOA, Tr. 5905 at 5965.

138 Id. at 5954.

139 Id.; letter from J. Harold Bailey, Executive Director, AOA, to FTC (Nov. 15, 1975), Exhibit IV-53, at R. 2550-51.

were adopted in 1946.¹⁴⁰ The AOA has in recent years gradually softened its official proscriptions on advertising, so that now it has no written policy on the subject. The initial impetus came from the Federal Trade Commission, which in 1968 advised the AOA that its prohibition against advertising "may be in violation of the laws administered by this Commission."¹⁴¹ The Association responded by amending its Supplements to the Code of Ethics so that advertising was "deemed ... to be unethical and to constitute unprofessional conduct in accordance with the laws and regulations of each particular state."¹⁴² This meant, as the AOA's executive director has explained, that:

Advertising is not deemed unethical insofar as the AOA is concerned, if engaged in in a state where it is not prohibited. In effect, Section C [of the Supplements] urges AOA members to respect the restrictions, if any, of their own state laws and regulations relating to advertising.¹⁴³

In March, 1976, after the current rulemaking proceeding had commenced, the AOA rescinded the Supplements in their entirety.¹⁴⁴

¹⁴⁰ Section C of the Supplements deemed the following "unethical and to constitute unprofessional conduct":

Advertising of any character which includes or contains any fee whatsoever, or any reference thereto, or any reference to the cost to the patient, whether related to that examination or the cost or fee for lenses, glasses, frames, mountings, or any other optometric services, article, or device necessary for the patient.

AOA, Code of Ethics and Supplements, Rules of Practice, Exhibit IV-54, at R. 2707.

¹⁴¹ Letter from Rufus E. Wilson, Chief, Div. of General Trade Restraints, FTC, to AOA (Feb. 27, 1968), attachment to rebuttal submission of AOA, Exhibit IX-179, at R. 17359.

¹⁴² Letter from Ellis Lyons, General Counsel, AOA, to Rufus E. Wilson, FTC (July 18, 1968), supra note 141, at 17361.

¹⁴³ Rebuttal submission of AOA, supra note 141, at 17347.

¹⁴⁴ AOA Bulletin No. 68, Vol. XXXIV (March 19, 1976), HX 368.

That the Association still manifestly opposes price advertising is evident in its role in this proceeding as the leading exponent of interested parties opposed to the proposed rule,¹⁴⁵ in the testimony of its president,¹⁴⁶ and in the written comments of the organization.¹⁴⁷ In its stated policy, however, the AOA defers to the state associations to set standards with respect to advertising.¹⁴⁸

Although not all of the state optometric associations responded to the staff's request for their respective codes of ethics, the evidence in the record shows that a substantial number do prohibit price advertising by their members.¹⁴⁹ Since most states ban price advertising by statute or board regulation,¹⁵⁰ such associational constraints are largely superfluous in those states.

In five of the six states in which optometrists are free from any legal restraints on price advertising, the associations have filled the void with code of ethics provisions explicitly

145 See letter from Edward A. Groobert, Volpe, Boskey and Lyons, Attorneys for AOA, to Henry B. Cabell, Presiding Officer, FTC (May 10, 1976), Exhibit X-17, at R. 17546; Presiding Officer's Notice Identifying Groups With the Same or Similar Interests in the Proceeding (May 19, 1976), Exhibit X-31, at R. 17812; Presiding Officer's Notice Identifying Representatives for Purposes of Examination Including Cross-Examination (June 2, 1976), Exhibit X-41, at R. 17831, which designated the AOA as the representative of Group 2, composed of professional groups opposed to the rule.

146 Testimony of Ron G. Fair, supra note 120, at 4694-95.

147 Comment of AOA, Exhibit VIII-160, at R. 14680; rebuttal submission of AOA, supra note 141; letter from J. Harold Bailey, supra note 139.

148 Testimony of J. Harold Bailey, supra note 137, at 5997-98; rebuttal submission of AOA, supra note 141, at 14684-86.

149 See State Laws, Regulations and Professional Codes, Exhibits IV-1 through IV-51.

150 See subsection A(2)(b), supra.

banning such advertising.¹⁵¹ The optometric association of the remaining state, Iowa, does not specifically mention price advertising in its Code of Ethics, although the Code contains numerous provisions limiting the form and content of professional cards printed in news media, telephone listings, office signs, and window displays.¹⁵² The Iowa Code also stipulates that its members must agree to uphold the AOA Code of Ethics, which contained an unqualified price advertising ban at the time the state code was adopted.¹⁵³ Thus, optometrists who are members of the respective associations in the states where price advertising is legally permitted are effectively prevented from disseminating price information by those privately-imposed strictures.

In addition to the widespread use of explicit price advertising prohibitions in codes of ethics and rules of practice, optometric associations employ a variety of other means to discourage general advertising by their members. Some state associations' membership requirements, for example, place more emphasis on the advertising and related business practices of prospective members than on their educational and professional qualifications. The Arizona Optometric Association's point system for membership eligibility consists of 110 possible points, of which 80 relate to advertising, telephone listings, window displays, office location and signs; 14 concern continuing education achievements; and 16 points can be earned for physical facilities and technical examination equipment.¹⁵⁴

Another means of effectively proscribing advertising is to delineate with specificity the association-approved modes of communicating one's availability to the public. The American Optometric Association has published a Manual of Professional

151 See Arizona Optometric Association, Policy Manual, Exhibit IV-3; California Optometric Association, Rules of Practice, Exhibit IV-5; Colorado Optometric Association, Code of Ethics, Exhibit IV-6; Optometric Society of the District of Columbia, Rules of Practice, Exhibit IV-9; letter from William S. Eisner, Administrative Director, Maryland Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3133.

152 Provisions H, I, J, K, and L, Iowa Optometric Association, Code of Ethics and Rules of Practice, Exhibit IV-16.

153 *Id.*, Provision N. The Code of Ethics was adopted May 5-6, 1968. The original AOA Code of Ethics was still in effect at that time. See note 142, *supra*.

154 Arizona Optometric Association, Policy Manual, Exhibit IV-3.

Practice for the American Optometrist,¹⁵⁵ which contains detailed instructions on the approved means of establishing and maintaining a professional practice. The Manual includes samples of approved business cards; cards for announcing the opening or changing of office locations; patient appointment cards; reminder notices for annual eye examinations; letterheads and envelopes; and recommended type styles and sizes.¹⁵⁶ It also contains detailed instructions for name plate and window lettering, fee statements, and telephone directory listings.¹⁵⁷ A list of "A.O.A. Recommended Terminology" in the Manual advises the optometrist who aspires to attain professional status to substitute the term "fees" for "price or cost"; "providing services" for "selling glasses"; "visual examination or visual analysis" for "eye examination or eye test"; "educational meeting" for "meeting," and so on.¹⁵⁸ State optometric associations provide their members with similarly detailed instructions for "professional" announcements, telephone listings, and other media for announcing the availability of their services,¹⁵⁹ all of which so narrowly circumscribe the approved means of advertising that they effectively discourage the dissemination of meaningful information to consumers.

The associations' only apparent enforcement mechanism is expulsion from membership of those who violate the advertising strictures.¹⁶⁰ The benefits of association membership, however,

¹⁵⁵ AOA Manual of Professional Practice for the American Optometrist (1966), Exhibit IV-117, at R. 5549.

¹⁵⁶ Id. at 5552-56.

¹⁵⁷ Id. at 5557-61.

¹⁵⁸ Id. at 5562.

¹⁵⁹ See, e.g., Missouri Optometric Association, Code of Practice, Exhibit IV-26; Montana Optometric Association, Code of Practice, Exhibit IV-27; New York State Optometric Association, Rules of Practice, Exhibit IV-33; Washington Optometric Association, Principles of Ethics and Economics for the Optometrist, Exhibit IV-48.

¹⁶⁰ Members of the Oregon Optometric Association, for example, are required to affirm as follows: "I now conform, in all respects, particulars, and details with the Code of Ethics and Code of Conduct, and will continue to conform with and abide by the same," and that it is "understood by me that any determination (after due hearing, as provided) that the Code of Ethics or Code of Conduct has been violated

(Continued)

are substantial: continuing education programs; research reports; newsletters and journals reporting current technical developments in the field; professional meetings and conventions; participation in certain prepaid eye care plans; membership insurance and retirement programs; public identification in telephone directory and other listings with association members; and increased prestige, to name a few.¹⁶¹ Those optometrists who might wish to advertise in the absence of legal restraints against it must weigh the loss of such benefits and the prospect of ostracism from the society of their colleagues against the advantages of publicizing their prices and availability.

3. Opticians

The ethical codes of opticians' associations are far less widespread and restrictive than those of the other ophthalmic practitioners; few of the associations submitted such codes in response to a staff request, and only two of those on the record prohibit price advertising by their members.¹⁶² The Opticians Association of America, the major national professional organization, has no stated policy against advertising by opticians.¹⁶³ Although there appears to be considerable debate among individual opticians as to the propriety of advertising,¹⁶⁴

¹⁶⁰ (Continued)

by a member will be just cause for the immediate expulsion of the violator for unprofessional conduct." Oregon Optometric Association, "Conformity Statement," Code of Ethics and Code of Conduct, Exhibit IV-38.

¹⁶¹ Testimony of J. Harold Bailey, supra note 137, at 5993; comment of NAOO (Exhibit 3), supra note 108.

¹⁶² Georgia Society of Dispensing Opticians, By-Laws, Exhibit IV-11; Nebraska Society of Dispensing Opticians, Code of Ethics, Exhibit IV-28.

¹⁶³ Letter from J. A. Miller, Executive Director, Opticians Association of America, to FTC (Oct. 30, 1975), Exhibit IV-55, at R. 2903.

¹⁶⁴ For example, of the 47 individual opticians whose views on the proposed rule are contained in the record (in the form of either testimony or written comments), 20 opposed price advertising, and 27 favored it.

organized opticianry as a whole has officially neither condemned nor condoned it.¹⁶⁵

Thus, the legal and private restraints on advertising combine to effectively prevent most ophthalmologists and optometrists --and opticians in numerous jurisdictions--from informing consumers of their prices. In the following sections we will discuss the effects of such restraints on the prices of eye care goods and services in the current market, and their impact on consumers.

165 Some evidence in the record suggests that opticians' groups which have obtained state licensure and the concomitant "professionalization" of their vocation may oppose price advertising as vigorously as do their optometric counterparts. For example, the Florida Association of Dispensing Opticians (FADO), believes that licensing status confers on opticians in that state a superiority over their unlicensed colleagues: "Opticians in Florida are actually specialists in the field compared to non-licensed states." FADO Legislative Fact Sheet (May 16, 1975), Exhibit IV-101, at R. 5235. The FADO lobbied actively against a bill to permit price advertising in Florida, partly on the basis that it would demean their professional status:

Opticians are not clerks or sales persons. Instead they are licensed and trained to prepare and dispense lenses, spectacles, eyeglasses, and optical devicesLet's keep fighting for our "professional functions." Id.

Legal Restrictions on Optometrists' Business Practices
Other than Price Advertising 1/

	BUSINESS PRACTICE RESTRAINTS (SEE KEY)							
	1	2	3	4	5	6	7	8
ALA.	X	X			X	X		X
ALAS.	X	X	X	X	X	X	X	X
ARIZ.			X		X		X	X
ARK.	X	X	X	X	X			
CAL.					X		X	X
COLO.		X	X		X			X
CONN.	X	X	X	X	X	X	X	
DEL.	X	X	X	X	X	X		X
D.C.								
FLA.	X	X	X	X	X	X	X	X
GA.	X	X	X	X		X	X	X
HAW.	X	X	X	X	X	X		
IDA.	X	X	X	X	X		X	X
ILL.		X	X	X				X
IND.		X			X			X
IOWA								X
KAN.	X	X	X	X	X		X	X
KY.	X	X	X	X	X		X	X
LA.								
ME.	X	X	X	X	X	X	X	X
MD.								
MASS.			X	X		X	X	X
MICH.		X		X				X
MINN.		X						
MISS.	X	X	X		X	X	X	X
MO.		X				X		
MONT.						X		X
NEB.		X						
NEV.	X	X	X	X	X	X		X
N.H.					X	X		
N.J.	X	X	X	X	X	X	X	X
N.M.	X	X				X		
N.Y.		X						X
N.C.	X	X						X
N.D.	X	X	X	X	X	X		X
OHIO					X			X
OKLA.	X	X			X	X	X	X
ORE.		X					X	X
PA.			X	X	X	X	X	X
R.I.	X	X	X	X	X	X		X
S.C.	X	X	X	X		X	X	X
S.D.	X	X		X	X	X		X
TENN.	X	X		X	X	X		X
TEX.				X	X	X	X	X
UTAH						X		X
VT.	X	X	X	X				X
VA.			X	X	X	X		X
WASH.		X						X
W.V.					X	X		X
WIS.			X	X				X
WYO.	X	X			X			
TOTALS	25	35	25	26	30	27	18	39

KEY

- 1 - All forms of media advertising prohibited, except announcement of new practice or location or other narrowly defined "institutional notices"
- 2 - Advertising of discounts or premiums prohibited 2/
- 3 - Telephone directory listing limitations
- 4 - Store sign and window display limitations
- 5 - Employment by lay persons or firms prohibited
- 6 - Practicing on mercantile premises prohibited
- 7 - Branch office limitations
- 8 - Trade names prohibited

1/ This chart is based primarily on statutes and regulations which staff obtained from the state boards in 1975. Subsequent modifications in laws or regulations of which staff has knowledge have been incorporated herein.

2/ Included are those state laws or regulations which specifically prohibit the publication of discounts, and those which prohibit all advertising as noted in category 1 of Key.

III. Economic Effect of Advertising Restraints

The proposed rule raised several economic issues considered during the rulemaking proceeding: (1) whether prices for ophthalmic goods are widely disparate; (2) if prices are widely disparate, do these differentials correlate with advertising restrictions; (3) would increased advertising result in lower retail prices for ophthalmic goods and services. A discussion of these issues follows.

A. Indications of Wide Price Dispersions

The evidence available at the time the rule was proposed suggested that a wide range of prices existed within many jurisdictions for comparable prescription eyewear.¹ The initiation of the rulemaking proceedings spurred several consumer groups and others to undertake an assortment of price surveys. Most were designed to illustrate the degree of existing price dispersion.

A single theme predominates throughout all of the surveys performed: prices for lenses, frames, or complete eyeglasses vary as much as 100% to 300% from seller to seller.² For example, a

1 See Staff Report to the Federal Trade Commission and Proposed Trade Regulation Rule Concerning Advertising of Ophthalmic Goods and Services (January 1976) Exhibit II-1, at pp. 35-51.

2 Numerous articles evidence that such differences are common. See, e.g., Miller, "Opticians Keep Eye on Ads," The Gloucester County Times (Mar. 7, 1976), Exhibit IV-128, at R. 5734; Arkansas Gazette (Dec. 24, 1975), Exhibit IV-81, at R. 4721; Arkansas Gazette (Dec. 4, 1975), Exhibit IV-81, at R. 4724; Arkansas Gazette (Dec. 10, 1975), Exhibit IV-81, at R. 4725; Hollar, "Eye Exam, Glasses Vary Widely in Cost," Exhibit V-17, at R. 7778; Sinclair, "Will Law Cut Cost of Your Eyeglasses," Miami Herald (May 24, 1976), Exhibit IX-64, at R. 15449.

Bryan Miller conducted a survey for Connecticut Magazine of 14 opticians in Connecticut which showed that prices for duplicating a pair of eyeglasses ranged from \$29.95 to \$50; differences of as much as 350% on frames and lenses were observed. Miller, "You Paid Too Much for Glasses," Connecticut Magazine (January 1976); Exhibit IV-140, at R. 5839.

A Tulsa Tribune survey showed prices varied from \$22.00 to \$37.50. Tulsa Tribune (April 25, 1976), Exhibit VI-33, at R. 12521.

(Continued)

Several consumer groups also conducted price comparison surveys. Many were conducted on limited budgets and all suffer to a greater or lesser degree from methodological and other infirmities. However, collectively, they indicate that prices do indeed vary widely.

A study conducted by North Carolina Public Interest Research Group (NCPIRG) of three cities in North Carolina sought price quotations by telephone and in-person visits for two eyeglasses prescriptions with frame specifications from a total of 29 optometrists and opticians. NCPIRG found that prices varied by more than \$33.00 in Burlington, \$31.00, in Durham, and \$45.00 in Winston-Salem. Testimony of William Bloss, North Carolina Public Interest Research Group, Tr. 124 at 126.

A telephone survey of 15 opticians in Cleveland conducted by Congressman Ronald M. Mottl revealed that identical prescriptions for bifocal lenses varied in price from \$28.00 to \$43.00, or a 54% difference, and single-vision lenses from \$17.50 to \$27.00, or 54%. Testimony of Congressman Ronald Mottl, Tr. 626 at 629.

The Commonwealth of Massachusetts Consumer's Council obtained price quotations for eyeglasses from 16 opticians in the Boston area and quotations for eye examinations from 98 optometrists. Surveyors found that glass and plastic single-vision lenses varied 62% and 67% respectively. Frame variations were even greater, averaging about 150% for plastic frames and 167% for wire frames. Surveyors also requested price quotations for eye examinations with glaucoma tests. Fees varied from \$12.00 to \$26.00, of 117%, with a mode price of \$20.00. Testimony of Terrance J. Hamilton, Counsel, Massachusetts Consumers' Council, Tr. 2625 at 2631-32 (Single-vision glass lenses ranged from \$18.00 to \$30.00; plastic from \$17.00 to \$27.50; plastic frames from \$8.00 to \$20.00; wire frames from \$15.00 to \$40.00).

A survey conducted by the Community Service Society of New York City sought to evaluate the impact of competitive price differences. Price quotations were obtained from 52 opticians, optometrists and optical retail firms in six middle-income areas, and ranged by the degree of competitiveness. Level of competition was determined by the number of high-volume outlets in the neighborhoods; the supposition being that the presence of such outlets could exert a competitive influence on prices. (Community Service Society classified those neighborhoods with median family incomes of \$8,500 as low-income, and those with median family incomes

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survey of 80 opticians conducted by the New Jersey Division of Consumer Affairs found that prices for replacing a specific pair of eyeglasses ranged from a low of \$16 to a high of \$55. Frames alone ranged from \$10.00 to \$30.00, while lenses ranged from \$6 to \$28.3

A similar survey was performed by the Commonwealth of Massachusetts Consumer's Council. In that survey, price quotations were obtained from 16 opticians in the Boston metropolitan area. Surveyors found that glass and plastic single-vision lenses varied 62% and 67% respectively. Frames variations were even greater, averaging about 150% for plastic frames and 167% for wire frames.⁴

In yet another survey, the Oregon Consumer League surveyed all dispensing optometrists and opticians in center-city Portland for price quotations for a specific set of single-vision glass lenses and metal frames. The results: a price range of from \$34 to \$74.⁵ In addition, the record is replete with the observations

2 (Continued)

of over \$10,500 as middle-income. Neighborhoods with no high-volume outlets were segregated from those with four or more.) In each neighborhood, those sampled comprised at least 60% of the total vision care establishments. Specific prescriptions and two identical frames were used to obtain quotes. Surveyors concluded that high-volume optical retailers demonstrated a pattern of statistically significant price differences, consistently reporting the lowest average prices with the least variation when compared to opticians and optometrists. Additionally, Community Service Society found that opticians and optometrists in competitive neighborhoods charged as much as 18% less than their counterparts in non-competitive neighborhoods. However, even in highly competitive neighborhoods, opticians and optometrists who charged widely different prices were able to coexist. Large price differences were revealed: lenses varied almost 200% in price, and frames varied as much as 225%. Testimony of William B. Haley, Acting Director, Department of Public Affairs, Community Service Society, New York, Tr. 2129 at 2132; Study by William B. Haley, A Look into the Price of Eyeglasses, HX-183.

3 Testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1850.

4 Testimony of Terrance Hamilton, supra note 2, at 2631.

5 Testimony of June Tanoue, Oregon Consumer League, Tr. 3298 at 3299.

of consumers noting the price variations they have observed in the course of their own shopping experiences.⁶

In the aggregate, these price surveys are consistent with staff's initial findings that prices for relatively homogeneous ophthalmic goods and services do in fact vary over a wide spectrum.

6 See, e.g., comment of Sam Schiffman, Exhibit VII-129, at R. 12808; comment of John M. Clubpick, Exhibit VII-524, at R. 13270; comment of Ben Aspy, Exhibit VII-509, at R. 13255; comment of William Bakir, Exhibit VII-437, at R. 13162; comment of Albert Bowen, Exhibit VII-372, at R. 13088, comment of Ethel Black, Exhibit VII-410, at R. 13127; comment of R. L. Boyd, Exhibit VII-455, at R. 13188; comment of L. R. Brown, Exhibit VII-440, at R. 13166; comment of Carroll N. Chenoweth, Exhibit VII-473, at R. 13213; comments of Charles and Hedy Hardy, Exhibit VII-374, at R. 13090; comment of Minnie M. Harper, Exhibit VII-323, at R. 13029; comment of William O. Hartwig, Exhibit VII-438, at R. 13163; comments of Mr. and Mrs. William Hauser and Mr. and Mrs. Walter G. Brauns, Exhibit VII-436, at R. 13161; comment of Florine E. Butman, Exhibit VII-544, at R. 13292; comment of G. W. Kassel, Exhibit VII-350, at R. 13064; comment of John Koralcik, Exhibit VII-457, at R. 13190; comment of Mrs. Seymour Lewis, Exhibit VII-435, at R. 13159; comment of Edna Lacey, Exhibit VII-330, at R. 13039; comment of William J. McDade, Exhibit VII-461, at R. 13197; comment of Horace G. Meals, Exhibit VII-369, at R. 13085, comment of Miles Murphy, Exhibit VII-338, at R. 13048; comment of Hilda T. Pearson, Exhibit VII-428, at R. 13151; comments of Mr. and Mrs. Leo W. Pietz, Exhibit VII-538, at R. 13286; comment of Martel Roberts, Exhibit VII-549, at R. 13300; comment of Irene Potthast, Exhibit VII-345, at R. 13058; comment of Dolan R. Stecher, Exhibit VII-449, at R. 13180; comment of Captain F. J. Trost, USNR (ret.), Exhibit VII-429, at R. 13152; comment of Joseph P. Sullivan, Exhibit VII-343, at R. 13055; comment of James Wells, Exhibit VII-371, at R. 13087-a; comment of B. M. Unger, Exhibit VII-543, at R. 13294; comment of Morris Rubin, Exhibit VII-618, at R. 13382; comment of Harold F. Baker, Exhibit VII-619, at R. 13383; comment of Donald Brims, Exhibit VII-597, at R. 13349; comment of T. R. Harrington, Jr., Exhibit VII-600, at R. 13353; comments of LeRoy Henderson, Mildred Henderson and Diane Studley, Exhibit VII-588, at R. 13340; comment of Connie M. Krallman, Exhibit VII-716, at R. 13514; comment of Harold Wordrum, Exhibit VII-616, at R. 13380; comment of Michael Palmer, Exhibit VII-691, at R. 13477; comment of Minnie A. Schaefer; Exhibit VII-637, at R. 13404; comment of Muriel Shaw, Exhibit VII-759, at R. 13571; comment comment of B. B. Swartt, Exhibit VII-589, at R. 13341; comment

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The criticisms leveled at the aforementioned surveys are exemplified by the rebuttal comments of the American Optometric Association:

It is clear that frames and lenses are not relatively homogeneous products, and that, in general, they may vary significantly in style, type, quality, and price. Yet, some of the surveys did not seek price quotations on a specific frame (Johns, Tr. 1604, 1623-24) or a particular prescription (Long, Tr. 1871-72) or inquire into the quality issue in a detailed or systematic manner (Haley, Tr. 2136; Long, Tr. 1883-1884). It is equally clear that the services provided in connection with the dispensing of eyewear (including the adaptation, fitting and verification of the prescription) are important, that they may vary from patient to patient depending on the patient's needs, and that the nature, extent and quality of services may vary significantly among providers of ophthalmic goods.⁷

Thus, critics of these studies charge that the studies failed to control for three variables:

- (1) the variability of the frame or prescription.
- (2) the quality of the goods provided.
- (3) variations in the associated professional services.

6 (continued)

of Clara E. Vose, Exhibit VII-658, at R. 13430; comment of Lillian C. Weitzler, Exhibit VII-570, at R. 13321; comment of Myrtle M. Wilson, Exhibit VII-631, at R. 13397; comment of Joe and Wanda Bartol, Exhibit VII-672, at R. 13447; comment of Marie E. Casey, Exhibit VII-763, at R. 13580; comment of Alice Gladish, Exhibit VII-845, at R. 13702; comments of Mr. and Mrs. Ben Herberts, Exhibit VII-802, at R. 13632; comment of J. Wilson, Exhibit VII-803, at R. 13633; comment of Larry P. Ribeiter, Exhibit VII-870, at R. 13736; comment of Shirley Peltz, Exhibit VII-857, at R. 13721; comment of Robert F. Steinke, Exhibit VII-865, at R. 13731; comment of Pearl H. Lanum, Exhibit VII-7, at R. 12660.

⁷ Rebuttal submission of J. Harold Bailey, Executive Director, AOA, Exhibit 1X-179, at R. 17353-54.

Staff does not believe that any of these criticisms, either individually or collectively, rebuts the finding that a wide range in prices exists for ophthalmic goods.

In a number of surveys, prices were obtained for a very specific item, such as a brand-name frame. For example, in one survey prices were obtained for three particular frames. The results of the survey are consistent with the finding that prices for homogeneous items do vary widely. The table below shows the range of available prices and the percentage of variation in price for the three frames.⁸

	Number of prices <u>received</u>	<u>Low Price</u>	<u>High Price</u>	<u>% variation</u>
Frame #1	71	\$20.00	\$40.00	100%
Frame #2	45	\$24.95	\$49.85	100%
Frame #3	55	\$12.00	\$40.00	233%

In a similar study conducted by the New Jersey Division of Consumer Affairs, prices were obtained from 80 opticians for a specific ophthalmic frame.⁹ The resultant range of prices was \$10 to \$30, or a variation of 200%.¹⁰ Of the 80 price quotations obtained, over 20 fell between \$25-\$30, and another 10 were between \$10 and \$15.¹¹

Thus, in those instances in which prices were quoted for a specific ophthalmic frame, the results conclusively demonstrate the wide range of available prices. Similar results are found in those instances in which both the ophthalmic prescription and the frame were specified. For example, in the survey conducted by Terry Freeman, Staff Aide to the Ohio Senate Health and Retirement Committee, price quotations were obtained for two

⁸ Terry Freeman, Ohio Senate Health and Retirement Committee, Survey of Eyeglass Prices in Ohio, HX-139.

⁹ Testimony of Virginia Long, supra note 3, at 1850.

¹⁰ Id.

¹¹ Statement of Virginia Long, Director of New Jersey Division of Consumer Affairs, HX-164, tables C-F.

different lens prescriptions. In each of these two prescriptions, the precise refractive power was specified, as was the lens material and necessary tint.¹² The prices obtained were for the lenses only, so price differences cannot be attributed to variations in the frames. The results indicated a range of \$16 to \$46 for the first prescription or a 188% difference, and a range of \$25 to \$58 for the second prescription, or a 132% difference.¹³ Similarly, in the California study performed by SFCA¹⁴ prices were compared for a specific prescription of lenses, both glass and plastic, two specified frames, two complete pairs of eyeglasses with both the frame and prescription specified, and for hard and soft contact lenses.¹⁵ The price ranges varied from 63% for soft contact lenses¹⁶ to as high as 329% for a particular American Optical frame.¹⁷

Thus, in those instances in which the variability of the frames and the ophthalmic prescription were controlled for, the results are unaltered. The data reveal a staggering variation in prices for ophthalmic goods. However, in its rebuttal comments, the AOA has challenged the use of the range as a proper measure of the variability in prices:

[T]he use of the range as the measure of price dispersion may be misleading and has limited value at best. One or two extreme prices might tend to indicate that a wide

¹² Freeman, Survey of Eyeglass Prices in Ohio, supra note 8, at 2.

¹³ Id.

¹⁴ D. Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (1976), Exhibit II-65, at R. 1526.

¹⁵ Id. at 1593.

¹⁶ Id. at 1610.

¹⁷ Id. at 1609. Prices for tempered glass lenses varied from \$15-\$35 (133%); plastic lenses \$15-\$50 (233%); tempered glass bifocal lenses \$25-\$60 (140%); plastic bifocal lenses \$25-\$75 (200%); frame #1 \$7-\$30 (329%); frame #2 \$16-\$38 (138%); complete eyeglasses #1 \$19.90-\$66.00 (230%); complete eyeglasses #2 \$33.90 to \$73.00 (115%); hard contact lenses \$120-\$337 (181%); and soft contact lenses \$220-\$358 (63%).

dispersion of prices exists when, in fact, the other prices may not be widely dispersed at all.¹⁸

To support this contention, the AOA offered this analysis of the survey performed by Terry Freeman, staff aide to the Ohio Senate Health and Retirement Committee:

For example, Mr. Freeman compared prices for 2 prescriptions for lenses quoted by providers in various cities in Ohio. We have computed the mean price and standard deviation for each prescription on the basis of the data submitted by Mr. Freeman in Hearing Exhibit 139. For the first prescription, the mean price is \$31.32, the standard deviation is \$5.03, and 71% of the observations reported fall within plus or minus one standard deviation of the mean. For the second, the mean price is \$38.27, the standard deviation is \$7.45, and 71% of the observations fall within plus or minus one standard deviation of the mean. In the case of both, the observed prices are consistent with normal theory relating to price dispersion and tend to cluster very well around the mean price.¹⁹

In staff's view, such an argument provides no basis for concluding that prices are not highly variable. The range of possible prices within the "standard deviations" noted above are roughly \$26 to \$36 for the first prescription, and \$31 to \$45 for the second. Moreover, an additional 30% of the prices in both categories fall outside these ranges. While the range may be an inappropriate measure of the variability of one sample versus another, it is an appropriate measure or yardstick of the potential consumer loss which is occurring. As we demonstrate in the next section, consumers are unaware of the available price alternatives. Thus, the upper limits of the range in prices represent the area of potential consumer injury. Moreover, studies such as those conducted by the New Jersey Division of Consumer Affairs (supra note 11) demonstrate that prices do not cluster around the mean as in the one survey selected by the AOA for comment.

¹⁸ Rebuttal submission of J. Harold Bailey, supra note 7, at R. 17356.

¹⁹ Id.

The second category of criticisms leveled against the price dispersion studies concerns the failure to control for the quality of the goods being sold by the particular practitioner. It is argued that the lower prices charged by some practitioners are only a reflection of the lower quality of goods they provide.²⁰ However, even where no quality variation could exist, such as in those studies in which particular frames were priced, variations of 100% to as high as 329% were found.²¹ Similar results are found in the area of lenses. In the Freeman study,²² sellers were asked to state the manufacturer of the lenses which would be provided in addition to the price.²³ The survey data indicated that the lowest-priced sellers claimed to use the same sources for lenses as the high-priced sellers.²⁴ Thus,

20 Id. at 17358.

21 See, e.g., Optical Illusion, supra note 14, at 1609; T. Freeman, Survey of Eyeglass Prices in Ohio, supra note 8, at 2-3.

22 Freeman, Survey of Eyeglass Prices of Ohio, supra note 8.

23 Id. at 1.

24 Testimony of Terry Freeman, Administrative Aide to Anthony O. Calabrese, Ohio State Senator, Tr. 1543 at 1546:

The scare tactics of the professional associations in regards to the quality of eye care and eyewear are without validity. The survey I conducted notes that the manufacturers of the lenses used by the high priced suppliers is the same as those used by the lower priced suppliers.

See also, Optical Illusion, supra note 14, at 1613: In this survey, the correlation between product quality and price was discussed:

While some lower fees may be occasioned by a practitioner opting to dispense the less expensive materials as that provided by Dal Tex, such is not always the case. In some instances practitioners who relied on the lower priced Texas laboratories, such as Omega, were also to be numbered among those charging higher fees. On the other hand several of those at the lowest end of the price spectrum as regards charges for single vision lenses were also those claiming to dispense "first quality" A/O, B/L, and Shuron lenses.

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staff can see no basis for concluding that the price variations are necessarily the product of quality variations. Indeed, in our discussion of the quality issues,²⁵ we note that the evidence does not support a finding that price variations correlate with quality.

The final criticism concerns the variation in professional services offered by each of the sellers. There is little doubt that the range of services offered by a seller impacts on the price charged by that seller. The availability of credit, product guarantees, or related benefits carry with them price tags. However, in any market in which both a product and a service are involved, the price charged reflects a combination of the two. The same advertising bans which serve to deny consumers price information also prevent sellers from informing the consumer about the range of ancillary product benefits and professional services.²⁶ The fact that price variations may reflect varying levels of services in no sense negates the fact that the prices do vary.

Thus, staff concludes that prices for ophthalmic goods are highly variable. Moreover, the available evidence indicates that consumers are not aware of the range in purchase alternatives.²⁷ Staff concludes that significant consumer loss has occurred and continues to occur because of these factors.

B. Will Increased Information Lower Prices?

1. General discussion

In the preceding section, staff concluded that prices for ophthalmic goods vary as much as 100% to 300% for the same or

24 (Continued)

The claim that one of the chief sources of price differences in the optical field is the name brand or quality differences of the products dispensed really falls down when we come to the question of soft contact lenses. At present, only two brands of corrective soft lenses have been approved for marketing by the FDA--namely the Bausch & Lomb "Soflens" and the "hydrocurve" lens made by Soft-Lens, Inc. Despite the fact that all dispensers of soft lenses must be using these products one is still able to find an \$138 difference between the highest and lowest sellers among optometrists and ophthalmologists.

25 See Section V(C), infra.

26 See Section II(B)(2), supra.

27 See Section IV(B), infra.

substantially similar item. In other sections of this report, we note that consumers are unaware of these price variations,²⁸ and that sellers of ophthalmic goods are prohibited from disseminating the information necessary to inform consumers of these variations.²⁹

Thus, staff concludes that advertising may result in substantial price savings as consumers are made more aware of their price alternatives. The evidence demonstrates that in jurisdictions where price advertising is permitted, consumers are more aware of the price variations for ophthalmic goods than are consumers in states where advertising is prohibited.³⁰ Accordingly, even if advertising did not serve to reduce prices, consumer savings could result from individual consumers acting on their increased knowledge of their price alternatives by purchasing from lower-priced sellers.

A substantial body of economic theory and evidence was introduced into the record in this proceeding discussing the impact on prices which would occur if advertising was permitted. In the initial Staff Report, staff discussed the concept of "information theory" or the theory of price dispersion.³¹ That theory holds that wide price variations for relatively homogeneous goods are characteristic of a market in which there is inadequate information. Advocates of this theory argue that the introduction of information by those most efficient at so doing, i.e., sellers, tends to decrease consumer search costs and force sellers to become more price conscious and price competitive.

Simon Rottenberg, Professor of Economics at the University of Massachusetts, offered detailed testimony on the issue of search costs.³² In his testimony Professor Rottenberg noted:

Society gains, in the aggregate, from the dissemination of information. Information is a valuable commodity. In its absence, choice is less-informed and error is more.

28 Id.

29 See Section II(B), supra.

30 See Section IV(C) infra.

31 FTC Staff Report on Ophthalmic Goods and Services, supra note 1, at 35-51.

32 Testimony of Dr. Simon Rottenberg, Professor of Economics, University of Massachusetts, Tr. 2404.

frequent. Society also gains, in the aggregate, from the cheapening of the cost of disseminating and assimilating information. Higher costs in acquiring information means, explicitly, that more resources are put to use in the search for and the acquisition of each unit of information . . . the resources so employed are lost to other uses that produce valuable products for society.

Public and private policy that makes information more expensive, thus, diminishes the output of the society, diminishes its welfare, adversely affects more efficient and cheaper-cost sellers of goods and services.³³

Rottenberg explained that since the amount of search a consumer engages in is dependent upon the frequency of purchase, it would be rational for a consumer to spend less time searching out information for infrequent eyeglass purchases than for commodities more frequently purchased or for those involving larger expenditures.³⁴ Thus, where advertising bans make the acquisition of information difficult, the result will be wide price dispersions and resultant higher mean purchase prices.³⁵ In sum, Professor Rottenberg believed that if advertising were permitted, total average costs to consumer would be diminished; more efficient sellers would be nourished and survive, and society would benefit from the reduced time and resources expended in search for information.³⁶

Similarly, David Tuerck, Director of the Center for Research on Advertising of the American Enterprise Institute, noted that while the benefits of advertising may not always be immediately measurable in terms of actual price reductions, the ability to economize on search costs is a genuine consumer benefit not captured by estimates of price changes alone.³⁷

33 Id. at 2407.

34 Id. at 2429.

35 Id.

36 Id.

37 Testimony of David G. Tuerck, Director, Center for Research on Advertising, American Enterprise Institute, Tr. 13 at 17.

In a market in which the normal channels of commercial communication have been closed, consumer search is difficult, if not impossible. Advertising facilitates consumer search.³⁸ By providing the consumer information concerning product price and performance characteristics, advertising helps the consumer to more easily assess product differences and make a rational purchase decision.

The burdens associated with consumer search in the ophthalmic market are graphically illustrated by the experiences of the Oregon Consumer League in conducting a price comparison survey in Portland:³⁹

The actual survey area covers approximately 66 acres and was chosen due to its cluster of opticians and optometrists, all within walking distance of one another. The total time to complete the survey on foot was approximately six hours. This did not include the time spent ferreting out only those opticians and optometrists in the city center area and then planning the fastest route to get them all included in the survey. If a consumer were to take the time and effort

³⁸ See, e.g., George Stigler, "The Economics of Information," The Organization of Industry (Irwin 1968) at pp. 186-87:

Price advertising has a decisive influence on the dispersion of prices. Search now becomes extremely economical, and the question arises why, in the absence of differences in quality of products, the dispersion does not vanish. And the answer is simply that, if prices are advertised by a large portion of the sellers, the price differences diminish sharply. That they do not wholly vanish (in a given market) is due simply to the fact that no combination of advertising media reaches all potential buyers within the available time. . . . The effect of advertising prices, then, is equivalent to that of the introduction of a very large amount of search by a large portion of the potential buyers. It follows from our discussion . . . that the dispersion of asking prices will be much reduced.

³⁹ Statement of June Tanoue, Oregon Consumer League, HX-253.

to visit all the opticians and optometrists in the area, the consumer would find the best price for eyeglasses, relatively speaking.⁴⁰

For some groups, such as the aged, the absence of advertising imposes almost insurmountable obstacles to effective search. Donald F. Reilly, Deputy Commissioner on Aging, Department of Health, Education and Welfare, testified concerning the peculiar search problems of the elderly engendered by the lack of ophthalmic advertising.

In terms of the special mobility problems of the elderly, price advertising is especially important for older persons in light of these problems

As we concluded in our report, 'stated simply, the mobility problem of older Americans is that they cannot get to and from the places they need, and would like, to go.'

It is clear that limited mobility places many older consumers in a position where they cannot shop around by visiting a number of businesses.

Those older consumers with mobility problems require easy access to information on prices if they are going to be able to intelligently spend their limited incomes. Advertising certainly can help to make such information available.⁴¹

Thus, in terms of both time and expense, the costs and burdens associated with search in the ophthalmic market are markedly increased due to the lack of information normally provided by advertising.

40 Testimony of June Tanoue, supra note 5, at 3299-3300; See also testimony of Dr. Phoebe Harris, Ph.d, Consumer Economics and Home Management, Mississippi State University, Tr. 6210 at 6217; testimony of Douglas Hurdelbrink, Consumer Protection Center, Baton Rouge, Louisiana, Tr. 6247 at 6248.

41 Testimony of Donald F. Reilly, Deputy Commissioner on Aging, DHEW, Tr. 111 at 114; See also testimony of Charles J. Copeland, representative, Upper Arlington, American Association of Retired Persons (AARP), Tr. 985 at 991; testimony of Glenn R. Workman, Legislative Research Project for Ohio's Elderly, Tr. 1209 at 1210.

However, it must be recognized that advertising will not necessarily be a panacea with respect to reducing search costs. Some economists noted that advertising which attempts to persuade rather than inform leads to product differentiation and has the potential for making search more difficult.⁴² Realistically, it would be expected that both informative advertising and persuasive advertising would result from the lifting of eyeglass advertising bans. On balance, staff concludes that freeing the channels of commercial information will serve to provide consumers with at least a portion of the information necessary for comparison shopping, thereby reducing search costs.

Proponents of the "information theory" economic model argue that price advertising serves to reduce mean prices in two ways:

- (1) by informing the public of price alternatives, a greater percentage of the public will purchase from lower priced sellers, thereby reducing the aggregate mean price.
- (2) by inducing greater price competitiveness among sellers, thereby either reducing prices, or deterring future price increases.

A number of studies in other product fields lend support to these arguments. For example, economist Alex Maurizi conducted two studies which focused on the effects of laws which prohibit the posting of retail gasoline prices. These studies found that

⁴² See, e.g., K. Boyer, Informative and Goodwill Advertising, HX 121; testimony of Robert O. Zimmerman, Associate Professor of Economics, Xavier University, Tr. 684 at 687-88:

Product differentiation means that at any one time the consumer will be offered a wide range of types, styles, brands, and quality gradations of any given product. Compared with the situation under pure competition, this correctly suggests possible advantages to the consumer. His range of free choice is widened, and variations and shadings of consumer tastes are more fully met by producers. But skeptics warn that product differentiation is not an unmixed blessing. Product proliferation may reach the point where the consumer becomes confused and rational choice is highly unlikely. Variety may add spice to the consumer's life, but only up to a point. Worse yet, some observers fear that the consumer, faced with a myriad of similar products, may rely upon such a dubious expedient as judging product quality by price; that is, the consumer may irrationally assume that price is necessarily an index of product quality.

a direct correlation existed between the intensity with which retail posting of gasoline prices occurred and the mean retail price prevailing in the area.⁴³

Maurizi concluded that laws which prohibit the posting of retail gasoline prices increased the dispersion of prices, and increased the overall mean price paid by consumers.⁴⁴ Maurizi estimated that if advertising had occurred across the United States as intensively as it had been engaged in in Los Angeles, generally regarded as the most competitive areas for retail gasoline, consumers would have saved \$444 million in 1970 on regular gas alone. He estimated that if posting has the same percentage effect on prices which are substantially higher now than in 1970, consumer savings resulting from universal posting patterns like those in the most competitive markets would have amounted to a consumer savings of between one billion and 1.5 billion dollars annually. While admitting that differences exist between gasoline and ophthalmic goods, he stated that these differences might affect the magnitude of the effect on prices, but not the direction.⁴⁵ Additionally, he noted that these consumer savings do not even include gains to consumers in the form of lower search costs.⁴⁶ While product homogeneity is a basic assumption in his analysis, he further noted that if there were substantial product differences among eyeglasses, the effects on prices of advertising may not be as noticeable, but would in fact exist. Consumers would be required to engage in some additional search to determine the differences and decide whether those differences were worth the increase in price.⁴⁷

In an analogous market, John F. Cady conducted a study of the impact of prescription drug advertising restraints on prices in that market.⁴⁸ Cady found that prices for prescription drugs

43 Testimony of Alex R. Maurizi, Economist, Tr. 3518 at 3519; See also Maurizi, "The Effect of Laws Against Price Advertising: The Case of Retail Gasoline," 10 W. Econ. J. 321 (1972), Exhibit V-6, at R. 6334. Second study unpublished.

44 Testimony of Alex R. Maurizi, supra note 43, at 3520.

45 Id. at 3523.

46 Id. at 3534.

47 Id.

48 J. Cady, Restricted Advertising and Competition: The Case of Retail Drugs, (American Enterprise Institute for Public Policy Research, Center for Research on Advertising, Domestic Affairs Study 44, 1976), Exhibit V-85, at R. 11894.

were higher for all size classifications of pharmacies in states regulating advertising. Moreover, Cady concluded that in states without the advertising restraints there was no diminution in either the number of pharmacies or in the level of services offered by each pharmacy.⁴⁹ The estimates of consumer loss attributable to the advertising bans ranged as high as \$380 million annually.⁵⁰

Cady's studies, like Maurizi's gasoline studies, are subject to the claim the eyeglasses are a less homogeneous product than prescription drugs. However, the available evidence indicates that the greater diversity of ophthalmic goods would affect the degree, but not the direction, of price changes which would occur from price advertising.

2. Comparative Eyeglass Surveys

Most of the surveys of prescription eyeglass prices introduced into the record, while not purporting to demonstrate a causal relationship between advertising and prices, tend to show (1) that prices are lower in states that permit advertising; (2) that consumers benefit from increased information; and (3) that no direct correlation exists between the prices and quality of ophthalmic goods. The findings as they relate to consumer awareness⁵¹ and quality⁵² are discussed in depth elsewhere in this report.

The American Association of Retired Persons (AARP) conducted a ten-state survey of their membership. The average age of those sampled was 70 years, with the majority ranging in age from 65-75 years.⁵³ AARP found that about 50% of those surveyed had income levels of less than \$5,000 and about 75% relied almost totally on social security for their income.⁵⁴ Significantly, over 90% had

49 Id.

50 Id. at 11912-20.

51 See Section IV(B), infra.

52 See Section V(C), infra.

53 Testimony of Dr. Grady St. Clair, Chairman of the Board, National Retired Teachers Association, and member, American Association of Retired Persons, Tr. 4115 at 4117.

54 Id.

no form of insurance to cover eyeglass expenditures.⁵⁵ In addition to ascertaining what their sample actually paid for eyeglasses, AARP attempted to control for a certain degree of consumer initiative. Thus, while only about 20% of those interviewed said they shopped around for eyeglasses, 75% indicated that advertisements would facilitate their comparison-shopping efforts.⁵⁶

AARP's findings revealed that in non-advertising states, consumers who did not comparison shop paid an average of \$71.25 for their eyeglasses. Those in non-advertising states who did shop around paid an average of \$65.00. A third group, those in advertising states who also comparison shopped, paid an average of only \$58.00 for eyeglasses. Thus, AARP concluded that people who lived in advertising states and who did shop around saved an average of 18% on the price of their eyeglasses.⁵⁷

The experiences of retail chains and numerous consumers bear witness to the fact that price differentials exist across state lines and correlate with advertising bans.⁵⁸

55 Id. at 4117-18.

56 Id. at 4119.

57 Id.

58 See, e.g., testimony of William Schwartz, Vice President, Wall & Ochs, Inc., Tr. 346 at 371.

William Schwartz, Vice President of Wall and Ochs, Inc., a large East Coast retail chain, testified that its prices are lower in those states where Wall and Ochs is allowed to advertise. While Schwartz stated that there is no difference in the quality of eyeglasses his firm sells in restrictive and non-restrictive states, he attributed the higher prices charges in the non-advertising states to the higher business costs resulting from state advertising bans; Sheldon Fantle, President of Peoples Drug Stores of the Washington, D.C. metropolitan area, stated that despite demographic studies indicating that their Maryland and Virginia markets were similar, their Maryland stores did 50% more business. He attributed this phenomenon to the ability in Maryland to offer certain premiums and discounts, which are illegal under the Virginia statute. Testimony of Sheldon Fantle, Chairman of the Board and Chief Executive Officer, Peoples Drug Stores, Tr. 481 at 482.

One of the most controversial price comparison surveys was conducted by San Francisco Consumer Action (SFCA), funded by the Federal Trade Commission's public participation program. Price quotations for ophthalmic lenses, complete pairs of eyeglasses and contact lenses were collected first in California in June of 1976 (price advertising was not permitted in California at that time); similar quotations were obtained a year later in Arizona, where price advertising is allowed.⁵⁹ Table 3-1 sets out the median prices obtained in both California and Arizona.

(58 continued)

Many individual consumers related observed price differences between states. See, e.g., comment of James A. Schnell, Exhibit VII-4, at R. 12652; comment of Horace M. Seeley, Exhibit VII-224, at R. 12919; comment of John Shulnes, Exhibit VII-267, at R. 12729; comment of Leacelle Herrin, Exhibit VII-40, at R. 12706-07; comments of Dale and Rebecca LaFollette, Exhibit VII-83, at R. 12761; comment of Harold Nordrum, Exhibit VII-616, at R. 13380; comment of Lillian M. Ross, Exhibit VII-711, at R. 13508; comment of Harriet A. Towns, Exhibit VII-786, at R. 13613; comment of Genelda L. Johnson, Exhibit VII-766, at R. 13584; comment of Eugene Shannon, Exhibit VII-739, at R. 13546-47; comment of J. F. Walker, Exhibit VII-713, at R. 13510; comment of Clyde W. Haynes, Exhibit VII-853, at R. 13715; comment of Anna K. James, Exhibit VII-860, at R. 13724; comment of Thomas B. Thornton, Exhibit VII-841, at R. 13696; comment of Rita Thomas, Exhibit VII-806, at R. 13638; comment of Henry A. Muhlenbeck, Exhibit VII-537, at R. 13282-83; comment of W. M. Russell, Exhibit VII-580, at R. 13332; letter from consumer to FTC (Sept. 9, 1975), Exhibit III-6, at R. 2426; Letter from consumer to Rep. Joseph D. Waggoner (Oct. 13, 1975), Exhibit III-6, at R. 2444; letter from consumer to FTC (Jan. 26, 1976), Exhibit III-6, at R. 2445.

59 Testimony of Delia Schletter, San Francisco Consumers Action Tr. 6297 at 6440.

TABLE 3-1

Comparison of Median Fees for Arizona and California⁶⁰

	Single-Vision Lenses		Bifocal Lenses		Complete Eyeglasses		Contact Lenses			
	Glass / Plastic	Glass / Plastic	Glass / Plastic	Glass / Plastic	R _x 1 / R _x 2	R _x 1 / R _x 2	O.D.'s and M.D.'s / Opticians		Hard / Soft	
California June 1975	\$28	\$29	\$40	\$48	\$45	\$56	\$200	\$300	\$145	\$245
Arizona June 1976	\$21	\$26	\$36	\$48	\$37	\$53	\$200	\$300	\$125	\$250
Percentage Difference	33.3%	11.5%	11.1%	0%	21.6%	5.7%	0%	0%	16.0%	(2%)

Data as Adjusted for 6.3% Inflation

California	\$29.76	\$30.83	\$42.52	\$51.02	\$47.84	\$59.83	\$212.60	\$318.90	\$154.14	\$260.44
Arizona	\$21	\$26	\$36	\$48	\$37	\$53	\$200	\$300	\$125	\$250
Percentage Difference	41.7%	18.6%	18.1%	6.3%	29.3%	12.3%	6.3%	6.3%	23.3%	4.2%

⁶⁰ Data compiled from There's More Than Meets the Eye, San Francisco Consumer Action, HX-397, table 9, at p. 114.

As the data show, in six of the ten categories in which prices were obtained, prices ranged from 5.7% to 33.3% lower in Arizona than in California.⁶¹ In three of the remaining four categories the prices were identical, and in the final category, prices were 2% higher in Arizona.⁶² Based on these data, it is clear that prices in most categories are substantially lower in Arizona, a state in which price advertising is permitted. Additionally, these results do not reflect the effects that the one year time differential may have had on the data collection. On cross-examination, SFCA had no explanation for their failure to adjust the California data for price rises in the material costs which had occurred during that year.⁶³

The data can be adjusted to control for the time-lag variable. The Consumer Price Index compiled by the U.S. Department of Labor⁶⁴ indicates that prices for "examination, prescription and dispensing of eyeglasses" nationwide rose 6.3% from May, 1975 to May, 1976.⁶⁵ This period coincides with the collection dates for the two portions of the SFCA survey.⁶⁶ Similarly, price lists for the frames used in the comparisons of eyeglasses indicate that the wholesale price of the frames increased approximately 7% during that time period.⁶⁷ Using the 6.3% estimate from the

61 See table 3-1 at note 60, supra.

62 Id.

63 Testimony of Delia Schletter, supra note 59, at 6641.

64 Consumer Price Index, U.S. City Average and Selected Areas, U.S. Department of Labor, Bureau of Labor Statistics, HX-392.

65 Id.

66 See note 59, supra.

67 Frames, a catalogue produced by Zulch and Zulch Inc., Sylmar, California (June 1975), Exhibit V-15, at R. 6781. As of June, 1975, the price listed for the "Stadium" frame was \$4.95. The price for the "Metal Liner" frame was \$14.25. The Frames catalogue dated September 1976, lists the following prices: "Stadium" frame, \$5.25 and "Metal Liner" frame, \$15.25. Thus, based on this calculation, the "Stadium" frame increased 6.06% during the time period in question, and the "Metal Liner" frame increased 7.02%. These statistics are not intended to specify the precise amount of price increase which occurred during the time lag in SFCA's data collection. Rather, they are intended to establish approximations.

Consumer Price Index to adjust the California data provides a more realistic approximation of the differences in prices between California and Arizona. Table 3-1 contains the adjusted data.

The data from the adjusted table demonstrate that the prices in Arizona are from 4.2% to 41.7% lower than those in California.⁶⁸ Indeed, for most categories of the surveyed ophthalmic goods the prices in Arizona fall into the range of 12.3% to 41.7% lower than in California. From staff's analysis of the SFCA study, there appears to be little doubt that prices are significantly lower in Arizona, which permits advertising, than in California, which did not at the time the survey was conducted.

However, even though prices are lower in Arizona, the question arises as to whether these lower prices are attributable to price advertising, or to other sources. As a portion of their study, SFCA performed a media search to determine the pervasiveness of current price advertising in Arizona. SFCA's conclusion was that there is very little price advertising presently occurring in Arizona, and thus that these observed differences could not be attributed to the existence of price advertising:

[I]f there are no bans on price advertising and if there are still lower prices, but if there is no actual price advertising, then it's really hard to say that price advertising is the cause of lower prices⁶⁹

Other economists, however, have testified that the ability to price advertise, even in the absence of actual advertising, might serve to deter sellers from raising prices because of threat of potential price advertising.⁷⁰ SFCA notes that as recently as five years ago price advertising was very prevalent,⁷¹ and that there were large "price wars" in Arizona as recently as two to three years ago.⁷² Since that time, the evidence indicates that price advertising has tapered off, although some firms continue to price advertise.⁷³

68 See Table 3-1 at note 60, supra.

69 Testimony of Delia Schletter, supra note 59, at 6325.

70 See, e.g., testimony of David Tuerck, Director of the Center for Research on Advertising, American Enterprises Institute, supra note 37, at 17.

71 Testimony of D. Schletter, supra note 59, at 6430.

72 Id.

73 Id.

Economic theory suggests that continued price advertising becomes uneconomical when it can no longer serve to attract new customers.⁷⁴ Thus, as long as prices are higher than would occur in a normally competitive market, a competitor can capture a large share of the market by advertising.⁷⁵ However, once prices achieve a competitive level, price advertising becomes an additional expense which cannot be recouped. However, in such a situation, an effective check is placed on future price increases by competitors, since renewed price advertising could be used to attract customers away from such a firm.⁷⁶ The observed pattern in Arizona of heavy price advertising,⁷⁷ price wars,⁷⁸ followed by limited price advertising⁷⁹ and a consequently low priced market, is consistent with the economic model set out above. On the basis of this evidence, staff concludes that the lower prices in Arizona can be attributed, at least in part, to price advertising.

An alternate theory, however, suggests that once large retail firms "capture" the market through price advertising, they are able to use their economic leverage to charge whatever price they choose. SFCA suggests that the dearth of advertising may be attributable to such an informal agreement not to price compete.⁸⁰ The fact that prices are considerably lower in Arizona than California significantly undercuts this hypothesis.

74 David Tuerck, Director of the Center for Research on Advertising of the American Enterprise Institute, testified in his individual capacity in favor of lifting advertising restraints. He noted that advertising expenditures are, to an extent, self-limiting since the return to firms, in terms of attracting clientele, diminish. The freedom to threaten higher-priced rivals with advertising may further deter firms from attempting to maintain higher than competitive prices, since a competitor will also be motivated to inform consumers of lower-priced alternatives. Testimony of David G. Tuerck, supra note 37, at 17, 28.

75 Id.

76 Id.

77 See note 71, supra.

78 See note 72, supra.

79 See note 73, supra.

80 There's More Than Meets the Eye, supra note 60, at 65.

SFCA advanced two alternative hypotheses for the lower prices in the Arizona market. First, SFCA argued that the lower retail prices simply reflect the overall lower level of per capita income and standard of living in the area.⁸¹ However, SFCA proffered no basis, either theoretical or factual to support this contention. In another study discussed in more depth below, prices were not found to correlate with per capita income.⁸² Indeed, economic theory suggests that lower income persons may well pay more because of their decreased ability to search out the best buy.⁸³

SFCA's alternative explanation for the lower prices which prevail in Arizona, concerns the differences between the relative laboratory costs for wholesale ophthalmic goods in the two jurisdictions. SFCA found that wholesale laboratory prices in Arizona are significantly lower than in California.⁸⁴ Upon closer inspection of the underlying data, while the wholesale costs in Arizona are lower, the differentials are not as significant as SFCA concluded.⁸⁵ This finding is somewhat difficult to assess. Lower

81 Id. at 165. SFCA's data set the median family income at \$11,133 in California and \$8,260 in Phoenix, Arizona.

82 See HX 390. Prices were found to be lower in New York than Mississippi even though per capita income was higher in New York.

83 See e.g., Benham, "Regulating through the Professions: A perspective on Information Control," 18 J.L. & ECON. 421 (1975), Exhibit V-2, at R. 6241-42.

84 There's More Than Meets the Eye, supra note 60, at 165.

85 In making their wholesale cost comparison, SFCA obtained price quotations from six labs in the Phoenix area, and five in the San Francisco area, totaled the prices and obtained an average. For example, for single-vision glass lenses, SFCA cites a California average of \$10.31 and an Arizona average of \$7.86. Id. at 168.

However, in the study SFCA asked the practitioners to indicate the laboratory from which they obtain their lenses. In HX 393, staff has compiled the frequency with which practitioners cited various labs. The compilation reveals that SFCA failed to weight the average for frequency. For example, one lab (Hoya) was not cited by anyone, yet SFCA included it in the average.

Moreover, 22 of 128 observations from the California sample note the use of out-of-state laboratories. Indeed, the SFCA study itself notes that many California dispensers carry accounts with Arizona labs. Id. at 165.

retail prices in Arizona may in fact be partially the results of lower wholesale costs. However, an equally logical inference is that the lower wholesale prices are a reflection of the increased competition at the retail level. For example, a witness for the California Optical Laboratory Association testified that after price advertising was permitted in Florida, significant pressure was applied by the retail sellers upon the wholesale laboratories to reduce prices.⁸⁶ Thus, the lower level of wholesale prices in Arizona may be attributable to competitive pressure exerted from the retail sector.

Two surveys introduced into the rulemaking record have been touted as evidence that advertising leads to higher, not lower, prices. The first of these surveys was conducted by the Ohio Optometric Association (OOA).⁸⁷ The survey attempted to measure the average prices for a pair of single-vision eyeglasses and a pair of bifocals in three Ohio cities. For purposes of the survey, sellers were categorized into two different groups; those who advertised and those who did not.⁸⁸ The sample was drawn from among the sellers in Dayton, Cincinnati, and Columbus.

The data, as analyzed by a consultant for the Ohio Optometric Association, produced the following result:

The advertising outlet's prices were higher by a statistically significant degree on the bifocals, and higher, but not by a statistically significant degree, on the single vision. On the basis of such evidence one is forced to conclude that the advertising outlets in the three cities studied definitely do not offer lower prices, likely do not offer "about the same" prices but likely do offer higher prices than non-advertising outlets. Thus, if advertising were to become more extensive within the ophthalmic community a predictable resultant might very well be increased prices.⁸⁹

⁸⁶ See, e.g., testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3783.

⁸⁷ Testimony of George G. Trebbi, Ph.D, Associate Professor Marketing, Xavier University, Tr. 673.

⁸⁸ Id. at 676-77.

⁸⁹ Id. at 683.

A number of critical factors should be considered in evaluating this survey. First, in Ohio unlike most other states, price advertising prohibitions are found solely in local ordinances.⁹⁰ Each of the three cities involved in this survey specifically prohibits price advertising.⁹¹ Thus, the most the survey could establish is that non-price advertising does not serve to reduce prices. Indeed, one of the prime factors in the argument that price advertising will result in consumer savings is that once consumers are educated about the various price alternatives, many consumers will purchase from a lower point on the price spectrum.

The most critical shortcoming of the OOA survey concerns the biased nature of the sample which was selected. In its prepared testimony, the OOA claimed to have selected the sample randomly,⁹² from the classified directories of the respective cities.⁹³ However, upon cross examination it was revealed that not all of the sellers listed in the telephone directories were included in the universe from which the sample was drawn. The OOA compiled a selective listing of advertising and non-advertising optometrists and opticians for each of the three cities involved in the survey.⁹⁴ The actual sample was then drawn from these OOA lists.⁹⁵

An examination of the telephone directories for each of these cities reveals some significant defects in the sampling technique used. First, many of the persons categorized as "non-advertisers" by the OOA have large advertisements in the classified directories.⁹⁶ More importantly, virtually every optician

90 See Section II(B)(2), supra.

91 Statement of William J. Brown, Ohio Attorney General, HX 56, at note 1.

92 Testimony of George G. Trebbi, supra note 87, at 673.

93 Id. at 710.

94 Letter from Harry Fagedes, O.D., President, Ohio Optometric Association, to FTC (July 9, 1976), HX 197, at p. 10.

95 Testimony of George G. Trebbi, supra note 87, at 677.

96 For example, the "Yellow Pages Classified Directory of the Dayton Metropolitan Area," corrected through November 5, 1976, lists or contains advertisements for Cambridge Optical Co., at p. 556; Centerville Optical Co., at p. 556; Kenton Optical Service, Inc., at p., 553; and Williamson, Robert E., at p. 556. Each of these opticians or optical outlets was

(continued)

whose advertisement contained price-related information such as "low cost," "reasonable prices" or "moderate cost" was not included in the list from which the sample was drawn.⁹⁷ The

(96 continued)

listed as a "non-advertising" optician and included in the OOA sample which was actually surveyed.

Similarly, the Columbus and Vicinity, 1976-77 Telephone Directory, issued July 1976, contains classified advertising for Howard Opticians, at p. 630; and Chatham Village Optical Service, at p. 629, both of which are contained in the Columbus sample as non-advertising opticians.

97 A survey of the Columbus classified directory, Id., reveals that the following outlets advertised information which related to price:

1. Lambert Optical (p. 630) "Fair prices"
2. Associated Professional Opticians (p. 628)
"Finest Quality--Moderate Cost--Always"
3. Co-op Optical Center (p. 629) "Share the savings"
4. Harris Opticians (p. 629) "A price for every budget"
5. Coffman Optical (p. 629) "Our merchandise is of the highest quality at the lowest prices available"
6. H.B. Perler Opticians (p. 632) "Before you buy ... Compare! We have been offering high fashion and exceptional quality eyewear for less since 1943."

Of these six opticians who engage in price related advertising, only Harris Opticians and Coffman Optical were included in the listing from which the sample was drawn. See, Letter from Harry Fagedes, O.D. to FTC, supra note 94, at p. 4.

A survey of the Dayton area classified directory, Id., reveals that the following outlets advertised price-related information in the "opticians" listing:

1. Opto-Mart (p. 554) "eye care/eyewear for all the family at tremendous savings ... When you need glasses, you can't wait for a sale, so here's a sale that "waits for you!" Fashion eyewear at discount prices."
2. 20-20 Mart (p. 555) "Are you a union member? ... Save \$\$\$ here!"
3. Union Optical Plan (p. 556) "Where your union card saves you money"
4. Union Eye Care (p. 556) "Where your union card saves you money"

(continued)

ultimate sample drawn by the OOA's market analyst excluded virtually every seller whose advertisement included any indication of possible savings.⁹⁸

Accordingly, staff concludes that at most, the OOA survey demonstrates that non-price advertising, in a jurisdiction where price advertising is prohibited, does not lead to lower prices. Given the magnitude of the bias inherent in this survey, staff believes that the OOA survey provides no basis for concluding that advertising outlets are more expensive than non-advertising outlets.

The Kansas Optometric Association (KOA) conducted a survey of dispensers in Wichita, Kansas. Opticians in Kansas can and do advertise, while optometrists cannot.⁹⁹ In all, 14 optical dispensers and 12 optometric offices which included 32 optometrists were shopped. An investigative reporter armed with a written prescription was detailed to obtain prices for single-vision plastic frames similar to his own. The KOA found that the range of prices quoted by opticians was considerably higher than for optometrists.¹⁰⁰ Only three optometrists quoted prices higher than the lowest price charged by an optician.¹⁰¹ The KOA

(97 continued)

Even though Union Optical and Opto-Mart advertised as opticians, they were categorized as "advertising optometrists" by the OOA. HX 197. The two other opticians who advertised price related information were not included in the listing of advertising opticians from which the sample was drawn. See letter from Harry Fagedes, O.D. to FTC, *supra* note 94, at 6.

⁹⁸ Of the six Columbus area sellers who advertise price-related information, only two were included in the OOA-compiled list from which the survey sample was drawn, *Id.* at 4. Of those two, only one, Coffman Optical, was actually included within the sample. See Chart, Cost of Ophthalmic Goods in Cincinnati, Columbus and Dayton, HX 70. It should be noted that Coffman Optical was one of the lowest cost sellers in the survey.

⁹⁹ See Section II(B)(2), *supra*.

¹⁰⁰ Testimony of James W. Clark, Jr., Executive Director, Kansas Optometric Association, Tr. 4272 at 4275-76.

¹⁰¹ *Id.*

concluded on the basis of this survey that advertising does not decrease retail prices, but conversely may in fact increase prices.¹⁰²

The credibility of the KOA survey was somewhat lessened on cross-examination when it was revealed that the optometrists in the sample may have had prior knowledge that the survey was being conducted.¹⁰³ Additionally, the record demonstrates that many optometrists dispense optical goods at "cost" and charge a separate dispensing fee.¹⁰⁴ While the KOA claimed that the prices quoted by optometrists included the dispensing fee, no written instructions for obtaining the price data were produced. Thus, whether the optometrists' prices uniformly included their dispensing fees is open to question.

In a rebuttal submission, the Certified Ophthalmic Dispensers of Kansas reported the results of a survey it conducted in the same city as the KOA survey. The prices obtained in the Ophthalmic Dispensers' survey indicated that opticians were the lower-cost providers, not the optometrists.¹⁰⁵ While this survey demonstrates relatively little in and of itself, it again raises the question whether the KOA's study accounted for all of the optometric fees included in the prices actually paid by Wichita consumers.

3. The Benham studies

Two studies conducted by Lee Benham sought to analyze the impact of information restraints on eyeglass prices. These studies were discussed at length in the initial Staff Report, but will be discussed again with the context of the criticisms they received.

102 Id. See also Statement of James W. Clark, Jr., Executive Director, Kansas Optometric Association, HX 305-HX 307.

103 Testimony of James W. Clark, Jr., supra note 100, at 4289.

104 See, e.g., South Carolina Optometric Association, Practice Reference Manual, 1975-1976, Exhibit IV-109, at R. 5309; testimony of Lester H. Sugarman, O.D., Connecticut Optometric Society, Tr. 2876 at 2896; testimony of James E. Washington, O.D., Tr. 2591 at 2609; testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3640; testimony of Sylvester Bradford, O.D., Tr. 5401 at 5430; testimony of James W. Clark, Jr. supra note 100, at 4289.

105 Rebuttal submission of Gaynell H. Owens, President, Certified Ophthalmic Dispensers of Kansas, Inc., Exhibit IX-175, at R. 17270.

In his first study, Benham compared prices paid for eyeglasses in those states which had complete advertising prohibitions with prices paid in states which had no restrictions. Data on prices of eye examinations and eyeglasses was obtained from a 1964 survey of 634 persons in 23 states conducted by the National Opinion Research Center.

Benham found that the mean price for eyeglasses in states with restraints on advertising was \$33.04, compared to a mean price of \$26.34 in states where advertising was permitted; a difference of 25%.¹⁰⁶ Comparing the most restrictive states with the least restrictive states, he found mean costs of \$37.48 and \$17.98, respectively, or a difference of more than 100%.¹⁰⁷ States were classified as allowing advertising if any one group of providers--opticians, optometrists, or ophthalmologists--was permitted to advertise.¹⁰⁸ By use of regression analysis, Benham demonstrated a positive correlation between the differences in prices and the presence or absence of advertising restraints.¹⁰⁹

Farrell Aron, statistician for the American Optometric Association, characterized Benham's first study as "an excellent example of how to mislead with statistics."¹¹⁰ Pointing out that a greater percentage of persons sampled from non-advertising states used physicians as their source for eyeglasses and eye examinations, Aron argued that higher prices could be attributed to the greater likelihood of treatment being included in the cost of eye exams and eyeglasses.¹¹¹ In assailing Benham's regression analysis, Aron claimed that by not including variables such as type of practitioner, lens type and frame, Benham's model was

106 Benham, The Effect of Advertising on the Price of Eyeglasses, 15 J.L. & ECON. 337 (1972), Exhibit V-1, at R. 6222.

107 Id. Tables 1 and 2 at R. 6220-22. Benham analyzed figures for the extreme states, the most and least restrictive, separately.

108 Id. at 6216.

109 Id. at 6227.

110 Aron, "Debunking Benham: A Critique," American Optometric Association News (Oct. 1, 1973), Exhibit V-8, at R. 6459-61.

111 Id. 39.17% of the sampled population reported physicians as source of eye care in non-advertising states versus 22.1% in advertising states.

incomplete in its explanatory and predictive ability. Additionally, Aron criticized Benham's exclusion of questionable data from North Carolina in his analysis.¹¹² In response, Benham observed that many of the weaknesses Aron pointed out were fully discussed in this study. Ultimately, Benham remained steadfastly behind the findings of this first study, arguing that alternative explanations for phenomena always may exist, but such alternatives should not be seriously entertained without supporting evidence.¹¹³

His second study,¹¹⁴ undertaken with Alexandra Benham, attempted to investigate the proposition that more stringent professional control of the types and quantity of information leads to restraints on the usual flow of commercial information, thereby decreasing competition and increasing prices. When information is limited, mechanisms of choice and control become the prerogative of the profession rather than the consumer. The Benhams constructed three indices which reflected alternative

112 Id. Benham admitted that other restrictions in North Carolina might tend to raise prices independently of advertising regulations.

113 "Benham Responds to Statistician's Debunking Article," American Optometric Association News (Nov. 15, 1975), Exhibit V-9, at R. 6462.

114 Benham and Benham, Regulating Through the Professions: A Perspective on Information Control, 18 J.L. & ECON. 421 (1975), Exhibit V-2, at R. 6232.

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 for Health Administration Studies of the University of Chicago. Id. at 6239. The data file includes 10,000 individuals, of whom 1625, 929 reported price paid for eyeglasses separately, 422 reported combination price 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. Id. at 6239, note 18.

but interrelated approaches for examining the impact of professional control on the market.¹¹⁵ They then attempted to estimate the overall impact of professional control both on prices paid for eyeglasses as well as on the frequency with which individuals obtained eyeglasses during a given time. Other associated factors and variables which affect eyeglass prices or consumption were also considered in their estimations.¹¹⁶

The Benhams found that all three indices of professional control are strongly associated with the prices paid as well as the frequency with which eyeglasses are purchased:

1. Prices increase at nearly one half the rate at which membership in the American Optometric Association (AOA) increases. As the proportion of optometrists who are members of the AOA increases from 43% to 91%, eyeglass prices increase approximately \$12.18.
2. Individuals living in states with greater professional control pay 25% to 40% more for eyeglasses.

¹¹⁵ Three indicies of professional control:

- (1) proportion of licensed optometrists who were members of the American Optometric Association;
- (2) the difficulty of commercial firms to enter the eyeglass market in a given state; and
- (3) the number of individuals who obtained their eyeglasses from commercial sources other than optometrists or physicians.
Id. at 6235-38.

¹¹⁶ Id. For discussion of the model used and other variables included in the estimates, see Id. at 6241-46. 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 6241, note 19. Thus other associated factors were considered: family income, family size, location of residence, age, sex, and race. Id. at 6243. 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 6246.

3. The mean price of eyeglasses increases substantially as the proportion of eyeglasses purchased from commercial firms declines from 70% to 0%.
4. The proportion of individuals obtaining eyeglasses is directly related to the price of glasses. As the mean price increased in the restrictive states, the percentage of people buying glasses in a specified time period, declines as much as 35%. In states with a lower level of AOA membership per capita expenditures were 3% lower, but the frequency of purchase was increased with 36% more of the population obtaining eyeglasses during that time period. When multiple purchases of eyeglasses were taken into account, there is a 7% greater expenditure per capita for eyeglasses in non-restrictive states while 50% more eyeglasses are obtained.
5. The mean price paid for eyeglasses increases for each category of supplier (physician, optometrist or commercial outlet) as the level of professional control increases. Comparisons of states with low and high AOA membership levels show that mean prices paid for eyeglasses obtained from physicians are 20% higher, while increases for optometrists are 42% higher and increases for commercial firms are 41% higher than in states with low levels of professional control.¹¹⁷

The Benhams' studies were strongly criticized in a study financed by the American Optometric Association and conducted by the Southern Research Institute (SRI).¹¹⁸

With regard to Benham's first study, SRI notes three "short-comings": (1) the use of the gross retail price paid for eyeglasses without accounting for the possible variations in the eyeglasses purchased, (2) failure to account for other variables which might affect price such as:

overall competitiveness of a local market-degree of monopoly, oligopoly, or monopolistic competition; choice of practitioner . . . a

¹¹⁷ Id. at 6241-51.

¹¹⁸ Testimony of John Burdeshaw, Southern Research Institute, Tr. 5712 at 5713; 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, 1976), HX 356.

particular demographic characteristic of consumers, namely race; and geographic character of a market119

and (3) the use of a simple linear equation to explain the relationship between the dependent variable (i.e., price) and the independent variable (i.e., restrictiveness of state laws).

As to the first SRI criticism, Benham agrees that it would have been preferable to use the net retail price (i.e., a price for the identical item, eliminating all possible product variations), however, such information was not available. Further, Benham noted that as mentioned in his first article, a survey similar to the one suggested by SRI was carried out comparing prices for a given frame and lens specification in Texas and New Mexico; and that that survey, plus other similar pair-wise comparisons that had been conducted were consistent with his findings. Significantly, he commented that such comparisons tend to understate price differences, since such measured differences in mean prices do not account for the higher volume of sales in low-priced firms as compared to the average volume of other outlets.¹²⁰ As to SRI's second and third criticisms concerning the failure to account for other variables which could have affected the result, Benham noted that these were accounted for in his second study.¹²¹

In regard to the second Benham article, published in 1976, SRI contends that the data only establish with a high degree of certainty, that there is a limited association between price and

119 Southern Research Institute, supra note 118, at 26.

120 Rebuttal Submission of Lee and Alexandra Benham, Exhibit IX-181, at R. 174000.

121 Benham continues to stand by the results of his first article, in light of the fact that all evidence to date has been consistent with his findings. Most important, he points out that the relationships estimated show systematic differences in prices between restrictive and non-restrictive states, although not always with a high degree of significance. His second article confirms the findings of his first with a greater degree of statistical validity. See testimony of Lee and Alexandra Benham, Economists, Washington University, Tr. 294 at 318. See also, rebuttal submission of Lee and Alexandra Benham, supra notes 120, at 17400.

professional control.¹²² Additionally, SRI criticized the study for failing to control for the heterogeneous nature of the eyeglasses purchased.

The Benhams responded that the objective of their second study was to determine whether the mean price paid for eyeglasses was systematically higher in some states than others. To determine this, a wide variety of alternative model specifications were tested against three alternative measures of professional control.¹²³ Substantially higher mean prices were consistently observed in those sites with greater professional controls.¹²⁴ The Benhams were unwavering in their opinion that these estimates show that the typical consumer pays, on the average, a substantially higher price in the more restrictive states.¹²⁵

As to the argument that the heterogeneous nature of eyeglass 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 are 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.¹²⁶

¹²² Southern Research Institute, supra note 118, at 33.

¹²³ A full explanation of the three measures of control is found at note 115, supra.

¹²⁴ Benham, "Regulating through the Professions," supra note 120, at 17405.

¹²⁵ Rebuttal submission of Lee and Alexandra Benham, supra note 120, at 17405.

¹²⁶ Id. at 17404:

We know of no a priori reason why consumers' taste should differ between more and less restrictive states. We examined a wide variety of individual characteristics to see if they were systematically associated with the price differences across states and found they were not. All the estimates appeared to be very robust with respect to heterogeneous population characteristics. With respect to quality variations across states, we have seen nothing yet to persuade us that the quality of eyeglasses is in fact lower in the less restrictive states.

Finally, the Benhams specifically responded to a number of criticisms of their R^2 coefficients and regression coefficients.¹²⁷

The Benhams concluded:

In summary, some weaknesses of our studies have been pointed out, but we believe our overall results remain intact. Consumers in some states pay substantially higher prices than in others. These higher prices are systematically associated with greater professional control, which includes as a major element reduction in the amount of information provided to the consumers.¹²⁸

The report of the Presiding Officer offers a realistic appraisal of the Benham studies and the SRI critique:

[A] perfect survey, above the reproach of every expert, probably has never existed. Even SRI representatives testified that a first-class study of the market structure of this industry would be a very difficult, time consuming task costing into the six-digit figure range. Tr. 5832. Even then, the first-class study would no doubt be questioned by other experts. Accordingly, it would appear that it is necessary to proceed using the very best material available.¹²⁹

127 The Benhams continued to explain that the low value for the R^2 is only relevant insofar as some of the excluded variables are systematically related to the measures of professional control. They admit that this possibility always exists, but submit that they have examined a wide range of associated variables without affecting the essential relationship between professional control and prices. In response to the SRI criticism that the net impact of professional control is not as strong as indicated by the regression coefficients, the Benhams again refer to Table 4 of their second study at page 439, to emphasize that the mean difference in price between states with AOA membership less than .5 and those with AOA membership greater than .7 is \$11.53. Id. at 17403.

128 Id. at 17405.

129 Report of the Presiding Officer, Exhibit III-1, at p. 45.

Based on the foregoing discussion of the economic evidence contained in the record staff believes that the following conclusions are warranted:

(1) Prices for the same or similar ophthalmic product vary substantially from seller to seller. Moreover consumers are incurring substantial economic loss because they are generally unaware of these price variations.

(2) Prices in states which restrict the free flow of information have higher prices for ophthalmic products than do non-restrictive states.

A number of other criticisms made by SRI provide an excellent vehicle by which to discuss a number of issues concerning the economics of the ophthalmic market.

In its study, SRI asserted that the initial Staff Report lacked any "hard" or explicit evidence of demand elasticity which would indicate that low-income groups would directly benefit from increased advertising.¹³⁰ In addition, SRI contended that the potential economies of scale in the ophthalmic market were restricted to the wholesale level.¹³¹

Both of these criticism warrant discussion, not in terms of the adequacy of staff's initial report, but rather in terms of their importance in predicting the impact of price advertising. In the Benhams' second study, an attempt was made to determine the elasticity of demand. In his study he concluded that if multiple purchases of eyeglasses are disregarded, an approximately unitary price elasticity of demand results. However, if multiple purchases are included demand is indeed elastic.¹³² That is, the percentage decrease in price is less than the percentage increase in demand, resulting in a total increase in expenditures.

Demand elasticity is an important concept with respect to price advertising. Throughout this proceeding many persons have contended that advertising will increase consumer prices by imposing an additional expense which must be passed onto the

¹³⁰ Southern Research Institute, supra note 118, at 5.

¹³¹ Testimony of John A. Burdeshaw, supra note 118, at 5179.

¹³² Benham and Benham, "Regulating Through the Professions," supra note 114, at 6241-51.

consumer.¹³³ However, if consumption does increase as price decreases, then the additional costs incurred because of the use of advertising may be more than offset by the increase in the amount of sales. Indeed, the Benhams' data suggest that this is precisely what happens.

With respect to the issue of the potential economies of scale at the retail level SRI notes:

The principal economies of scale are apparently relegated to the wholesale laboratory function, rather than to retail dispensing per se, and such economies are apparently already being exploited.¹³⁴

Quite clearly there are economies of scale at the laboratory level. Manufacturers' price lists for both finished-uncut lenses, and semi-finished blanks, offer volume discounts for laboratory purchasers. For example, a Bausch & Lomb manufacturers' price list for laboratory purchasers offers the following prices:¹³⁵

Branch Service--Orthogon Finished
(Uncut) Single Vision - White

Single Pair	\$3.92
2 Pairs	\$3.18
5 Pairs	\$2.76
75 Pairs	\$2.42

133 See, e.g., testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1004; testimony of David C. Hendershot, Executive Director, Ohio Optometric Association, Tr 660 at 663; testimony of Ron G. Fair, O.D., President, American Optometric Association, Tr. 4638 at 4755; testimony of William Johnson, Kentucky Optometric Association, Tr. 1419 at 1420; testimony of Carolyn A. Nordstrom, President, Hilltop Advertising Incorporated, Tr. 6128 at 6147; statement of Larry Nieman, Attorney, Texas Optometric Association, HX 338.

134 Southern Research Institute, supra note 118, at 5.

135 Letter from Jerome Dienstag, Associate General Counsel, Bausch and Lomb, Incorporated, to FTC (Nov. 17, 1975), Exhibit V-20, at R. 7796.

However, some economies of scale on material purchases also exist at the retail level. For example, discounts are often offered in frame purchases in quantities of 10 or 50 units.¹³⁶ Bausch & Lomb's price list of ophthalmic frames lists a "Potomac" frame at \$14.95 for a single frame. In quantities of ten it lists for \$14.20, and in quantities of fifty it lists for \$13.46.¹³⁷

Aside from economies of scale with respect to material costs other economies are achieved by larger volume outlets. For example, the non-productive time during which employees in lower volume outlets wait for new customers could be reduced if sales volume were increased.¹³⁸

On balance, staff believes that the increased per-unit cost attributable to advertising expenses would be more than offset by increased sales volumes, and by the economies of scale associated with such volumes. However, given that the greatest economies of scale exist at the wholesale level, staff acknowledges the possibility that increased competition caused by price advertising might stimulate the potential for backward vertical integration by retailers into the wholesale level.¹³⁹

In its report, SRI contended that because some 35,000 practitioners are engaged in the dispensing of prescription eyewear, the retail ophthalmic industry would seem to be highly competitive.¹⁴⁰ In this regard SRI stated:

One might infer from the FTC staff statement on the large number of professional and optician establishments . . . that the retailing of ophthalmic goods and services is actually a highly competitive business, advertising restraints notwithstanding. Such an inherent and pervasive competitiveness may, in fact, explain why such restraints, which are but one consideration in the totality of market

¹³⁶ Testimony of Jack Perry, Perry Optical Centers, Tr. 2328 at 2340.

¹³⁷ Letter from Jerome Dienstag, supra note 135, at 7841.

¹³⁸ See, e.g., testimony of Jack Perry, supra note 136, at 2346.

¹³⁹ See Section VIII, infra.

¹⁴⁰ Southern Research Institute, supra note 118, at 4.

relationships or influences, were found to have only a minor association with the prices of ophthalmic goods and services.¹⁴¹

The number of practitioners engaged in dispensing is not determinative of the competitiveness of the industry. In their rebuttal submission Lee and Alexandra Benham noted:

[R]estraints which increase prices may or may not increase the number of firms providing the services. Certainly, no inferences can be drawn concerning the effects of restraints in this market on the basis of the number of firms providing services.¹⁴²

4. Economic Effects of Other Restraints

The Benhams' studies provide an explanation for only a portion of the price differentials between restrictive and non-restrictive states. Many persons have argued that other restraints, such as bans on corporate employment, branching restrictions, prohibitions on mercantile location and others are instrumental in increasing consumer costs.¹⁴³

In a study performed on behalf of the National Association of Optometrists and Opticians (NAOO), eyeglass prices were compared between New York and Mississippi.¹⁴⁴ Mississippi permits advertising but prohibits corporate employment of optometrists, optometrists from practicing in "mercantile" locations or leasing space owned by opticians, and operating more than one

¹⁴¹ Id.

¹⁴² Rebuttal submission of Lee and Alexandra Benham, supra note 120, at 17400.

¹⁴³ See, e.g., testimony of James J. Ryan, National Association of Optometrists and Opticians and New York State Optical Retailers Association, Incorporated, Tr. 2360 at 2361-62; testimony of Lee and Alexandra Benham, supra note 120, at 295; testimony of Walter Johns, Jr., Cleveland Press, Tr. 1603 at 1621; testimony of Michael Magura, Ph.D. Professor of Economists, University of Toledo, Tr. 1261 at 1263-65.

¹⁴⁴ Testimony of R. Burr Porter, Ph.D., Associate Professor of Finance, Southern Methodist University, on behalf of NAOO, Tr. 6264 at 6264-D.

branch office.¹⁴⁵ Conversely, New York permits these so-called "commercial activities" but prohibits advertising.¹⁴⁶

The data indicate that prices for ophthalmic goods are substantially lower in New York than they are in Mississippi.¹⁴⁷ Based on this evidence the NAOO concluded:

[W]hile restrictions on advertising should be eliminated, that action, in itself, is insufficient. There are a number of other practices in the provision of ophthalmic goods and services that appear to restrict competition to the detriment of the consuming public.¹⁴⁸

The study conducted by NAOO is not determinative of the relationship between other commercial restraints present in the ophthalmic market and increased consumer prices. On January 20, 1976, the Commission announced that the staff had been authorized to conduct an industry-wide investigation of such commercial restraints.¹⁴⁹ While preliminary evidence such as the NAOO study

145 Id. at 6264-F.

146 Id.

147 Id. at 6264-J.

148 R. Burr Porter, Price of Ophthalmic Goods and Services, HX 390 at p. 19.

149 The text of the press release stated:

The Federal Trade Commission has unanimously authorized an investigation of providers and sellers of ophthalmic goods and services to determine whether industry members have been or are now violating the Federal Trade Commission Act.

The investigation is concerned with restraints on commercial practices such as limitations on the number of branch offices an industry member may own or operate, prohibitions on the employment of optometrists and opticians by commercial retailers, and bans on the practice of optometry on the premises of mercantile establishments.

might suggest that a causal relationship may exist between these restraints and increased prices, further investigation is warranted. Thus, while it appears that other market factors may influence consumer prices, this does not negate the finding that advertising restrictions positively correlate with increased prices.

Conclusion

In his report, the Presiding Officer offered the following analysis of the economic evidence on the record:

Based on the evidence in the record as a whole, it is my conclusion that in many jurisdictions there is a lack of price competition among sellers of ophthalmic goods and services. This lack of price competition results in higher prices to consumers, and as a consequence a significant number of consumers is unable to purchase such goods and services as frequently as they might if prices were lower.¹⁵⁰

Staff's foregoing analysis of the evidence comports with that of the Presiding Officer.

¹⁵⁰ Report of the Presiding Officer, Exhibit XIII-1,
at pp. 61-62.

IV. Effects of Advertising Restraints on Consumers

A. Purchasers of Ophthalmic Goods and Services

Ophthalmic goods and services are presently used by over 50% of the United States population. Of the estimated 219 million persons in the United States in 1975, approximately 112,000,000 or 51% used corrective lenses.¹ The extent of the monetary expenditures for these goods and services for the year 1975 alone is estimated to have been approximately \$4.1 billion.² In a study prepared by Gordon R. Trapnell, Consulting Actuaries, the following statistics were provided. During 1975, approximately \$1.1 billion was spent for diagnostic eye examinations,³ \$2.3 billion was spent for corrective lenses and frames,⁴ \$640 million was spent for optometric and medical therapy related to visual needs,⁵ and another \$60 million was spent for items such as tints, coatings, cleaning kits, and other related materials.⁶

However, the substantial number of persons requiring and wearing corrective lenses is not evenly distributed over all groups and classes of persons. In a 1974 report, the Public Health Service (PHS) published a comprehensive report of the characteristics of persons likely to receive eye care services and to purchase eyeglasses and contact lenses.⁷

In the first instance, the PHS determined that while persons 45 or older represent 31% of the total population, they purchase 59% of all corrective lenses.⁸ The PHS found that:

¹ Gordon R. Trapnell Consulting Actuaries, The Impact of National Health Insurance on the Use and Spending for Sight Correction Services (Jan. 1976), Exhibit II-68, at R. 1968.

² Id.

³ Id.

⁴ Id.

⁵ Id.

⁶ Id.

⁷ Public Health Service, National Center for Health Statistics, DHEW, Characteristics of Persons with Corrective Lenses--United States, 1971, Series 10, #93.

⁸ Id. at table 1, p. 10.

Usually by age 20, persons with myopia, strabismus, congenital eye defects, and other conditions causing visual impairment have been identified and corrective lenses have been obtained. As a rule, changes in visual acuity are at a minimum during the age interval 25-44 years; then, during the midforties the gradual deterioration of near vision due to the aging process (presbyopia) leads to an increased proportion of persons in need of corrective lenses.⁹

Indeed, the PHS concluded that while 41.9% of those aged 25 to 45 used eyeglasses, 88% of those 45 and over had them and 93% of those 65 and older had them.¹⁰

9 Id. at p. 3.

10 Id. at 16. The Trapnell study, supra note 1, at table 9, produced the following statistics on consumer use of corrective lenses:

<u>Age Group</u>	<u>% of the Persons in the Age Group Who Wear Corrective Lenses</u>	<u>% of All Eyeglass Wearers by Age</u>
0-12	10%	4%
13-17	33%	6%
18-44	46%	35%
45-64	89%	36%
65+	93%	19%

See also Transcripts, California Attorney General's Fight Inflation Committee Hearings (Jan. 8 and 10, 1975), Exhibit IV-141, at R. 5963; Report and Recommendations of the California Attorney General's Inflation Committee, March, 1975: "Advertising the Price of Eyeglasses--Majority Report" and "Minority Report on Advertising the Price of Eyeglasses," Exhibit IV-133, at R. 5762.

It should be emphasized that these data reflect the number of respondents within a group who actually had or used corrective lenses. It does not speak to the issue of the number of people in an given age group who need lenses but do not have them.

Thus, the evidence demonstrates that the usage of ophthalmic goods is not uniform across all age categories. As would be expected, the need for corrective lenses increases with age.

The incidence of eyeglass usage also seems to correlate with other variables such as race and income. Persons in low income categories purchase fewer eyeglasses than do their more affluent counterparts. Set out below is a table which states the percentage of persons in each income group who use corrective lenses expressed as a function of their age.

Percentage of Persons in Age Group Who Wear Corrective Lenses by the Income Level of the Family¹¹

Age	All Incomes	\$0 to \$3500	\$3500 to \$6000	\$6000 to \$8000	\$8000 to \$11,700	\$11,700 to \$17,500	\$17,500+
0-12	10%	8%	9%	9%	10%	10%	12%
13-17	34%	25%	27%	28%	31%	35%	38%
18-44	46%	40%	41%	42%	44%	47%	51%
45-64	89%	81%	87%	87%	89%	91%	92%
65+	94%	92%	93%	95%	95%	96%	96%

As the table shows, within each age category, the frequency of eyeglass usage increases as the income level of the family increases. Numerous witnesses testified at the hearings in this proceeding that a positive correlation exists between the financial capabilities of the family and the frequency with which members of the family are able to purchase eyeglasses.¹²

¹¹ Gordon R. Trapnell, supra note 1, at R. 1971.

¹² Testimony of John Collins, Chairman, Health Care Task Force, North Jersey Federation of Senior Citizens, Tr. 2430 at 2431-32; statement of Frank W. Newell, M.D., HX 115; testimony of Donald F. Reilly, Deputy Commissioner on Aging, DHEW, Tr. 111 at 112; testimony of Robert Ring, San Francisco Consumer Action, Tr. 4082 at 4112. See also comment of Cyril C. Tulley, Exhibit VII-303, at R. 13011; Expenditures for Personal Health Services--National Trends and Variations, 1953-1970, DHEW Publication No. (HRA) 74-3105 (Oct. 1973), Exhibit III-5, comment of Nancy C. Bilello, Exhibit VII-341, at R. 13053; Douglas Coate, Studies in the Economics of the Profession of Optometry, CCNY Univ. Microfilms, No. 74-20 (1974), Exhibit V-5, at R. 6300.

However, there are other factors which affect the significance of these correlations. The available evidence indicates that the need for ophthalmic goods and services is lower among certain minority groups.¹³ In a report published by the Public Health Service, it was found that among black youths aged 12 to 17 years, the need for corrective lenses was lower than among white youths of the same ages.¹⁴ In that report, the PHS concluded:

Racial differentials in the wearing of glasses could be expected since the previous report on visual acuity of youths shows the prevalence of defective acuity to be substantially greater among white than Negro youths.¹⁵

Thus, to the extent that the nation's black population falls disproportionately into lower income categories,¹⁶ the lower frequency of usage of eyeglasses among low income persons might only reflect a lesser need in those categories. However, the same study concluded that the proportion of black youths who need corrective lenses but did not have them is significantly greater than among whites:

13 Douglas Coate, supra note 12, at R. 6301; Characteristics of Persons with Corrective Lenses--United States, July, 1965 - June, 1966, Public Health Service, National Center for Health Statistics, DHEW, Series 10, #53, 1969, Exhibit II-13, at R. 399; Expenditures for Personal Health Services - National Trends and Variations, 1953-1970, DHEW Publication No. (HRA) 74-3105, (October 1973), Exhibit III-5, at R. 2389. But see Aran Safir, Casimir A. Kulikowski, Kurt M. Deuschle, and Francis Edgerton, Automatic Refraction of Schoolchildren, Mount Sinai School of Medicine of the City University of New York, Exhibit IV-26, at R. 12289.

14 "Eye Examination Findings Among Youths Aged 12-17 Years, United States," DHEW Publication No. (HRA) 76-1637, HX 116.

15 Id. at 15.

16 See, e.g., "Subject Reports--Low-Income Population," 1970 Census of Population, U.S. Department of Commerce, Bureau of the Census, Vol. 9A. At table 11, it is noted that 8.6% of all "white" families are below "poverty level" while 29.7% of the "black" families are below "poverty level."

Among youths, while proportionately more white than Negro youths are wearing corrective lenses and have defective acuity, the proportion of Negro youths not wearing but needing glasses is significantly greater than among their white counterparts.¹⁷

Again, with respect to the correlation between income level and the frequency with which eyeglasses are used, the PHS study concluded that a correlation does exist between income and frequency of use:

Youths age 12-17 years from higher income level families are substantially more likely than those from poorer families to wear glasses or contact lenses, either all day or part of the time. Some, but not this extent of association with income, would be expected since the proportion with defective acuity among these U.S. youths has been shown to increase with income.¹⁸

Among youths both the need for glasses and the need for a change, if they are now worn, is substantially greater among those in the lower income families.¹⁹

Thus, based on the foregoing evidence, it is staff's conclusion that there is a significant relationship between family income level and the frequency with which eyeglasses are purchased.

B. Present Consumer Knowledge

The proposed rule was premised in part on the belief that adequate information was not present in the ophthalmic market to allow consumers to make intelligent and informed purchase decisions.²⁰ This contention has frequently been challenged by opponents of the proposed rule, and in particular by both state

17 Supra note 14, at 16.

18 Id. at 18.

19 Id.

20 16 C.F.R. § 456.3, "Statement of Reason for the Proposed Rule" part (a).

and national associations of optometry.²¹ Many state optometric associations, as well as the American Optometric Association (AOA), pointed to the existence of public education and information programs as evidence that adequate information is available to all consumers.²²

21 See, e.g., statement of J. Harold Bailey, Executive Director, American Optometric Association, HX 367; letter from Lee H. Albright, Virginia State Board of Examiners in Optometry, to FTC (Oct. 30, 1975), Exhibit IV-59, at R. 3067; letter from Warren V. Ales, Louisiana State Association of Optometrists, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3113; testimony of Jesse C. Beasley, President, California Optometric Association, Tr. 3598 at 3602; letter from Charles M. Bowers, Arkansas State Board of Examiners in Optometry, to FTC (Oct. 13, 1975), Exhibit IV-59, at R. 2964; letter from James W. Clark, Kansas Optometric Association, to FTC (Oct. 13, 1975), Exhibit IV-60, at R. 3105; letter from Ed Craig, Alaska Optometric Association, to FTC (Oct. 10, 1975), Exhibit IV-60, at R. 3074; letter from William S. Eisner, Maryland Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3135; letter from J. LeRoy Oxford, Oklahoma Optometric Association, to FTC (undated), Exhibit IV-60, at R. 3164-65; letter from Murray Rappoport, Connecticut Optometric Society, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3081; letter from Lee DeSilet, Washington Optometric Association, to FTC (Oct. 20, 1975), Exhibit IV-60, at R. 3243; letter from Jan S. Dorman, New York State Optometric Association, Inc., to FTC (Oct. 29, 1975), Exhibit IV-60, at R. 3152; letter from Irby P. Dupont, Louisiana State Board of Optometry Examiners, to FTC (Oct. 16, 1975), Exhibit IV-59, at R. 2990; letter from Donald H. Evans, Pennsylvania Optometric Association, to FTC (Oct. 15, 1975), Exhibit IV-60, at R. 3183; letter from Paul W. Lycette, Mississippi State Board of Optometry, to FTC (Oct. 13, 1975), Exhibit IV-59, at R. 3020.

22 In its comments on the proposed rule the AOA stated:

Adequate information currently is available to allow patients to select eye care services and materials that best meet their budgets and needs The names and addresses of optometrists, ophthalmologists and opticians are listed in the yellow pages and are readily accessible. Moreover, AOA, State optometric associations, and other organizations conduct public information programs, including public service announcements on radio and television, concerning vision care. We believe that these

(Continued)

Despite the stated belief of the professional associations that adequate information is available to consumers, the available evidence indicates otherwise. In a survey of practicing AOA members conducted by the American Optometric Association, over 55% of those expressing an opinion indicated their belief that consumers do not have enough information available to them to select the ophthalmic goods and services which best meet their budgets and needs.²³

Measured from the perspective of the consumer, the lack of consumer knowledge becomes even more apparent. Pursuant to a grant under the Commission's Rules of Practice,²⁴ California Citizen Action Group (CCAG) performed a survey of consumer knowledge and attitudes. The study conducted by CCAG was designed to measure consumer knowledge and purchasing habits through the use of three separate measures. First, the study asked consumers to rate their own level of knowledge on issues such as the cost and quality of ophthalmic goods, and the roles and responsibilities of the three groups of practitioners. Secondly, CCAG attempted to objectively measure the level of "real" knowledge possessed by those persons surveyed concerning the ophthalmic market. Finally, CCAG sought to determine whether consumers would alter their purchasing patterns if provided with additional information.

The first portion of the CCAG study focused on the consumers' own assessments of their knowledge of the eye care field. In each case, the consumer was asked to rate his level of knowledge on a scale of "completely informed" to "completely uninformed" in relation to the following items:

22 (Continued)

sources of information which involve no real burdens for patients, provide more reliable and meaningful information than price advertising.

Comment of American Optometric Association, Exhibit VIII-160, at R. 14727.

23 Testimony of Farrell Aron, AOA Statistician, Tr. 3877 at 3882. The specific question asked was: "In general, adequate information is presently available to consumers to allow them to select the type of professional services and corrective lenses that best meet their budgets and needs." 47.9% disagreed with this statement, 40.7% agreed and 11.4% had no opinion.

24 Section 1.17, Organization, Procedures and Rules of Practice, Federal Trade Commission (Aug. 15, 1971).

1. quality of materials used in eyeglasses,
2. eyeglass prices,
3. examination fees,
4. frame prices,
5. which practitioners can fill prescriptions,
6. role differentiation between various practitioners in the eye care field, and
7. where to go for an eye exam.²⁵

In response to each of the first five categories over 50% of those responding indicated that they were "uninformed" consumers.²⁶ Significantly, over 70% of the consumers surveyed indicated that they were uninformed about the quality of materials being sold in

25 Outline of testimony of Paul A. Fine, California Citizen Action Group, HX 279. The actual format of the questions asked consumers to rate the level of their knowledge on a scale of 1 to 10, with 1 representing "completely informed" and 10 being "completely uninformed." For purposes of categorization, CCAG defined 1-4 to be "more informed," 5-6 to be "neutral," and 7-10 to be "less informed."

26 The precise results were as follows:

	Completely Informed Only	More Informed	Neutral	Less Informed	Completely Uninformed Only
	(1)	(1-4)	(5-6)	(7-10)	(10)
Quality of Materials	6.4%	17.4%	12.4%	70.2%	45.0%
Glasses Prices	6.4%	23.0%	18.0%	58.0%	34.1%
Fees Charged	4.5%	23.2%	23.7%	53.1%	28.6%
Price of Frames	7.5%	26.4%	21.1%	52.6%	28.0%
Ability to Fill Prescriptions	6.4%	25.8%	22.5%	51.6%	30.0%
Role Knowledge	9.3%	38.9%	19.5%	41.0%	19.9%
Where to go for Exam	11.8%	34.7%	29.4%	35.9%	14.7%

the eyeglass market.²⁷ The absence of information normally provided through advertising may well be a contributing factor to this disturbingly high level of consumer unawareness of the quality characteristics of prescription eyewear. Increased information could enhance consumers' ability to distinguish good quality from poor quality in the market.

Thus, consumers believe themselves to be basically uninformed in purchasing prescription eyewear. This lack of knowledge is even more pronounced when the data are analyzed by income and race. In the CCAG study, the poor ranked themselves almost twice as frequently as "totally uninformed" than did the non-poor.²⁸

27 Id. The data show that only 6.4% believed that they were completely informed on this issue, whereas 45% said they were completely uninformed.

28 Data compiled from outline of testimony of Paul A. Fine, California Citizen Action Group, HX-279.

Percentage of those who rate themselves totally uninformed:

	<u>Welfare¹</u>	<u>Other Poor²</u>	<u>Non-poor Minority³</u>	<u>Non-poor White⁴</u>
Quality of Materials	53.3%	42.3%	39.4%	44.3%
Glasses Prices	50.0%	35.5%	28.7%	26.4%
Fees Charged	46.7%	31.0%	19.1%	19.5%
Price of Frames	41.7%	32.0%	21.3%	18.5%
Ability to fill Rx	45.2%	27.8%	29.8%	21.8%
Role Knowledge	37.5%	21.4%	16.0%	9.8%
Where to go for Exam	28.8%	16.0%	11.7%	7.5%
Average	43.3%	29.4%	23.7%	21.1%

1 "Welfare" includes those on welfare and those receiving state assistance in obtaining eyeglasses or eye exams.

2 "Other poor" includes those persons with incomes below \$7500.

3 "Non-Poor Minority" includes those with incomes in excess of \$7500 who are Black, Oriental, American Indian, or Chicano.

4 "Non-Poor White" includes those with incomes in excess of \$7500 who are of European extraction.

Even among those persons considered "non-poor," those in minority groups were more frequently "totally uninformed" than were their nonminority counterparts.²⁹

One of the most important features of the CCAG study is its finding that consumers possess little awareness of prices for both eyeglasses and examinations.³⁰ This finding is strongly supported by testimony from others contending that consumers are simply not aware that wide price variations exist among sellers of eyeglasses.³¹

Another aspect of the CCAG study was the measurement of actual consumer awareness. Researchers questioned consumers as to the roles and functions of ophthalmologists, optometrists, and opticians. The results revealed that consumers were not only confused, but also misinformed.

In the critical areas of diagnosing eye disease, treating eye disease and prescribing medication consumers frequently were confused. For example, when asked who was qualified to treat eye disease approximately 11% felt that both opticians and

29 Id.

30 Id. Approximately 30% of those surveyed stated that they were totally uninformed on "glasses prices," "fees charged" and "frame prices." Only about 25% indicated that they were "informed."

31 See, e.g., testimony of Roy Alper, California Citizen Action Group, Tr. 3733 at 3734-35; testimony of Edith Barksdale-Sloan, Director, District of Columbia Office of Consumer Affairs, Tr. 609 at 617; testimony of Jack S. Folline, member, South Carolina Board of Examiners in Optometry and Opticianry, Tr. 574 at 588; testimony of William P. Bloss, North Carolina Public Interest Research Group, Tr. 124 at 128; testimony of William J. Brown, Attorney General, State of Ohio, Tr. 637 at 655; testimony of Conrad Donner, counsel, Bay Area Union Professional Center, Tr. 3389 at 3391; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1964; testimony of Elena Hangii, Arkansas Community Organizations for Reform Now, Tr. 4611 at 4632; testimony of Douglas Hurdelbrink, Consumer Protection Center, Baton Rouge, Louisiana, Tr. 6247 at 6254-55; testimony of Michael Magura, Ph.D. Professor of Economics, University of Toledo, Tr. 1261 at 1276; testimony of Theodore S. Weiss, Councilman, New York City, Tr. 1953 at 1955; letter from John Pound, SFCA, to FTC (Oct. 21, 1975), Exhibit III-7, at R. 2463.

optometrists could do so,³² when in fact only ophthalmologists are so qualified. At the same time over 30% did not know that ophthalmologists are qualified to treat eye disease.³³ Similarly, about 27% of the sample believed incorrectly that opticians and optometrists can prescribe eye medication.³⁴

The most significant finding was the consumers' inability to distinguish among the type of "examination" or "service" performed by the three practitioners. Almost 40% of the sample believe opticians can examine patients' eyes to determine if they need glasses,³⁵ 20% believe opticians are qualified to diagnose disease,³⁶ and 33% believe optometrists can examine eyes for disease.³⁷

A factor which compounds the problems created by this role confusion is the CCAG finding that while 73% of the total sample knew that ophthalmologists examine eyes for disease,³⁸ those that were white and non-poor were far more likely to be aware of this than those in minority or low-income groups. Only 51% of those on welfare gave correct responses about the functions of ophthalmologists while almost 92% of non-poor whites did so.³⁹ Even among the non-poor, whites were far more likely to have this knowledge than minorities; 92% of the former group understood the ophthalmologist's role, as opposed to 79% of the latter group.⁴⁰ On each question as to which type of practitioner can diagnose eye disease, treat eye disease, and prescribe medication, a clearly definable pattern exists. In each case those who were white and

32 Fine computer printout and definitions, HX 280, tables 37 and 38.

33 Id., Table 39.

34 Id., Tables 37 and 38.

35 Id., Table 38.

36 Id.

37 Id., Table 37.

38 Id., Table 39.

39 Id.

40 Id.

non-poor were the most knowledgeable, followed by non-poor minorities, non-welfare poor, and finally those on welfare.⁴¹

41 As the following charts show, those on welfare have far less actual knowledge of the role of each profession than do the "other poor" and the non-poor. Even among those categorized as non-poor, minorities fare far worse than their white counterparts.

The following table shows the percentage of persons in each category who answered the questions contained in the chart incorrectly. Fine computer printout and definitions, HX 280, Tables 37-39.

	Welfare	Other Poor	Non-poor Minority	Non-poor White
Opticians can examine eyes for glasses	44.8%	44.0%	33.7%	32.6%
Opticians examine eyes for disease	24.8%	23.2%	19.6%	11.0%
Opticians can treat eye disease	17.1%	14.9%	8.7%	5.2%
Opticians write prescriptions for medicine	27.6%	18.5%	12.0%	7.0%
Optometrists write prescriptions for medicine	26.9%	24.1%	16.0%	15.3%
Optometrists treat eye diseases	16.3%	11.8%	9.6%	7.1%

A clear pattern emerges from the chart. In every instance, the poor prove to possess less knowledge.

A second chart, compiled from HX 280, Table 39, confirms this hypothesis from a different perspective. The following chart shows the percentage of persons who knew that ophthalmologists performed the activities shown in the chart.

	Welfare	Other Poor	Non-poor Minority	Non-poor White
Ophthalmologists examine eyes for disease	51.0%	63.6%	78.5%	91.9%
Ophthalmologists treat eye disease	47.1%	63.6%	71.0%	87.9%

(Continued)

In commenting on the overall impact of the public's confusion, Paul Fine, author of the CCAG study, stated:

Price advertising restrictions, far from being a protection from a dangerous open sesame to public deception is, in fact, a barrier to the possibility of the public's being able to take appropriate action to protect itself.⁴²

Thus, the absence of information in the market has created a situation with potentially serious health ramifications. Indeed, it would appear that a substantial proportion of the public views each of the three professions as "eye doctors." Furthermore, the findings clearly point to the conclusion that the poor and those in minority groups are, by their disproportionately larger share of misinformation, the most seriously harmed.

Advertising clearly holds the potential to educate the public on many of the above-noted factors. For example, Wall & Ochs, a large East Coast optical chain, ran the following advertisement in a number of newspapers:

The Four Questions People Ask When They Buy Glasses

#4. Where Should I Have My Eyes Examined?

We recommend having your eyes examined by an ophthalmologist every two years. An ophthalmologist (medical eye doctor) is the only person who can diagnose and medically treat eye problems.

41 (Continued)

Ophthalmologists do eye surgery	41.2%	57.0%	61.3%	78.6%
Ophthalmologists prescribe eye medicine	46.1%	52.1%	67.7%	88.4%

Only ophthalmologists are legally qualified to diagnose eye disease, treat eye disease and prescribe medication. Optometrists are trained only to detect eye disease, not diagnose it. Opticians can perform none of these functions. For a more detailed description of the roles of each practitioner, See Section I(C), supra.

42 Testimony of Paul Fine, Ph.D., Paul Fine Associates, Tr. 3648 at 3669.

There is one way to tell if an eye doctor is an ophthalmologist. Ophthalmologists have "M.D." after their names.

Much of the information discussed above directly affects the consumer purchase decision. However, it also appears that consumers have become desensitized to price considerations due to a lack of understanding of the process by which eyeglasses are manufactured. Even though the evidence indicates that the majority of all lenses are produced in their finished form at the manufacturing level⁴³ close to 60% of those sampled did not believe it was possible to mass produce lenses.⁴⁴ Moreover, consumers appear to have little understanding of the wholesale costs of eyeglasses, often believing that their dispenser has paid two to three times more than he actually has.⁴⁵

As previously mentioned, a wide divergence of views exists as to whether or not consumers have access to sufficient information to make an intelligent, and informed, decision as to their

43 See Section I(A), supra.

44 Outline of testimony of Paul A. Fine, HX 276, p. 4.

45 Fine computer printout and definitions, HX 280, Table 58. 49% of the sample believed a pair of lenses cost their dispenser \$12 or more; 25% believed that the cost was \$18 or more.

eyeglasses purchase. Interestingly, those who possess the information, optometric associations,⁴⁶ optician associations,⁴⁷ and

⁴⁶ See, e.g., letter from Warren V. Ales, Louisiana State Association of Optometrists, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3113; testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3602; letter from James W. Clark, Jr., Kansas Optometric Association, Inc., to FTC (Oct. 13, 1975), Exhibit IV-60, at R. 3105; letter from Ed Craig, Alaska Optometric Association, to FTC (Oct. 10, 1975), Exhibit IV-60, at R. 3074; letter from Lee Desilet, Washington Optometric Association, to FTC (Oct. 20, 1975), Exhibit IV-60, at R. 3243; letter from Jan S. Dorman, New York State Optometric Association, Inc., to FTC (Oct. 29, 1975), Exhibit IV-60, at R. 3152; letter from Donald H. Evans, Pennsylvania Optometric Association, to FTC (Oct. 15, 1975), Exhibit IV-60, at R. 3183; letter from Elvira W. Jestrab, North Dakota Optometric Association, to FTC (Oct. 16, 1975), Exhibit IV-60, at R. 3159; letter from Joseph W. Jenkins, South Carolina Optometric Association, to FTC (Oct. 22, 1975), Exhibit IV-60, at R. 3189; letter from Robert R. Kimbro, New Mexico Optometric Association, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3148; letter from Robert J. Louderback, West Virginia Optometric Association, to FTC (Oct. 13, 1975), Exhibit IV-60, at R. 3247; letter from Robert W. McNevin, Indiana Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3101; letter from Murray Rappoport, Connecticut Optometric Society, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3081; letter from Ronald G. Schmidt, South Dakota Optometric Society, to FTC (Oct. 9, 1975), Exhibit IV-60, at R. 3234; letter from Claude M. Walters, Arkansas Optometric Association, to FTC (Oct. 13, 1975), Exhibit IV-60, at R. 3077; letter from Kenneth J. Young, Tennessee State Optometric Association, to FTC (Oct. 28, 1975), Exhibit IV-60, at R. 3236; letter from Karl D. Morrison, Florida Optometric Association, to FTC (Oct. 28, 1975), Exhibit IV-60, at R. 3089.

⁴⁷ See, e.g., letter from J. M. Hatcher, Tennessee Dispensing Opticians Association, to FTC (Oct. 21, 1975), Exhibit IV-62, at R. 3486; letter from Gaynell Owens, Certified Ophthalmic Dispensers of Kansas, Inc., to FTC (Oct. 20, 1975), Exhibit IV-62, at R. 3469.

representatives of state licensing boards⁴⁸ strongly espouse the view that consumers have sufficient information. On the contrary, virtually every consumer group and individual consumer⁴⁹ as well

48 See, e.g., letter from Charles M. Bowers, Arkansas State Board of Examiners in Optometry, to FTC (Oct. 13, 1975), Exhibit IV-59, at R. 2964; letter from Irby P. Dupont, Louisiana State Board of Optometry Examiners, to FTC (Oct. 16, 1975), Exhibit IV-59, at R. 2990; letter from Victor Isaacson, Nevada State Board of Dispensing Opticians, to FTC (Oct. 17, 1975), Exhibit IV-61, at R. 3397; testimony of Jesse Johnson, Jr., O.D., Vice President, Board of Examiners in Optometry of Oklahoma, Tr. 5607 at 5611; letter from Thomas J. Joyce, Maine Board of Optometry, to FTC (undated), Exhibit IV-59, at R. 2992; letter from Dick L. Kleinkopf, Alaska State Board of Dispensing Opticians, to FTC (Oct. 9, 1975), Exhibit IV-61, at R. 3391; letter from Charles J. Kroll, South Dakota Board of Optometry, to FTC (undated), Exhibit IV-59, at R. 3061; letter from A. L. Lindell, Wisconsin Optometry Board, to FTC (Oct. 24, 1975), Exhibit IV-59, at R. 3070; letter from Paul Lycette, Mississippi State Board of Optometry, to FTC (Oct. 13, 1975), Exhibit IV-59, at R. 3020; letter from Mary Ellen McCabe, Rhode Island State Board of Examiners in Optometry, to FTC (Dec. 9, 1975), Exhibit IV-59, at R. 3040; letter from E. E. Osborne, Ohio State Board of Optometry, to FTC (Oct. 20, 1975), Exhibit IV-59, at R. 3035; letter from H. L. Ridgeway, North Carolina State Board of Opticians, to FTC (Oct. 10, 1975), Exhibit IV-61, at R. 3400; letter from Allan Wasserman, Georgia State Board of Examiners in Optometry, to FTC (Oct. 15, 1975), Exhibit IV-59, at R. 2971; letter from Guy D. Wingert, Pennsylvania State Board of Optometrical Examiners, to FTC (Oct. 7, 1975), Exhibit IV-59, at R. 3033.

49 See, e.g., statement of UAW Consumer Affairs Department, HX 148; comment of Rose Agliata, Exhibit VII-295, at R. 13000; comment of Jeanette Olfant, Exhibit VII-256, at R. 12954; testimony of Roy Alper, CCAG, Tr. 3733 at 3734; comment of Mrs. W. A. Anderson, Exhibit VII-28, at R. 13530; comment of R. Baker, Exhibit VII-793, at R. 13621; comment of Jack Baskette, Exhibit VII-191, at R. 12884; comment of Argue Bays, Exhibit VII-785, at R. 13610; comment of Laverne Bennett, Exhibit VII-794, at R. 13622; statement of Gordon S. Black, HX 317; testimony of William Bloss, North Carolina Public Interest Research Group, Tr. 124 at 128; comment of F. W. Brenckle, Exhibit VII-765, at R. 13582; comment of Harold S. Burnside, Exhibit VII-522, at R. 13268; comment of Robert H. Bergman, Exhibit VII-1007, at R. 14011; comment of Paul B. Christian, Exhibit VII-356, at R. 13070; comment of Dorothy Jane Cooley, Exhibit VII-773, at R. 13595; comment of Josephine M. Corris, Exhibit VII-142, at R. 12825; comment of Mary C. Costa, Exhibit (Continued)

VII-241, at R. 12936; comment of Irving V. Deickmiller, Exhibit VII-55, at R. 12727; comment of Edna C. Denton, Exhibit VII-299, at R. 13004; comment of John Dezzani, Exhibit VII-157, at R. 12844; comment of Walter A. Dietz, Exhibit VII-627, at R. 13393; comment of Blye Ellen Dollahite, Exhibit VII-169, at R. 12856; testimony of Barbara W. Drossin, Tr. 1120 at 1128; comment of John E. Emanuelson, Exhibit VII-206, at R. 12900; testimony of Bernard Englander, Cooperative Services of Detroit and Group Health, Inc., Tr. 1333 at 1334; comment of Ann M. Fillman, Exhibit VII-259, at R. 12957; comment of Joyce Frazier, Exhibit VII-1003, at R. 14002; testimony of Kristin K. Graves, Director, Davis Consumer Affairs Bureau, Tr. 3825 at 3826; testimony of Leona Green, consumer, Tr. 1575 at 1581; letter from Justine Gubin, Consumer Affairs Committee, Americans for Democratic Action and D.C. Democratic Central Committee, to FTC (Nov. 13, 1975), Exhibit III-7, at R. 2459; comment of Toubner H. Hamma, Exhibit VII-598, at R. 13351; testimony of Phoebe T. Harris, Ph.D., Consumer Economics and Home Management, Mississippi State University, Tr. 6210 at 6218; comment of Frances R. Hart, Exhibit VII-66, at R. 12741; comment of L. M. Haskin, Exhibit VII-128, at R. 12809; comment of Leacelle Herrin, Exhibit VII-40, at R. 1307; comment of Hal Jacques, Exhibit VII-67, at R. 12742; comment of Murphy Jones, Exhibit VII-246, at R. 12943; comment of Muirerun Jondreau, Exhibit VII-253, at R. 12950; testimony of Dennis A. Kaufman, General Counsel, New York Public Interest Research Group, Inc., Tr. 2513 at 2515; comment of Edwin E. Koskela, Exhibit VII-277, at R. 12982; comment of Debbie Liptai, Exhibit VII-168, at R. 12855; comment of Myrtle A. Lund, Exhibit VII-603, at R. 13364; letter from Sandra Washburn, N.Y. Public Interest Research Group, to FTC (Oct. 9, 1975), Exhibit III-7, at R. 2453; testimony of Michael Magura, Ph.D., Professor of Economics, University of Toledo, Tr. 1261 at 1265; comment of Peter A. McNulty, Exhibit VII-24, at R. 12684; comment of Blanche A. Mutz, Exhibit VII-617, at R. 13381; comment of Quincy A. Murphee, Exhibit VII-228, at R. 12923; comment of Miles J. Murphy, Exhibit VII-338, at R. 13048; testimony of Mark Otto, Public Interest Research Group in Michigan, Tr. 831 at 843; letter from John Pound, staff attorney, San Francisco Consumer Action, to FTC (Oct. 21, 1975), Exhibit III-7, at R. 2464; Amicus Curiae of the Consumers' Council of the Commonwealth, Meyer Finkelstein, O.D. v. John E. Quinn, et al., Massachusetts Supreme Judicial Court, No. 446 (Feb. 2, 1976), and Supplemental Brief of Amicus Curiae (Mar. 2, 1976), Exhibit IV-118, at R. 5588; Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (1976), Exhibit II-65, at R. 1539; comment of Sam Schiffman, Exhibit VII-129, at R. 12810; comment of Marjorie Schafer, Exhibit VII-625, at R. 13390; comment of Ora Swick, Exhibit VII-415, at R. 13133; testimony of June Tanoue, Oregon Consumer League, Tr. 3298

49 (Continued)

at 3300; comment of Dorothy Thomas, Exhibit VII-394, at R. 13111; comment of George Thompson, Exhibit VII-46, at R. 12718; testimony of Judith Tiffen, CCAG, Tr. 3453 at 3460; comment of unnamed consumer, Exhibit VII-823, at R. 13673; testimony of J. O. Vernon, representative of the elderly in Oklahoma, Tr. 4439 at 4447; comment of A. Walton, Exhibit VII-573, at R. 13325; comment of Ralph Ward, Exhibit VII-254, at R. 12951.

50 See, e.g., testimony of Edith Barksdale-Sloan, Director, District of Columbia Office of Consumer Affairs, Tr. 609 at 616; testimony of Anthony O. Calabrese, Ohio State Senator and Chairman, Ohio Senate Health and Retirement Committee, Tr. 1537 at 1539; Complaint filed against the American Optometric Association and others in the Superior Court of California, Sacramento, also designated as California Dept. of Consumer Affairs, Exhibit 1, HX 287; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1968; testimony of Joseph Garcia, California Department of Consumer Affairs, Tr. 3962 at 3962; testimony of Terry Goggin, Assemblyman, California State Assembly, Tr. 3017 at 3029; testimony of Terrance J. Hamilton, Counsel, Massachusetts Consumers' Council, Tr. 2625 at 2626; Amended Complaint and Plaintiff's Memorandum of Law in Support of Preliminary Injunction, Consumers' Council v. Board of Registration in Optometry, Superior Court, Commonwealth of Massachusetts, No. 10715 (Apr. 2, 1976), Exhibit IV-122, at R. 5655; testimony of Douglas Hurdelbrink, Consumer Protection Center, Baton Rouge, Louisiana, Tr. 6247 at 6253; New Jersey Division of Consumer Affairs, "Price Survey of Eyeglasses and Prescription Drugs," and press release (Apr. 6, 1976), Exhibit V-79, at R. 11732; Transcripts, California Attorney General's Fight Inflation Committee Hearings (Jan. 8 and 10, 1975), Exhibit IV-141, at R. 5965; testimony of Charles W. Tapp, Director, Governor's Consumer Protection Division, State of Louisiana, Tr. 4200 at 4201; testimony of Phil Watson, Oklahoma State Senator, Tr. 4570 at 4577.

51 See, e.g., "Easy on the Eyes," Los Angeles Times (Nov. 18, 1975), Exhibit VI-18, at R. 12246; Complaint and related documents in Arkansas Community Organizations for Reform Now, et al. v. Arkansas State Board of Optometry, Arkansas Optometric Association, et al., U.S. District Court, Eastern District of Arkansas, Western Division, with "ACORN Comparison Price Survey of Optometric Goods and Services," Exhibit IV-91, at R. 4983; statement of Elena Hangii, HX 322; "What
(Continued)

lack necessary information. Indeed, even some opticians,⁵² optometrists,⁵³ and professional associations⁵⁴ agreed that consumers lacked adequate information to make rational purchase decisions in the ophthalmic market.

51 (Continued)

Do Eyeglasses Cost," The Cleveland Press (Nov. 1, 1975), Exhibit V-19, at R. 7781; "What Price Eyeglasses," The Cleveland Press (Dec. 26, 1975), Exhibit V-66, at R. 11602; RxO Journal of Opticianry, Opticians Association of America, Vol. XXV, Nos. 1-8, 10 (January - October 1975), Exhibit IV-72, at R. 4321; comment of M.D. Hoyt, Exhibit VII-792, at R. 13620; "Eyeglass Ads Debated," Oklahoma City Times (Sept. 9, 1975), Exhibit V-59, at R. 11587; Transcripts, California Attorney General's Fight Inflation Committee Hearings (Jan. 8 and 10, 1975), Exhibit IV-141, at R. 6091; testimony of Larry Wade, Oklahoma Press Association, Tr. 4494 at 4498; Pearl Wittkop, "Glasses Cost Linked to Ad Ban," Tulsa Tribune (April 28, 1975), Exhibit VI-34, at R. 12522.

52 See, e.g., letter from William Goldenberg, General Manager, Union Eye Care Center, Inc., to FTC (Oct. 29, 1975), Exhibit III-7, at R. 2455; letter from J. J. Tope, Vice President, Finance, and Treasurer, Jack Eckerd Company, to FTC (Nov. 7, 1975), Exhibit V-43, at R. 10069; testimony of Stephen LaVerdiere, LaVerdiere's Super Drug Stores, Tr. 2573 at 2589; testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4326; letter from Stanley C. Pearle, O.D., President, Opticks, Inc., to FTC (Nov. 24, 1975), Exhibit V-46, at R. 10714; testimony of Richard A. Schubach, Standard Optical Company, Tr. 3420 at 3421; testimony of Lee Starr, Optician, Tr. 4412 at 4412.

53 See, e.g., testimony of Erwin Jay, O.D., Tr. 1450 at 1484; testimony of Robert N. Sandow, O.D., Sandow Opticians, Tr. 2725 at 2726; testimony of Joseph Serian, O.D., 20/20 Contact Lens Service, Tr. 250 at 265; testimony of Bill Sturm, O.D., Tr. 3063 at 3066-68.

54 See, e.g., American Optometric Association, Code of Ethics and Supplements, Rules of Practice, Exhibit VI-54, at R. 2761; "Federal Trade Commission New Proposed Trade Regulation Rule for Eyeglass Price Advertising: What's Been Happening?," RxO Journal of Opticianry, Vol. XXVI (November - December 1975), Exhibit IV-87, at R. 4898; letter from Dwyn Anne Adams, Executive Director, Oregon Optometric Association, to FTC (Oct. 23, 1975), Exhibit IV-60, at R. 3181; letter from

(Continued)

During the course of this proceeding, a number of empirical studies were performed to measure the factors which affect the consumer purchase decision. Two questions were addressed in the surveys: (1) what factors do consumers consider important in deciding where and when to purchase eye care products and services, and (2) would additional information actually result in more informed decisionmaking by consumers.

1. What Factors Affect Consumers' Purchase Decisions?

Much evidence in the record bears on the question of what factors motivate consumer decisionmaking in the context of eye care. A study commissioned by the California Optometric Association (COA)⁵⁵ sought to evaluate some of those factors. A randomly selected sample of 500 consumers were asked to state whether the factors listed below were "very important," "somewhat important," "rather unimportant," or "completely irrelevant" in their decision to purchase eyeglasses.⁵⁶ The factors were:

1. reputation of doctor,
2. services provided by the doctor,
3. price for examination,
4. price for the glasses themselves,
5. variety of frames provided by the doctor, and
6. convenience of office location.⁵⁷

The results are enlightening. Close to 75% of the sample stated that the reputation of the doctor and the services he provides are very important to their decision.⁵⁸ Overall,

54 (Continued)

letter from J. A. Miller, Executive Director, Opticians Association of America, to FTC (Oct. 30, 1975), Exhibit IV-55, at R. 2911; letter from Leonard C. Swinsick, Jr., Michigan Society of Ophthalmic Dispensers, to FTC (Oct. 20, 1975), Exhibit IV-62, at R. 3476.

55 Statement of Dr. Harvey Adelman, HX 245.

56 Id. at p. 2 of Questionnaire.

57 Id. at p. 1 of Results.

58 74.6% indicated that the "reputation of doctor" and 72.4% indicated that "services provided by doctor" were "very important." Copy of computer results used by Dr. Adelman, HX 247.

more than 90% of the sample indicated that these factors were either very important or somewhat important.⁵⁹

In the area of price information, 50% of the sample classified the price for an examination and the price for the glasses themselves as being very important.⁶⁰ Close to 84% rated this price information as being either very important or somewhat important.⁶¹ The variety of frames offered by the practitioner⁶² and locational convenience⁶³ were both considered important factors by consumers, but to a lesser degree. A final important finding of the study was that almost 75% of the persons surveyed indicated that they desired more price information.⁶⁴

The results clearly evidence the fact that consumers believe price information to be an important factor in their decision, but not the only factor.

59 Id. 94.4% rated "reputation of doctor" as being either "very important" or "somewhat important." Similarly, 92.4% rated "services provided by doctor" as either "very important" or "somewhat important."

60 Id. The precise results were 50.2%.

61 Id.

62 The results indicate that 41% of the sample considered the variety of frames offered by the doctor to be a "very important" reason why they purchased eyeglasses from their practitioner. Overall, 77% indicated that frame variety was either very important or somewhat important. Copy of computer results used by Dr. Adelman, HX 247. Again, this demonstrates that the consumer is motivated by a number of different considerations, of which price is only one.

63 The "convenience of office location" was the least important consideration of those measured in the study. Yet the results reveal that 23.4% consider this factor "very important" and another 42.6% consider 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.

64 When asked whether they wished "more information about costs of eyeglasses were available to me," 27.4% strongly agreed, and another 47.1% agreed. Thus, 74.5% of the sample indicated a desire for more price information. Copy of computer results used by Dr. Adelman, HX 247.

The study conducted on behalf of the California Optometric Association substantiates the fact that factors such as the "doctor's reputation" and "doctor's services" are critical components in the consumer's purchase decision. This finding, however, does not in any sense indicate that price information is not important to consumers. The COA study⁶⁵ as well as other evidence on the record overwhelmingly shows that consumers believe that price information is an important factor in their ultimate purchase decision.⁶⁶ Many optometrists and opticians expressed the fear that were price information to become more

65 Statement of Dr. Harvey Adelman, HX 245.

66 See, e.g., "What Price Eyeglasses," The Cleveland Press (Dec. 26, 1975), Exhibit V-66, at R. 11602; testimony of Jerry M. Leach, Optician, Tr. 5846 at 5848; comment of Rose Agliata, Exhibit VII-295, at R. 13000; comment Jeanette B. Alfona, Exhibit VII-256; at R. 12954; letter from Andy Baldus, Arkansas Consumer Research, to FTC (Oct. 20, 1975), Exhibit III-7, at R. 2446; testimony of Edith Barksdale-Sloan, Director, District of Columbia Office of Consumer Affairs, Tr. 609 at 612; comment of Mr. & Mrs. William P. Bauer, Exhibit VII-149, at R. 12833; comment of Arque Bays, Exhibit VII-785, at R. 13610; comment of La Verne M. Bennett, Exhibit VII-794, at R. 13622; comment of Mrs. E. Bernard, Exhibit VII-782, at R. 13606; comment of Herbert B. Bravin, Exhibit VII-724, at R. 13526; comment of F. W. Brenckle, Exhibit VII-765, at R. 13582; comment of Mrs. L. R. Brown, Exhibit VII-440, at R. 13166; testimony of Silas Brown, Community Thrift Clubs, Inc., Tr. 1587 at 1591; comment of S. D. Cashat, Exhibit VII-36, at R. 12698; letter from Nancy H. Chasen, Consumers Union, to FTC (Nov. 14, 1975), Exhibit III-7, at R. 2450; testimony of Charles J. Copeland, AARP, Tr. 985 at 987; comment of Mary E. Costa, Exhibit VII-241, at R. 12936; comment of Nathan L. Cox, Exhibit VII-331, at R. 13040; comment of Mr. & Mrs. J. Daller, Exhibit VII-159, at R. 12846; comment of Irving V. Dickmiller, Exhibit VII-55, at R. 12727; comment of Edna C. Denton, Exhibit VII-299, at R. 13004; comment of John Dezzani, Exhibit VII-157, at R. 12844; comment of William A. Duckert, Exhibit VII-540, at R. 13289; letter from Ed Craig, Vice President, Alaska Optometric Association, to FTC (Oct. 10, 1975), Exhibit IV-60, at R. 3075; comment of Scott Doup, Exhibit VII-22, at R. 12682; comment of William W. Downey, Exhibit VII-884, at R. 13757; comment of David Downs, Exhibit VII-674, at R. 13449; testimony of Barbara W. Drossin, consumer, Tr. 1120 at 1127-28; comment of Kathe Drucker, Exhibit VII-780, at R. 13603; comment of James C. Drummond, Exhibit VII-401, at R. 13118; comment of Walter A. Ehrlich, Exhibit VII-35,

(Continued)

at R. 12697; comment of John E. Emanuelson, Exhibit VII-206, at R. 12900; comment of Rose Famiglietti, Exhibit VII-566, at R. 13317; comment of Viola A. Field, Exhibit VII-271, at R. 12975; comment of Ann M. Fillman, Exhibit VII-259, at R. 12957; comment of Henry R. Fogg, Exhibit VII-712, at R. 13509; comment of E. J. Fryer, Exhibit VII-485, at R. 13228; comment of Anne P. Getz, Exhibit VII-398, at R. 13115; comment of Taubner G. Hamma, Exhibit VII-598, Tr. 13351; comment of William N. Hammond, Exhibit VII-679, at R. 13456; comment of Leacelle Herrin, Exhibit VII-40, at R. 12706; comment of Richard Heirmann, Exhibit VII-358, at R. 13072; comment of Charles J. Hirsh, Exhibit VII-43, at R. 12710; comment of Edwina Hulsart, Exhibit VII-26, at R. 12686; testimony of Jerry K. Humphrey, M.Ed., F.N.A.O., certified optician, Ft. Worth, Texas, Tr. 5884 at 5885-86; comment of Murphy Jones, Exhibit VII-246, at R. 12943; comment of Stephen LaVerdiere, Exhibit VII-188, at R. 12877; testimony of Jerry M. Leach, optician, Lone Star Steel Company, Tr. 5846 at 5848; comment of Myrtle A. Lund, Exhibit VII-603, at R. 13364; testimony of Sebastian Lupica, Executive Secretary, Cleveland AFL-CIO Federation of Labor, Tr. 1674 at 1676; comment of Rose T. Lupich, Exhibit VII-770, at R. 13589; comment of Peter A. McNulty, Exhibit VII-24, at R. 12684; comment of Franklin J. Miller, Exhibit VII-727, at R. 13523; comment of John Moeller, Exhibit VII-722, at R. 13523; testimony of Bernard Morewitz, O.D., President, Virginia Optometric Association, Tr. 160 at 175; comment of Mr. and Mrs. P. J. Nardulli, Exhibit VII-690, at R. 13476; comment Mrs. Hilda I. Pearson, Exhibit VII-428, at R. 13151; comment of C. J. Richards, Exhibit VII-423, at R. 13144; comment of Marian Riley, Exhibit VII-686, at R. 13471; comment of Mr. and Mrs. Virgil Sandidge, Exhibit VII-287, at R. 12992; comment of A. M. Scherz, Exhibit VII-514, at R. 13260; comment of Sam Schiffman, Exhibit VII-129, at R. 12810; comment of C. Schimelfening, Exhibit VII-737, at R. 13543; Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (1976) Exhibit II-65, at R. 1540; testimony of Richard A. Schubach, Standard Optical Company, Tr. 3420 at 3421-22; comment of Ernest Skarella, Exhibit VII-180, at R. 12869; comment of Mrs. D. Stoddart, Exhibit VII-25, at R. 12685; comment of Ora Sewick, Exhibit VII-415, at R. 13133; comment of Mrs. Fern Taylor, Exhibit VII-216, at R. 12911; comment of Dorothy Thomas, Exhibit VII-394, at R. 13111; comment of Thomas B. Thornton, Exhibit VII-32, at R. 12693; comment of B. M. Unger, Exhibit VII-543, at R. 13294; comment of Ralph Wand, Exhibit VII-254, at R. 12951; comment of Mrs. Louise Whitney, Exhibit VII-480, at R. 13222; comment of William S. Wilbur, Exhibit VII-208, at R. 12902; testimony of Glenn R. Workman, Legislative Research Project for Ohio's Elderly, Tr. 1209 at 1210-11.

readily available, consumer decisionmaking would be solely price motivated.⁶⁷ The data simply do not support that fear.

C. Will Additional Information Alter Consumer Decisionmaking?

Two surveys in particular sought to establish whether or not increased advertising would beneficially affect consumer purchase decisions. The first of these studies was conducted by San Francisco Consumer Action (SFCA).⁶⁸ SFCA conducted a comparison of the ophthalmic markets in Arizona and California. Arizona permits price advertising, while California prohibited price advertising at the time the survey was performed. SFCA sought to determine whether retail prices in Arizona were lower as a result of the permissible price advertising, whether the quality of eye care products and services had been affected by the advertising, and the impact on the consumer of price advertising in terms of consumer knowledge. The issues with respect to the quality of eyewear⁶⁹ and the cost of the eyewear to consumers⁷⁰ are discussed elsewhere.

In its study, SFCA attempted to measure the impact of price advertising on consumer awareness of price differentials. When asked whether they were aware that a wide range of prices existed for eye examinations and eyeglasses, 34% of SFCA's Arizona sample indicated that they were aware that there was a wide range of prices for eye examinations, and 45% indicated their familiarity with the available range of eyeglass prices.⁷¹ Based on this data, SFCA concluded:

67 See, e.g., Transcripts, California Attorney General's Fight Inflation Committee Hearings (Jan. 8 and 10, 1975), Exhibit IV-141, at R. 5940; letter from Brian S. Klinger, President, New Hampshire Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3145; Report and Recommendations of the California Attorney General's Inflation Committee, March 1975: "Advertising the Price of Eyeglasses--Majority Report" and "Minority Report on Advertising the Price of Eyeglasses," Exhibit IV-133, at R. 5778.

68 Delia Schletter, More Than Meets the Eye, (August 1976), HX 397.

69 See Section V(C), infra.

70 See Section III(D)(2), infra.

71 Supra note 68, at p. 107.

[D]espite the fact that public price dissemination is not prohibited by law . . . consumers have not appreciably "benefited" in terms of increased knowledge.⁷²

However, SFCA did not attempt to obtain comparable data from any other jurisdiction, which staff feels is crucial to a meaningful assessment of relative levels of consumer awareness. Standing alone, the figures do not show that consumers in Arizona are any more or less informed than their counterparts in non-advertising jurisdictions. A 45% awareness of the range in eyeglass prices could be either high or low in comparison to those jurisdictions which do not permit price advertising. In an attempt to provide this comparison, SFCA states in a footnote:

See Paul Fine study performed in California where similar degrees of consumer ignorance were found to exist in a state where price advertising is prohibited.⁷³

If indeed this characterization of the Paul Fine (CCAG) study was accurate, then it might tend to indicate that price advertising is not particularly useful in informing the public concerning the range of available prices. However, not only does the CCAG study fail to support SFCA's contention, it diametrically opposes it. In the CCAG survey of consumers in California, where price advertising was prohibited at the time the survey was performed, consumers were asked to state whether they were "informed" with respect to the range of fees for eye examinations and eyeglasses.⁷⁴ Only 23.2% of the California respondents indicated that they were aware of the range in examination fees.⁷⁵ Similarly, only 23% indicated that they were aware of the range in eyeglass prices.⁷⁶ A comparison of the awareness levels in the two states is presented in the following table:

72 Id. at p. 108.

73 Id., note 3 at p. 120.

74 Survey form used by Fine Associates, HX 279, questions 1(c), 1(f) and 1(g).

75 Fine computer printout and definitions, HX 280, table 7. CCAG defined consumer knowledge on a scale of 1-10 with "1" being completely informed and "10" being completely uninformed. Categories 1-4 were defined as "informed." The total of the persons falling into this category is 23.2%.

76 Id. at table 7.

Consumer Awareness of Range in Eyeglass Prices
and Examination Fees

	<u>Eyeglass Prices</u>	<u>Exam Fees</u>
California	23.0%	23.2%
Arizona	45.0%	35.0%

Thus, although it would appear from the table that 50% more persons in Arizona believe they are aware that a wide range of prices exists in the market (100% more for eyeglasses), it may well be that a portion of this increase in self-perceived awareness of the price alternatives is attributable to the differences in the questions asked in the two surveys. However, to the extent that any conclusion can be drawn from the data, it would be that Arizona consumers are considerably more aware that varying prices exist in the market.

A second study addressing the impact of additional information on consumer decisionmaking was performed by California Citizen Action Group (CCAG). As we discussed in the previous section a portion of the CCAG study was devoted to assessing consumer knowledge of various elements in the ophthalmic market. In addition, CCAG constructed a two-part test for the purpose of determining the impact of additional information in the market. Consumers were shown an advertisement offering single vision eyeglasses for \$19.90.⁷⁷ They were then asked whether they believed they could actually obtain "a proper pair of glasses for as little as \$19.90?"⁷⁸ In response, 23.7% indicated their belief that good eyeglasses could be obtained at the price, and 46.9% indicated that they did not believe it was possible.⁷⁹ Respondents in the poor and minority group categories were even less likely to feel that such a bargain could exist. Only 14.7% of those on welfare and 24.8% of non-poor minority groups, believed it possible to obtain eyeglasses at that price, as compared to 32.9% of the non-poor whites.⁸⁰ As we note in a subsequent discussion, a pair of single vision lenses of the best quality can be purchased by the dispenser for approximately \$7.81.⁸¹ Coupled with the availability of hundreds, if not thousands

77 Survey form used by Fine Associates, HX 279, at p. 11.

78 Id.

79 Outline of testimony of Paul A. Fine, California Citizen Action Group, HX 276, at p. 17.

80 Id. at p. 19

81 See Section V(A)(1), infra.

of frames in the range of \$3 to \$5,⁸² a top quality pair of eyeglasses can be obtained at the specified price of \$19.90.

After asking the above-noted question, the CCAG surveyors provided the following information to consumers:

Most LENSES are mass produced. Six major companies do 87% of the business. The lab which fills your prescription buys their lenses for an average of \$2.40 per pair and sells them assembled in your frame for an average of about \$7.00.

The range of wholesale prices for frames is from \$1.57 to \$14.45, with a good selection of frames available at \$3.00 or less.

So, Jones Vision Center, whose ad you saw, can provide you with standard corrective lenses in a basic frame at a total cost of \$10.00 or less. So they can sell glasses for \$19.90 with a 100% markup.⁸³

After receiving this information, consumers were asked whether they would be likely to "check out" the possibility of obtaining their eyeglasses from this source. The following table contains the responses both before the additional information was provided and after.

Would You Check Out Jones' Ad?⁸⁴

	<u>Total</u>	<u>Welfare</u>	<u>Poor</u>	<u>Non-poor Minority</u>	<u>Non-poor White</u>
YES, I WOULD					
Before	43.7%	32.3%	44.6%	42.6%	48.0%
After	75.2%	70.8%	69.6%	81.5%	70.3%

Similarly, CCAG sought to determine whether the additional information provided would influence persons to comparison shop. When asked whether they had ever comparison shopped for eyeglasses to find a "best buy," only 23% indicated that they had. Again, the data showed that the poor and racial minorities were far

82 Id.

83 Supra note 74, at p. 24.

84 Supra note 79, at p. 19.

less likely to have comparison shopped. However, after being provided with the information dealing with costs, the consumers' reluctance to comparison shop diminished considerably.

Have You Ever Shopped to Find a Best Buy [in Eyeglasses]?⁸⁵

	<u>Total</u>	<u>Welfare</u>	<u>Poor</u>	<u>Non-poor Minority</u>	<u>Non-poor White</u>
Yes	23.0%	18.8%	20.6%	25.3%	27.2%

Do You Think You Will [Comparison] Shop More Now? - After Measure⁸⁶

	<u>Total</u>	<u>Welfare</u>	<u>Poor</u>	<u>Non-poor Minority</u>	<u>Non-poor White</u>
Certainly will	40.5%	36.5%	39.6%	46.7%	39.9%
Certainly plus probably	59.1%	50.0%	59.1%	61.4%	63.0%
Certainly, probably, might	68.6%	55.8%	69.8%	75.6%	72.2%

Thus, based on this evidence, it would seem that additional information will serve to make consumers more receptive to purchase alternatives. Moreover, increased comparison shopping appears to be stimulated by the increase in information. In its study CCAG concluded:

Dispensing of information changes attitudes and behavior. Those who have more information now behave differently. When given information all segments become more open to viable options in the marketplace, the poor catch up in their disadvantage and non-poor minorities make particularly strong use of the information.⁸⁷

However, these conclusions must be tempered by some inescapable realities. First, it is likely that consumers viewed the information provided them by CCAG with a good deal less skepticism than they would a typical advertisement. Indeed, both the CCAG study and the SFCA study found a large amount of consumer distrust

85 Id. at p. 20.

86 Id.

87 Id.

of advertising.⁸⁸ Thus, it is likely that in a true marketplace setting, the shift in consumer behavior would be much less dramatic. Secondly, the CCAG "test" presupposes that information of this nature will be advertised by sellers and providers. To the extent that the advertising engaged in seeks only to persuade instead of inform the consumer, a portion of the benefits of advertising may be lost.⁸⁹

In his testimony, Paul Fine, author of the CCAG study noted that the typical advertisement may not include, at least not to the same extent, the type of information disseminated by CCAG in their experiment. However, he noted:

. . . price advertising alone cannot do the job alone, because price advertising frightens people . . . [However] price advertising will be one aspect of the cure. It is a necessary but not a sufficient condition. Price advertising alone will not change this picture. [Price advertising] is a necessary part of a total set of informational tools which the public needs to make informative decisions to go into the marketplace.⁹⁰

On balance, staff concludes that increased information will increase consumer awareness of purchase alternatives, and facilitate comparison shopping.

D. Social Losses

The economic losses being borne by consumers as the result of state advertising bans,⁹¹ do not represent the full extent of the consumer injury associated with those restraints. Two groups in particular, the elderly and the poor, bear a disproportionately large share of the burden associated with these restraints.

⁸⁸ See outline of testimony of Paul A. Fine, California Citizen Action Group, HX 276, at p. 5; Delia Schletter, More Than Meets the Eye (August 1976), HX 397, table at p. 116.

⁸⁹ See, e.g., Kenneth D. Boyer, "Informative and Good Will Advertising," HX 121.

⁹⁰ Testimony of Paul A. Fine, Tr. 3648 at 3728-29.

⁹¹ See Section III, infra.

The problem is perhaps greatest with respect to the elderly. Earlier we noted that approximately 93% of those over age 65 use some form of corrective eyewear.⁹² In addition, we demonstrated that a higher percentage of the elderly in higher income categories used ophthalmic goods than did their poorer counterparts.⁹³ The problem is presented in its starkest form in the testimony of the American Optometric Association to a congressional committee on the aging:

As costs continue to rise, the effects on the older persons have been devastating. With more and more of the meager funds going to pay for rent increases, utility increases, and food increases, they are faced with the necessity of eliminating other services from their lives--regardless of the importance of those services . . . [W]e find too many elderly Americans who count up their remaining loose change at the end of a month and say to themselves that they cannot afford to have their eyes examined, they cannot afford to have spectacle frames repaired, they cannot afford new prescription lenses.

. . . At least 85 percent of all serious injuries sustained by persons 65 and older are caused by falls. Twenty-five percent relate directly to uncorrected vision problems.⁹⁴

A survey conducted by the American Association of Retired Persons (AARP) of its members sheds further light on the plight of the elderly American in purchasing ophthalmic goods:

Almost 50% of our sample [1364 persons] had an income level of less than \$5,000 a year. Furthermore, we find that slightly over 3/4 of our sample relied on social security income as [their] principal source of income. Noting the low income level of our sample, and their heavy reliance on social security as the source

92 Supra note 10.

93 Supra note 11.

94 Medical Appliances for the Elderly: Needs and Costs, Hearings Before the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging, 94th Cong. (June 23 and 24, 1976), at p. 156.

of income, we were not surprised to find that relatively few individuals carried insurance which covered purchases of ophthalmic goods and services. In fact, we found that almost 90% of our sample has no insurance to cover the expense of eye examinations; and slightly over 90% of our sample had no insurance to cover the cost of eyeglass purchases.⁹⁵

The AARP study also tended to show that the elderly in states which did not have advertising bans, were able to purchase ophthalmic goods more frequently, and have their eyes examined more frequently than in states which restrict advertising.⁹⁶ Witnesses for the AARP attributed this increase in consumption in nonrestrictive states to the lower prices which prevail in those states.⁹⁷ The AARP study suffers from a number of methodological flaws. The sample was not drawn randomly⁹⁸ and some confusion existed concerning the classification of states as restrictive and nonrestrictive.⁹⁹ However, the survey does bear witness to the plight of the elderly, and constitutes some evidence of a decline in consumption by the elderly attributable to high prices.

Finally, as we noted in the previous section, the elderly often suffer from decreased mobility.¹⁰⁰ The dearth of information in the market, particularly price information, makes comparison shopping extremely difficult for elderly consumers.

The problems associated with low-income persons have been discussed in some detail.¹⁰¹ The evidence suggests that persons in lower income categories are unable to purchase necessary

95 Statement of Dr. Grady St. Clair, Chairman, American Association of Retired Persons and National Retired Teachers Association, HX 296, at p. 2-3.

96 Testimony of Tom Borzilleri, staff economist, AARP, NRTA, Tr. 4124 at 4131.

97 Testimony of Dr. Grady St. Clair, AARP, NRTA, Tr. 4115 at 4131.

98 Supra note 96, at 4128.

99 Id. at 4129.

100 See Section III at note 42, supra.

101 See subsection (A), supra.

ophthalmic goods as frequently as their more affluent counterparts.¹⁰² Some economists, such as Lee Benham, have attempted to estimate the decrease in consumption of ophthalmic goods which is attributable to the higher prices in states which restrict price advertising. Benham's data indicate that the decline in consumption ranges upward to 35% from the least restrictive to the most restrictive states.¹⁰³

Accordingly, staff believes that the economic losses associated with advertising restraints represent only a portion of the total picture. Decreased consumption and increased burdens on the elderly are attributable, at least in part, to the existence of the state advertising bans.

102 Id.

103 See Section III at note 152, supra.

V. Justifications for Advertising Restraints

A. Will Advertising Lead to Deception?

In his report, the Presiding Officer concluded that the lifting of advertising restraints might lead to widespread deception.¹ In addition, he noted:

The evidence in this record supports the conclusion that consumers may, but not necessarily will, be misled by price advertising of ophthalmic goods. This is not because of the infinite variety of these goods but because of a conscious attempt of an advertiser to deceive, coupled with a failure on the part of regulatory and other authorities to prevent or halt such unlawful practices. Mandatory affirmative disclosures are not necessary to eliminate any potential for deception.²

To contend that an increase in deception would not attend an increase in advertising would be questionable on its face. It is axiomatic that in jurisdictions where advertising has been prohibited, no deceptive advertising can have occurred. Thus, with the advent of ophthalmic advertising, even a small amount of deceptive advertising would constitute an increase. However, staff can find no basis for accepting the Presiding Officer's conclusion that deception may become widespread.

In addition, with respect to the issue of mandatory affirmative disclosures, staff agrees with the Presiding Officer that disclosures are not necessary to prevent deception, but the staff is recommending that certain disclosures be left to the states' discretion.

The arguments advanced against ophthalmic advertising concerning the possibility of deception fall into two general categories. First, it is claimed that because ophthalmic goods are highly variable products, any price advertisements are inherently deceptive. Secondly, it is claimed that advertising would permit unscrupulous practitioners to engage in bait and switch sales tactics and enable such practitioners to obtain customers based on their advertising acumen rather than on their professional abilities.

¹ Report of the Presiding Officer, Exhibit XIII-1, at p. 84.

² Id. at p. 87.

These two categories will be dealt with separately. The first relates to the peculiar characteristics of prescription eyewear, while the second concerns problems common to all consumer products. Finally, in this section, staff will discuss the need for disclosures to be included in ophthalmic advertising.

1. Is Price Advertising of Ophthalmic Goods Inherently Deceptive?

It has frequently been contended that price advertising of ophthalmic goods is inherently misleading.³ This contention is predicated on the belief that because of the number of variables which affect both the preparation and pricing of ophthalmic goods, truthful price advertising is impossible. For example, one optometrist stated:

It is inherently impossible to completely and truthfully advertise the price of ophthalmic materials in the context of a normal newspaper advertisement. To be completely truthful and not mislead the consumer would require a document of the size and detail of a Securities and Exchange Commission prospectus.⁴

There is little doubt that there is an extremely large number of possible prescriptions which can be written for prescription eyeglasses. It has been estimated that the possible variations in the ophthalmic prescription may range as high as 10,000,000.⁵ Factors such as the refractive power of the corrective lenses, the axis of correction, whether a prismatic correction is necessary, and other factors vary considerably from person to person.

³ See, e.g., letter from J. Harold Bailey, Executive Director, American Optometric Association, to FTC (Nov. 15, 1975), Exhibit IV-53, at R. 2555; testimony of Paul E. Alony, Optician, Tr. 2544 at 2565; testimony of Stanley A. Anderson, O.D., Oregon Committee of Concerned Optometrists, Tr. 3192 at 3194; testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1008; testimony of George L. Haffner, President, Florida Optometric Association, Tr. 201 at 232; testimony of Alden N. Haffner, O.D., Dean, State College of Optometry, State University of New York, Tr. 2035 at 2047; statement of George Tracewell, California Association of Dispensing Opticians, HX 286.

⁴ Statement of Stanley A. Anderson, O.D., Oregon Committee of Concerned Optometrists, HX 250, at p. 15.

⁵ See, e.g., testimony of Robert Hart, Sr., Society of Dispensing Opticians of New Jersey, Tr. 2442 at 2444.

In addition, factors such as frame selection, frame size, lens form (i.e. single-vision or multifocal), segment characteristics and type of lens material also serve to increase the variability of prescription eyewear.⁶

However, the fact that eyeglasses are a highly variable product is not determinative of the issue of whether price advertising of eyeglasses would be deceptive. Examination of the price lists for ophthalmic goods, particularly lenses, indicates that the prices for lenses are infinitely less variable than the number of potential prescriptions would lead one to believe. For example, manufacturers such as Bausch & Lomb and American Optical, as well as most of the major wholesale laboratories, group a vast number of possible prescription combinations into a single price category.

⁶ See, e.g., testimony of David C. Hendershot, Executive Director, Ohio Optometric Association, Tr. 660 at 777; testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3807; testimony of Billie J. Odom, Vice President, Opticians' Association of Northern Virginia, Tr. 55 at 59.

Presiding Officer Cabell has described the important lens variables as follows:

The diopter is the basic unit of power for ophthalmic lenses, and this measure is applied to determine the spherical, cylindrical and prism powers respectively of a lens. A lens of spherical power is prescribed in plus ranges for farsightedness (hyperopia) and in the minus ranges for nearsightedness (myopia). Cylindrical lenses are used to correct astigmatism, a condition which exists when the focusing power of the eye is not equal in all meridians. The axis designation on a prescription is in degrees and is the reference for determining the power location on the lens of the cylindrical correction. A prism may be incorporated into a lens to deviate the light rays passing through it. The prism may be vertical with the base up or down or horizontal with the base in or out. Light is deviated toward the base. Prisms are incorporated in lenses for a variety of reasons such as to enable the individual to achieve normal binocular vision or to compensate for inadequate lens decentration that may occur, when oversize lenses and frames are used to line up the optical centers of the lenses with the patient's eyes.

Report of the Presiding Officer, Exhibit XIII-1, at p. 68.

For example, the following chart is indicative of the pricing practices of Bausch & Lomb's wholesale laboratories:

Bausch & Lomb--Single-Vision "Orthogon"
Glass and Hard Resin⁷

Spheres + or -

Plano to 4.00	\$5.20 per pair
4.25 to 8.00	\$6.40 per pair

Compounds

Plano to 4.00 Sph. 0.12 to 3.00 Cyl.	\$5.90 per pair
4.25 to 6.00 Sph. 0.12 to 3.00 Cyl.	\$7.10 per pair

During the public hearings, staff sought to ascertain the percentage of lenses dispensed which fall into the category specified above: Plano to 8.00 with up to a 3.00 cylinder. The results severely undercut the contention that price advertising of ophthalmic goods is inherently deceptive. Virtually every practitioner estimated that 85% to 95% of all single-vision lenses fall into this prescriptive category.⁸ Thus, for 85% to 95% of the single-vision lenses sold, the retailer's cost for a pair of lenses varies only \$1.90. This fact is critical, for although there may be millions of potential prescriptions within this range of prescriptions, the price is virtually the same in all instances.

7 Letter from Jerome Dienstag, Associate General Counsel, Bausch and Lomb, Inc., to FTC (Nov. 17, 1975), Exhibit V-20, at R. 7921.

8 See, e.g., testimony of Herman Gould, O.D., Tr. 4749 at 4783 (95%); testimony of J. R. Hale, Washington State Board of Optometry, Tr. 3007 at 3041 (90%); testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3807 (95%); testimony of J. A. Miller, Executive Director, Optician's Association of America, Tr. 4312 at 4335 (90%); testimony of George Tracewell, California Association of Dispensing Opticians, Tr. 3916 at 3928 (90%); testimony of Nelson F. Waldman, O.D., Tr. 5458 at 5463 (80% to 90%); testimony of Leonard White, O.D., Tr. 4150 at 4166 (90%); testimony of Jesse Johnson, Jr., O.D., Vice President, Board of Examiners in Optometry of Oklahoma, Tr. 5607 at 5619 (85%); testimony of Edward E. Crittenden, President, Eyear Optical, Tr. 6015 at 6021 (95%); testimony of James Elless, O.D., Tr. 5363 at 5400 (85% to 90%); testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5596 (95%).

Indeed, some wholesale laboratories charge a single price for all single-vision lenses regardless of the prescriptive power.⁹

Pricing patterns for multifocal lenses follow similar patterns. Wide ranges of prescriptive power are grouped into a relatively small number of price categories. For example, American Optical's wholesale laboratories employ the following pricing scheme:¹⁰

Tillyer Multifocals--Glass FDA
Hardened--Edged or Assembled

Spheres + or -

Plano to 4.00	\$17.50
4.25 to 7.00	\$19.20

Compounds (Sphero-
Cylinders)

Plano to 4.00 Sph.	
0.12 to 4.00 Cyl.	\$18.60
4.25 to 7.00 Sph.	
0.12 to 4.00 Cyl.	\$21.60

Some witnesses noted that a high percentage of all multifocal prescriptions fall within these categories.¹¹

As many persons have noted, other factors have the capacity to affect the price of the ultimate eyeglasses as well.¹² For

⁹ Optical Brochure of the Heard Optical Company, Long Beach, California, HX 282.

¹⁰ Letter from Larry D. Sharp, Attorney, Warner-Lambert Company, to FTC (Nov. 24, 1975), Exhibit V-27, at R. 9293. See also letter from Jerome Dienstag, supra note 7, at R. 7922.

¹¹ See, e.g., testimony of Mark A. Robin, California Optometric Association, Tr. 3543 at 3561 (85% of all prescriptions fall within this range); testimony of Bill Sturm, O.D., Tr. 3063 at 3080 (80% of all prescriptions).

¹² See, e.g., comment of J. Harold Bailey, Executive Director, American Optometric Association, Exhibit VIII-160, at R. 14702.

example, extra charges are imposed for tints¹³ and oversized lenses.¹⁴ Similarly, if the necessary correction is severe, an additional charge of approximately \$5.00 per pair of lenses may be imposed by the laboratory.¹⁵ Thus, there is no doubt that there are factors which can increase the cost of ophthalmic lenses. However, it is also clear that price advertising is not inherently deceptive. The vast majority of single-vision lenses sold vary little in cost.

With respect to ophthalmic frames a similar situation exists. The number of different frame styles manufactured and sold annually probably numbers in the tens of thousands.¹⁶ The prices for ophthalmic frames vary according to both the quality of the frame and the aesthetic features of the frame.¹⁷ However, again, this does not translate into a conclusion that advertising is inherently deceptive. Much of the advertising which has occurred to date has simply indicated that eyeglasses are available at

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- 13 Most laboratories impose additional charges for tints. See, e.g., letter from Jerome Dienstag, supra note 7, at R. 8081 (\$4.00 per pair for tints); letter from Larry D. Sharp, supra note 10, at R. 9196 (\$4.50 per pair for certain tints).
- 14 See, e.g., letter from Marshall S. Olson, President, Benson Optical, Inc., to FTC (Oct. 27, 1975), Exhibit V-34, at R. 9502 (\$2.00 to \$9.00 for oversized lenses); letter from Larry D. Sharp, supra note 10, at R. 9196 (\$4.00 for oversized lenses).
- 15 For example, American Optical imposes an additional fee of \$3.00 per pair of lenses when the cylindrical correction exceeds 4.00 cylinders. In addition, if the necessary spherical correction exceeds 7.00 diopters, an additional charge is imposed. However, as American Optical's basic price list does not include these severe correction categories, it would seem likely that they are not called for frequently. Letter from Larry D. Sharp, supra note 10, at R. 9208.
- 16 See Frames, Exhibit V-15. (Frames, published quarterly by Zulch and Zulch, Inc., Sylmar, California, is the standard catalog for frames sold in the United States and is accompanied by price lists applicable nationwide.)
- 17 See, e.g., testimony of Seymour Pollack, optician, Tr. 2307 at 2317-18; testimony of Frank W. Newell, M.D., Chairman, Department of Ophthalmology, University of Chicago, Tr. 1167 at 1179.

a fixed price from a predetermined selection of frames.¹⁸ It appears that most prepaid vision plans in which many "professional" optometrists participate operate on precisely this principle.¹⁹ A member of the prepaid plan is permitted to purchase eyeglasses with a specified price limit on the frame.²⁰ If a customer chooses to purchase a more expensive frame, he simply pays the incremental increase out of his pocket.²¹

Thus, the staff can find no basis for concluding that price advertising of ophthalmic goods is inherently deceptive. Lens prices fall into a small number of price categories which vary little. Similarly, prices for frames can be easily grouped into price categories.

Throughout this proceeding, examples have been cited wherein a consumer has sought to purchase eyeglasses at an advertised price only to be informed that his or her prescription did not qualify for the advertised price.²² It would be naive to assume that practices such as this will not occur. However, abuses such as this are not a function of the variability of eyeglasses; rather, they are attributable to an intent to deceive.

2. Deceptive Advertising in General

Aside from the argument that ophthalmic goods are inherently incapable of being advertised nondeceptively, it has been argued that the removal of advertising restraints will lead unscrupulous practitioners to engage in deceptive advertising techniques.²³

¹⁸ See, e.g., advertisement by Opti-Cal, Exhibit II-32, at R. 0849.

¹⁹ See, e.g., testimony of Roselyn Yasser, Associate Administrator, District Council 37 Health and Security Plan, Tr. 2716 at 2717; testimony of Conrad Donner, counsel, Bay Area Union Professional Center, Tr. 3389 at 3412; testimony of Jesse C. Beasley, President, California Optometric Association, Tr. 3598 at 3643.

²⁰ Id.

²¹ Id.

²² See, e.g., statement of Roy Ebihara, O.D., Lorain County Optometric Society, HX 110, at pp. 1-3.

²³ Testimony of Jerry Burger, O.D., Tr. 1056 at 1079; testimony of James W. Clark, Jr., Executive Director, Kansas Optometric Association, Tr. 4272 at 4281; testimony of Herman Gould, O.D., supra note 8, at 4771; testimony of Charles
(continued)

It is argued that practitioners will engage in bait and switch sales tactics,²⁴ and solicit customers based on their ability as advertisers rather than on their capabilities as eye care professionals.²⁵ An observation on these claims was offered by a California legislator:

Eye Care professionals contend that their own colleagues will cheat and mistreat their customer/patients if put under a system of price competition. It is a telling observation as to the industry's regard for the ethics of its members.²⁶

Concerns about practices such as bait and switch advertising are not unique to ophthalmic advertising. Advertising which is false and deceptive is generally prohibited in every state.²⁷ In addition, deceptive advertising is specifically prohibited by statutes on the federal level such as the Federal Trade Commission

(23 continued)

- I. Hughes, O.D., Arkansas Optometric Association, Tr. 4795 at 4800-01; excerpt from letter of J. Harold Bailey, Executive Director, AOA, in RxO Journal of Opticianry, Vol. XXVI, No. 11, (November - December 1975, Exhibit IV-87, at R. 4900; Ernest Dumas, "Arkansas's Eyeglass Prices Branded a 'Ripoff' by Texan," Arkansas Gazette (Dec. 6, 1975), Exhibit IV-81, at R. 4727.
- 24 Testimony of Carolyn A. Nordstrom, President, Hilltop Advertising Inc., Tr. 6128 at 6137; testimony of Jesse Johnson, Jr., supra note 8, at 5611; testimony of Roy Ebihara, O.D., Lorain County Optometric Society, Tr. 1235 at 1280-81; testimony of Paul E. Alony, supra note 3, at 2545; testimony of Stanley A. Anderson, supra note 3, at 3196.
- 25 Excerpt from letter of J. Harold Bailey, supra note 23, at 4900.
- 26 Testimony of Terry Goggin, California State Assemblyman, Tr. 3016 at 3018.
- 27 Forty-eight states and the District of Columbia have enacted laws similar to the Federal Trade Commission Act to prevent deceptive and unfair trade practices. In the two states lacking such laws, Alabama and Tennessee, consumer complaint clearinghouses have been established to facilitate the enforcement of existing laws, and to recommend possible new legislation.

Act.²⁸ One response which therefore can be made to claims that deception will occur is to note that such false, deceptive, or bait advertising is already prohibited in every jurisdiction.²⁹ Numerous state and local officials testified that existing machinery for policing deception was adequate to control ophthalmic advertising.³⁰ For example, the Attorney General of Ohio, testifying in support of the proposed rule stated:

I believe . . . that consumers will not necessarily be misled by price advertising of ophthalmic goods and that the proper means for policing this activity is through the consumer protection laws as are other goods and services .³¹

28 15 U.S.C. § 45 states:

Unfair methods of competition in or affecting commerce and unfair acts or practices in or affecting commerce, are hereby declared unlawful.

29 Supra note 27.

30 See, e.g., testimony of Edith Barksdale-Sloan, Director, District of Columbia Office of Consumer Affairs, Tr. 609 at 617-18; testimony of William J. Brown, Attorney General, State of Ohio, Tr. 637 at 651; testimony of Theodore S. Weiss, Councilman, New York City, Tr. 1953 at 1956; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1970; testimony of Terrance J. Hamilton, Counsel, Massachusetts Consumers' Council, Tr. 2625 at 2640; testimony of Howard C. Kaufman, Chief, Consumer Fraud and Protection Division, Attorney General's Office, State of Illinois, Tr. 1496 at 1512-13; testimony of Joseph Garcia, California Department of Consumer Affairs, Tr. 3962 at 3972-74; testimony of Charles W. Tapp, Director, Governor's Consumer Protection Division, State of Louisiana, Tr. 4200 at 4205-06; testimony of Norma Harrell, North Carolina Attorney General's Office, Tr. 6239 at 6246; Report and Recommendations of the California Attorney General's Inflation Committee, Exhibit IV-133, at R. 5770; "Statement of Bert Pikes, Los Angeles City Attorney, on Restrictive Price Advertising Statutes," Transcripts of California Attorney General's Fight Inflation Hearings, (January 1975), Exhibit IV-141, at R. 5974.

31 Statement of William J. Brown, Attorney General of Ohio, HX 56, at p. 9.

Many persons, including some state and local governmental officials, testified that existing regulatory mechanisms are inadequate, or too cumbersome to effectively respond to deceptive advertising.³² Staff recognizes that there is some validity to this contention. However, there does not appear to be any basis for singling out ophthalmic advertising for total prohibition. To totally prohibit ophthalmic advertising because of the possibility that a few practitioners will engage in deceptive advertising constitutes a classic example of overkill.

3. The Need for Mandated Disclosures

It has been argued that if the Commission permits ophthalmic advertising, it should either require the affirmative disclosure of certain information, or alternatively permit the states to require such disclosures. The case for a requirement that mandated disclosures accompany a rule permitting advertising was stated by the American Optometric Association in its formal comments.

[I]n the event that the Commission should decide to adopt a proposed rule, then disclosures in advertisements are essential to provide some measure of protection for patients It makes no sense to say that, since there are no restrictions on dispensing "shoddy" materials in some States, there therefore should be no restrictions on advertising them If advertising of ophthalmic goods should be unleashed, we submit that the public interest requires affirmative disclosures to enable consumers to obtain at least some bare meaningful information. Indeed, we perceive the absence of disclosure requirements from the proposed rule as a shocking omission.³³

A number different disclosures have been advocated by various persons. The disclosures which have been suggested fall into the following general categories:

³² See, e.g., testimony of R. Ted Bottiger, Counsel, Washington Optometric Association, Tr. 4047 at 4054; testimony of George Tracewell, supra note 8, at 3948; testimony of Robert G. Corns, O.D., Indiana State Board of Optometry, Tr. 1293 at 1299.

³³ Comment of J. Harold Bailey, Executive Director, American Optometric Association, Exhibit VIII-160, at R. 14726.

- (1) the name of the manufacturer of the lenses and/or frames advertised;³⁴
- (2) whether the lenses are glass or plastic;³⁵
- (3) the brand name of the ophthalmic goods advertised;³⁶
- (4) whether any price advertised applies to single-vision, multifocal or all types of lenses;³⁷
- (5) the country in which the lenses and/or frames were manufactured;³⁸

34 See, e.g., testimony of Stephen Lee Adams, President, Tennessee Dispensing Opticians Association, Tr. 6035 at 6048; testimony of Paul E. Alony, supra note 3, at 2549; testimony of Alden N. Haffner, O.D., supra note 3, at 2048; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1866; testimony of R. Ted Bottiger, Counsel, Washington Optometric Association, Tr. 4047 at 4050.

35 See, e.g., testimony of Stephen Lee Adams, supra note 34, at 6048; testimony of James W. Clark, Jr., supra note 23, at 4300; testimony of Jerry K. Humphrey, M.Ed., F.N.A.O., Tr. 5884 at 5886; testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2014.

36 See, e.g., testimony of Jack S. Folline, member, South Carolina Board of Examiners in Optometry and Opticianry, Tr. 574 at 576; testimony of Roy Ebihara, supra note 8, at 1238; testimony of William T. Heimlich, Chairman, Standards Committee, OAA and Guild of Prescription Opticians, Tr. 2185 at 2188; testimony of Ralph J. Rubinoff, Executive Director, Massachusetts Association of Registered Dispensing Opticians, Tr. 2532 at 2535; testimony of Robert N. Sandow, O.D., Tr. 2725 at 2725.

37 See, e.g., testimony of Stephen Lee Adams, supra note 34, at 6049; testimony of Jerry K. Humphrey, supra note 35, at 5886; testimony of George Tracewell, supra note 8, at 3922; testimony of Robert N. Sandow, O.D., supra note 36, at 2733; testimony of Virginia Long, supra note 34, at 1863.

38 See, e.g., testimony of Jerry K. Humphrey, supra note 35, at 5886; testimony of William T. Heimlich, supra note 36, at 2188; testimony of Alden N. Haffner, O.D., supra note 34, at 2048; testimony of Roy Ebihara, O.D., supra note 36, at 1238; testimony of Jack S. Folline, supra note 36, at 576.

- (6) the range of prescriptions (refractive power) which are included within an advertised price;³⁹
- (7) the length of time an advertised price will be available;⁴⁰
- (8) whether the lenses advertised comply with the voluntary ANSI standards, or alternatively whether the lenses are "first quality" or "second quality";⁴¹
- (9) whether the advertised price includes tints;⁴²
- (10) the serial or product number of any frame advertised;⁴³
- (11) whether the advertised price includes an examination;⁴⁴
- (12) both the low and high extremes if an advertisement offers prices "as low as";⁴⁵

39 See, e.g., testimony of David Volk, M.D., O.D., Tr. 1133 at 1161.

40 See, e.g., testimony of Jerry K. Humphrey, supra note 35, at 5886; testimony of Dr. Edward Hollander, Deputy Commissioner for Higher and Professional Education, New York State, Tr. 2652 at 2653.

41 See, e.g., testimony of Paul E. Alony, supra note 3, at 2549; testimony of Andrew Eiler, Consumer Affairs Department, United Auto Workers, Tr. 1650 at 1652; testimony of Dr. Edward Hollander, supra note 40, at 2653; testimony of George Tracewell, supra note 8, at 3937.

42 See, e.g., testimony of Michael Zagorac, Jr., Vice President, Jack Eckerd Corporation, Tr. 379 at 411.

43 See, e.g., Mandated disclosures recommended by the Ohio Optometric Association, HX 68.

44 See, e.g., testimony of Jack S. Folline, supra note 36, at 576; testimony of Paul Alony, supra note 3, at 2550; testimony of Virginia Long, supra note 34, at 1863; testimony of R. Ted Bottinger, supra note 34, at 4057; testimony of John Pound, San Francisco Consumer Action, Tr. 4079 at 4081.

45 See, e.g., testimony of Roy Ebihara, supra note 24, at 1238; testimony of Andrew Eiler, supra note 41, at 1653; testimony of Jack S. Folline, supra note 36, at 576; testimony of Nelson F. Waldman, supra note 8, at 5469.

(13) whether contact lens prices apply to hard contacts or soft contact lenses.⁴⁶

Two distinct bases have been advanced in support of the need for mandated disclosures in ophthalmic advertising. First, it has frequently been argued that without certain information being disclosed ophthalmic advertisements will be deceptive. Thus, it is contended that affirmative disclosures are necessary to prevent such deception.⁴⁷ Second, it is contended that affirmative disclosures are necessary to insure that advertisements contain sufficient information for consumers to comparison shop.⁴⁸

Conversely, many witnesses vigorously opposed the concept of mandatory disclosures, particularly if imposed by state law or state instrumentalities.⁴⁹ Accordingly, staff's discussion of this issue will consist of two parts:

- (1) Are affirmative disclosures necessary to prevent deception?
- (2) Would affirmative disclosures facilitate comparison shopping?
 - (a) Are affirmative disclosures necessary to prevent deception?

In its original form, the proposed rule would have preempted all laws which required affirmative disclosures in ophthalmic

46 See, e.g., testimony of Virginia Long, supra note 34, at 1863.

47 See, e.g., Mandated disclosures recommended by the Ohio Optometric Association, HX 68; testimony of Roy Ebihara, supra note 24, at 1235; testimony of Jack S. Folline, supra note 36, at 574; testimony of Bernard Englander, Cooperative Services of Detroit and Group Health, Inc., Tr. 1333 at 1333; testimony of Alden N. Haffner, supra note 3, at 2035.

48 See, e.g., comment of Richard D. Holbrook, President, Shuron Textron, Exhibit VI-60, at R. 12600; Mandated disclosures recommended by the Ohio Optometric Association, HX 68; testimony of Virginia Long, supra note 34, at 1862.

49 See, e.g., testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6207 (states may use disclosures to stifle advertising); testimony of Sheldon Fantle, Chairman of the Board and Chief Executive Officer, Peoples Drug Stores, Tr. 481 at 484 (states will use disclosures as a subterfuge to continue present restraints). See also testimony of David G. Tuerck, Director, Center for Research on Advertising, American Enterprise Institute, Tr. 13 at 49.

advertising. During the rulemaking hearings, it was recommended by various state officials that state or local governmental entities be permitted to require affirmative disclosures in ophthalmic advertising where the law requiring those disclosures applies to all consumer products. For example Elinor Guggenheimer, Commissioner of the New York City Department of Consumer Affairs, testified that regulations promulgated by the City of New York require that all advertisements conspicuously disclose any "material exclusions, limitations, reservations, modifications or conditions to the offer."⁵⁰ Similarly, New York's regulations require that in all advertisements in which a range of prices is advertised, "the highest price must be printed in type as large as the lowest price in the range."⁵¹

Without taking a position as to the necessity or desirability of laws or regulations which require mandatory affirmative disclosures in all advertising, staff believes that state and local governmental bodies should be permitted to enact and enforce such laws. From staff's perspective, it was never the intent of the proposed rule to place ophthalmic advertisers in a less restricted position than that occupied by other sellers of consumer products. In those instances where a state or local governmental body has determined that all advertising should include certain elements of information, staff's recommended Rule would not prevent those jurisdictions from applying such requirements to ophthalmic goods and services as well.⁵²

As we previously noted, many persons testified that the ability of both the states and the federal government to control deception on a case-by-case basis was limited.⁵³ In addition, we noted that the Commission itself increasingly has come to rely on rulemaking to remedy specific advertising abuses.⁵⁴ Staff believes it would be unwise to deny the states the opportunity to act in a similar fashion. Thus, staff recommends that state and local laws which apply to all product advertising not

50 See, e.g., testimony of Elinor Guggenheimer, supra note 30, at 1971-1972.

51 Id.

52 See § 456.3 of the recommended Rule, Section X, infra.

53 Supra note 32.

54 See, e.g., Proposed Trade Regulation Rule, Proprietary Vocational and Home Study Schools, 16 C.F.R. § 438; Proposed Trade Regulation Rule, Food Advertising, 16 C.F.R. § 437.

be preempted. The text of staff's recommendation makes clear our intention that only laws of general applicability will satisfy this standard.⁵⁵

In this same vein, staff believes a distinction must be drawn between those recommended disclosures which are applicable to all consumer products, and those which are uniquely applicable to ophthalmic advertising. For example, referring back to the listing of recommended disclosures,⁵⁶ items such as the name of the manufacturer of the product, the brand name of the product advertised, the country in which the product is manufactured, the serial number or product number, the length of time an advertised special is available, and a required disclosure of both the high and low ends in price range advertising, should--if they are deemed necessary--apply with equal force to all products, be they prescription eyeglasses, television sets, or automobile tires. None of these suggested disclosures addresses any unique characteristic of ophthalmic goods. To the extent that consumers would benefit from knowing the manufacturer of a product being sold by a retailer, it makes no difference whether the product being sold is a tire or a pair of eyeglasses.

Accordingly, staff finds no basis for requiring that such information be included in ophthalmic advertising. If such information is deemed necessary to prevent deception, then the states are free to require that these items be included in all product advertising.

A second category of recommended disclosures concerns the specific kinds of goods which might be included within an advertised price. It is argued that advertisements which offer prescription eyewear at a set price should include all of the information necessary for a consumer to determine what options fall within that price. It has been suggested that price advertisements should therefore state whether the advertised price includes tints,⁵⁷ single-vision and/or multifocal lenses,⁵⁸ and glass or plastic lenses;⁵⁹ whether prices for contact lenses refer to hard or soft contact lenses;⁶⁰ and the range of prescriptions

55 Supra note 52.

56 Supra notes 34-46.

57 Supra note 42.

58 Supra note 37.

59 Supra note 35.

60 Supra note 46.

which are available at an advertised price.⁶¹ In addition, it has been argued that all price advertisements should state whether the advertised price includes the examination fee.⁶²

Each of the disclosures suggested above must be viewed in light of whether it is necessary to prevent deception. If all advertising were to be judged by whether the advertisement delineated all of the potential variations which exist with respect to the product, virtually all advertising would be deceptive. The fact that ophthalmic products are to some extent variable does not differentiate them from other consumer products.

Certain of the variables associated with the pricing of ophthalmic goods possess the potential for significantly affecting the price ultimately charged the customer. For example, the wholesale prices of multifocal lenses are typically three to four times higher than single-vision lenses.⁶³ Soft contact lenses can be as much as twice as expensive as hard contact lenses.⁶⁴ Whether an examination fee is included within an advertised price for ophthalmic goods may mean a difference of as much as \$25 to \$30.⁶⁵

Addressing first the single-vision/multifocal variable, it is staff's belief that an advertisement which offered "eyeglasses" at a fixed price without specifying this variable might well

61 Supra note 39.

62 Supra note 44.

63 See comparative figures for single-vision lenses (at note 7) and multifocal lenses (at note 10), supra.

64 See, e.g., Delia Schletter, There's More Than Meets the Eye, San Francisco Consumer Action, HX 397, at p. 144. Data shows that retail opticians charge, on the average, almost twice as much for soft contact lenses. Median fees for area surveyed showed median fee for hard contact lenses to be \$125, while the median fee for soft contact lenses was \$250.

At the wholesale level, the disparity in price is even greater. See, e.g., letter from Jerome Dienstag, Associate General Counsel, Bausch and Lomb, Inc., to FTC (Nov. 17, 1975), including price list of Bausch & Lomb Soflens Division, Exhibit V-20 at R. 7876 (soft contact lenses \$34.85 per lens); letter from Larry D. Sharp, Attorney, Warner-Lambert Company, to FTC (Nov. 24, 1975), Exhibit V-27, at R. 9384 (hard contact lenses \$9.00 per lens).

65 See Section IX, infra, for a discussion of examination fees.

serve to deceive some consumers. A significant percentage of the lenses sold in the United States annually are multifocal.⁶⁶ Thus, it would not seem unreasonable for a consumer to assume that such an advertised price included multifocal lenses. Similarly, an advertisement which offered contact lenses at a fixed price without specifying whether the price applied to hard or soft contact lenses, would also have the capacity to deceive. In each of these instances the variations in price associated with these variables may be significant.

As to other items such as tints, over-sized lenses, and glass versus plastic lenses, similar considerations do not apply. Items such as tints or over-sized lenses do impose an additional cost to the seller.⁶⁷ The additional expense associated with these variables is in the range of \$5 to \$10.⁶⁸ However, both of these items are clearly optional features which are nearly always matters solely of consumer preference. Much as with any other consumer product, there is no basis to assume that consumers would expect to be able to obtain these "options" without incurring an additional expense. Thus, staff cannot conclude that an advertisement which failed to specify whether the advertised price included these items would be deceptive. Similarly, it is difficult to conclude that the failure to specify whether advertised lenses were available in glass or plastic would render that advertisement deceptive.

The suggested requirement that all advertisements state whether advertised prices include examination fees poses different considerations. As we note in our discussion regarding staff's recommendation that consumers be provided with copies of their prescriptions,⁶⁹ a significant percentage of consumers do not differentiate between the process of examination and the process of dispensing.⁷⁰ For example, the survey conducted by California Citizen Action Group (CCAG)⁷¹ found that close to 40%

⁶⁶ See, e.g., letter from Robert C. Morrow, President, Walman Optical Co., Exhibit VI-60, at R. 12607 (50% single-vision/50% multifocal); testimony of Jack Bridwell, O.D., President, Texas Optometric Association, Tr. 5212 at 5240 (60% single-vision/40% multifocal).

⁶⁷ Supra note 13.

⁶⁸ Id.

⁶⁹ See Section VII, infra.

⁷⁰ Id. at note 115.

⁷¹ Id. at note 114.

of the consumers surveyed received only one price for the combined examination and eyeglasses.⁷² CCAG's data indicate that many consumers do not differentiate between these two functions; rather, they simply "go to their eye doctor to get their glasses."⁷³ Thus, staff believes that a price advertisement for eyeglasses could have the effect of misleading consumers who may believe that it includes the examination fee.

The final suggested disclosure concerns the range of refractive powers available at a specified price. It is argued that since the price of ophthalmic lenses varies with the strength and type of correction, advertisements should be required to state the range of power available at the advertised price.⁷⁴ Earlier in this section, we discussed at length the manner in which ophthalmic lenses are priced at the wholesale laboratory level.⁷⁵ Except in the most extreme cases, prices for the various categories of prescriptive power vary relatively little in price. In both single-vision and multifocal lenses, the prices for lenses required by approximately 90% of the population vary only \$1.00 to \$2.00 per pair.⁷⁶ Persons with severe corrective requirements clearly must pay more substantial prices. However, it would seem logical to assume that a person suffering from such severe corrective requirements would not expect to pay the same that the typical consumer pays. Moreover, the suggested format of such a disclosure (e.g., high, medium, or low power) would mean little to a consumer.

Thus, staff believes that only three items warrant disclosure to deter deception: (1) whether an advertised price for "eyeglasses" includes single-vision and/or multifocal lenses; (2) whether an advertised price for contact lenses refers to hard or soft contact lenses, and (3) whether an advertised price includes an eye examination.

Two factors appear to militate against the need for the Commission to mandate these disclosures. First, an analysis of the evidence indicates that the majority of the advertising which

72 Id. at note 119.

73 Id. at note 115.

74 Supra note 39.

75 Supra notes 7-15.

76 Supra note 8.

currently exists in the ophthalmic market specifies these variables.⁷⁷ Only in a small number of instances have advertisements failed to include this information.⁷⁸ Second, from an economic perspective, the evidence indicates that it is in the advertisers' self-interest to include such information in their advertisements. Numerous persons testified that their businesses could not survive without repeat customers.⁷⁹ The failure to adequately identify the aforementioned variables is likely to injure the business reputation of the advertising practitioner.⁸⁰ Thus, both from the perspective of the practitioners' own economic incentives as well as from the advertising which has occurred to date, staff does not feel it is necessary for the Commission to impose requirements of this type.

However, staff does not believe that the Commission should deny the states the ability to impose disclosure requirements in these limited instances. As we previously noted, many persons testified that neither the states nor the FTC has the resources to police deception on a case-by-case basis.⁸¹ Affirmatively requiring that advertisements include certain information may well be a means by which the states may choose to minimize their enforcement burden for ophthalmic advertisements as well as other advertisements.

Thus, staff's recommended Rule would permit the states to require affirmative disclosures in three limited areas:

77 See, e.g., advertisement by Opti-Cal, Exhibit II-32, at R. 849; advertisement by 20/20 Contact Lens Service, Exhibit II-53, at R. 1449.

78 See, e.g., advertisement by Drug Mart Optical, HX 119.

79 See, e.g., testimony of James J. Ryan, NAOO, and N. Y. State Optical Retailers Association, Inc., Tr. 2360 at 2378:

We [optometrists and opticians] don't exist out there if we see somebody once. If they are not pleased with the product they are getting, they don't come back. Their friends don't come back. Their relatives don't come back.

See also testimony of Richard A. Schubach, Standard Optical Co., Tr. 3420 at 3438; testimony of Stephen LaVerdiere, LaVerdiere's Super Drug Stores, Tr. 2573 at 2584.

80 Id.

81 Supra note 32.

- (1) Whether an advertised price includes both single-vision and multifocal lenses;
- (2) Whether an advertised price for contact lenses refers to hard or soft contact lenses; and
- (3) Whether an advertised price includes the examination fee.

As to all of the other recommended disclosures, staff concludes, based on the available evidence, that they are not necessary to prevent deception.

(b) Would affirmative disclosures facilitate comparison shopping?

A number of persons have suggested the imposition of mandatory disclosure requirements as a means to facilitate comparison shopping by consumers.⁸² Indeed, some of the strongest advocates of this basis for affirmative disclosures have been those in the optometric profession.⁸³ There can be little doubt that the more relevant information included in an advertisement, the more useful that advertisement is to consumers. However, as we discuss elsewhere in this report, affirmative disclosures hold the potential for stifling nondeceptive advertising by making it uneconomical or unduly burdensome.⁸⁴ Staff believes that two considerations are paramount in this area.

First, if affirmative disclosures are to be required solely to make comparison shopping more effective, then there is no basis for distinguishing ophthalmic advertising from other product advertising. The staff's recommended Rule would permit the states to impose those kinds of requirements which are designed to facilitate comparison shopping, but only where those requirements apply to all retail product advertising. If consumers would be aided by knowing from an advertisement all of the optional features included within the advertised price for a pair of eyeglasses, they similarly would be assisted by knowing what options or accessories were available at an advertised price for an automobile or any other variable consumer product.

Secondly, many of the recommended disclosures would appear to be of little utility to the average consumer. The country of manufacture of lenses or frames would provide little relevant

82 Supra note 48.

83 See, e.g., testimony of Bernard A. Morewitz, O.D., President, Virginia Optometric Association, Tr. 160 at 170-71; testimony of J. Howard Sturman, Academy of California Optometrists, Tr. 3348 at 3354-55.

84 See Section XI(B), infra.

information to consumers. There has been no showing that lenses or frames manufactured in the United States are uniformly superior to foreign products.⁸⁵ Similarly, the brand name of the product being sold by the retailer would not be particularly useful to the average consumer. While the term "American Optical Tillyer" may carry some significance to someone intimately acquainted with the ophthalmic industry, the typical consumer would have little or no way of assessing the product quality attributes of such a brand name.

A related suggestion has been that advertisers disclose whether lenses being sold at an advertised price are "first quality" or "second quality."⁸⁶ Like the suggested disclosure of manufacturer brand names and country of origin, quality designation disclosures have been suggested as a means of helping the consumer assess the quality of the product being sold. However, as we note in our discussion of the quality related issues,⁸⁷ there is a wide divergence of views as to what constitutes a first or second quality lens.⁸⁸ Thus, a disclosure requirement of this sort would be not only of dubious informational value to the consumer, but also virtually impossible to enforce.

The theme which runs throughout this line of disclosure recommendation is that the consumer should have some means to discern whether an advertised product is a "quality" product. If a problem exists in this area, it is the use of poor quality lenses, not the advertising of them. For example, the Regulations adopted by the Virginia Board of Optometry require advertisers to state whether advertised lenses conform to the ANSI standards.⁸⁹ However, a practitioner who chooses not to advertise is free to dispense whatever level of quality he chooses.

If those in the ophthalmic industry who advocate a quality related disclosure are concerned about product quality, it would seem that the direct remedies which are available would be the appropriate mechanism by which to ensure that all ophthalmic retailers--regardless of whether they advertise--dispense high quality eye care goods. A discussion of those direct remedies appears elsewhere in this report.⁹⁰

85 See Section V(C), infra.

86 Supra note 41.

87 See Section V(C), infra.

88 Id.

89 See Section VI(B)(1), infra.

90 See Section V(C), infra.

Thus, with respect to the overall issue of requiring disclosures to facilitate comparison shopping, staff can find no basis on which to distinguish ophthalmic goods from other variable consumer products. Again, the states remain free to enact disclosure requirements designed to provide consumers with greater product information, where those requirements apply to all advertisements in all retail product areas.

Finally, a number of consumer groups have advocated a related form of disclosure. Specifically, it has been recommended that practitioners be required to post their prices conspicuously in their places of business, to itemize their bills, and to quote prices over the telephone. Each of these recommendations is discussed in detail in a later section.⁹¹

⁹¹ See Section XI, infra.

B. Potential Loss of Professionalism

Some industry members have expressed the fear that if the recommended Rule is promulgated, and ophthalmic practitioners begin to advertise, a loss of "professionalism" will result. They believe that advertising will undermine the professional image of the ophthalmic practitioner groups. The predicted effects of a lowered professional image are twofold: (1) consumers will be directly harmed by a loss of confidence in their practitioners and a deterioration of the doctor-patient relationship, and (2) the public will eventually suffer from the consequences of a failure to attract high-caliber entrants to the professions in the future.⁹²

Optometrists are the major proponents of the professionalism arguments. The history of organized optometry has been characterized by a concerted effort to elevate the optometrists' status from their origins as "spectacle peddlers"⁹³ to their current status as "primary health care providers."⁹⁴ Because the preoccupation with professionalism appears from the evidence in the record to be primarily an attribute of optometry, this discussion will focus on their concerns.

The first consequence of a lowered professional stature envisioned by some optometrists is that consumers will lose confidence in the doctor-patient relationship. As one optometrist stated:

⁹² The U.S. Supreme Court considered, and subsequently rejected, a similar argument in regard to pharmacists. The Court succinctly summarized the professionalism argument as follows:

[I]t is argued that damage will be done to the professional image of the pharmacist. This image, that of a skilled and specialized craftsman, attracts talent to the profession and reinforces the better habits of those who are in it. Price advertising, it is said, will reduce the pharmacist's status to that of a mere retailer.

Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, 96 S.Ct. 1817 (1976).

⁹³ See, e.g., Maurice E. Cox, Optometry, The Profession: Its Antecedents, Birth, and Development (Philadelphia: Chilton Co., 1957), at pp. 25-28.

⁹⁴ See Sections I(C)(4) and II(A)(2)(e), supra.

[P]rofessional people must, above all else, maintain their self-confidence and self-esteem . . . it is well known that a professional cannot devote his best attentions to his patient's . . . welfare if he is constantly beset by a feeling of inferiority. The very nature of the doctor-patient relationship requires that both the doctor and the patient recognise the doctor's superior knowledge, and that they both recognise that the doctor puts his patient's best interest foremost. The merchant-consumer relationship often takes on the nature of an adversary relationship; this the doctor-patient relationship can never be.⁹⁵

The prediction that the recommended Rule would alter the relationship between providers and consumers of eye care goods and services rests on one or both of two premises: (1) that the ability to advertise will interfere with the optometrist's professional obligations to his patients, and (2) that consumers will perceive advertising as indicative of lowered professional standards.

Proponents of the first premise contend that practitioners may lower their standards of eye care in response to a generally unfavorable professional climate which advertising would purportedly foster. The American Optometric Association expressed such a concern: "[advertising] could generally have a demoralizing effect on professionals and impair the quality of care they provide."⁹⁶ A member of the Washington State Board of Optometry predicted that "[l]ittle or no restrictions on price advertising will allow the FTC to juggernaut the structure of ethics and weaken standards."⁹⁷

95 Letter from Brian S. Klinger, O.D., President, New Hampshire Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3144.

96 Letter from J. Harold Bailey, Executive Director, American Optometric Association, to FTC (Nov. 15, 1975), Exhibit IV-53, at R. 2558.

97 Testimony of J. R. Hale, Tr. 3006 at 3008.

Perhaps the most compelling counter-argument to the contention that advertising will impair the self-image of the professional and thus result in inferior eye care was made by the optometrists themselves in testimony at the hearings. Virtually all of the optometrists who testified asserted that they would not lower their own standards of professional care if advertising were allowed.⁹⁸ It is staff's view, based on the considerable evidence generated in this proceeding attesting to the generally high level of professional standards adhered to by the optometric profession,⁹⁹ that the colleagues of those who testified would be no more likely to abandon those standards with the advent of advertising. Staff doubts that the optometric profession's adherence to ethical, patient-oriented standards rests upon the continued existence of the advertising bans.¹⁰⁰

⁹⁸ See, e.g., testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1042; testimony of M. F. Keller, O.D., Montana Optometric Association, Tr. 3469 at 3513; testimony of Charles W. McQuarrie, O.D., President-Elect, American Optometric Association, Tr. 3838 at 3858; testimony of Norman G. Michaud, O.D., New Hampshire Optometric Association, Tr. 2789 at 2799; testimony of Lester H. Sugarman, O.D., Connecticut Optometric Society, Tr. 2876 at 2888; testimony of James E. Washington, O.D., Tr. 2591 at 2608; testimony of Myron Shofner, O.D., Tr. 4842 at 4851; testimony of Jesse Johnson, Jr., Vice President, Oklahoma Board of Examiners in Optometry, Tr. 5607 at 5621.

⁹⁹ See, e.g., sources cited in note 98, *supra*; testimony of Charles E. Seger, O.D., Fellow of the American Academy of Optometry, Tr. 506 at 510-18; testimony of J. Harold Bailey, Executive Director, American Optometric Association, Tr. 5905 at 5909, 5913, 5988-89; letter from William S. Eisner, Administrative Director, Maryland Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3135; letter from Joseph W. Jenkins, Executive Director, South Carolina Optometric Association, to FTC (Oct. 22, 1975), Exhibit IV-60, at R. 3186; letter from Indiana Optometric Association to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3099; letter from Lowell B. Zerbe, O.D., Secretary, Indiana State Board of Optometry, to FTC (Oct. 16, 1975), Exhibit IV-59, at R. 2973.

¹⁰⁰ The California Citizen Action Group agrees, pointing out that the industry's contention that optometrists would lower their professional standards if advertising were allowed

(Continued)

Others agree that advertising would not result in unprofessional behavior by optometrists.¹⁰¹ The Massachusetts Consumers' Council believes that, far from undermining the doctor-patient relationship, advertising could improve it:

[T]here is nothing unprofessional about normal business activity, including advertising [P]rofessionalism, in fact, would if anything be enhanced by giving consumers the requisite price and service information to make intelligent and informed decisions regarding their purchase of ophthalmic goods and services.¹⁰²

A final argument for the proposition that advertising does not in and of itself lead to diminished professionalism can be inferred from the fact that individual practitioners, as well as national and state optometric associations, have long engaged in "institutional" advertising to a considerable extent. Numerous optometrists testified that they advertise their availability and other information such as their specialties and affiliations with professional associations in the yellow pages

100 (Continued)

is seemingly an admission that the members of the industry, or a considerable number of them, are unethical by nature and will indulge in unethical practices as soon as advertising restrictions are removed [T]hose fears are unfounded [optometrists'] . . . ethical standards are as high as those of any profession.

Rebuttal submission of California Citizen Action Group, Exhibit IX-176, at R. 17283-84.

101 See, e.g., testimony of Roy Alper, California Citizen Action Group, Tr. 3733 at 3742; testimony of Charles W. Tapp, Director, Louisiana Governor's Consumer Protection Division, Tr. 4200 at 4206; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1854.

102 Brief for Amicus Curiae of the Consumers' Council of the Commonwealth, Meyer Finkelstein, O.D. v. John E. Quinn, et al., Massachusetts Supreme Judicial Court, No. 446 (Feb. 2, 1976), Exhibit IV-118, at R. 5602-3.

of telephone directories.¹⁰³ Although the American Optometric Association (AOA) has taken the position that such yellow pages listings do not constitute advertising,¹⁰⁴ they clearly are effective means of attracting patronage. Optometrists confirmed in their testimony that telephone directory advertising is not demeaning to their professional stature.¹⁰⁵

In addition to allowing its members to list themselves together under the AOA logo in a separate block of the yellow pages listings,¹⁰⁶ the Association itself disseminates considerable "institutional" advertising on behalf of its members.¹⁰⁷ Included in this category are press releases, television and radio spots, brochures, pamphlets, and similar materials which urge the public to attend to their eye care needs by seeking the services of practitioners such as optometrists.¹⁰⁸ According to the AOA's executive director, such announcements "[come] under the heading of 'Public Information,'" rather than advertising.¹⁰⁹ Staff believes that such public relations initiatives

103 See, e.g., testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3630-31; testimony of Jerry Burger, O.D., Tr. 1056 at 1078, 1096; testimony of Roy Ebihara, Lorain County Optometric Society, Tr. 1235 at 1243; testimony of Paul S. Hornick, O.D., Tr. 1355 at 1373; testimony of Jack Bridwell, O.D., President, Texas Optometric Association, Tr. 5212 at 5227-28; testimony of Erwin Jay, O.D., Tr. 1450 at 1481-82; testimony of Richard C. Reed, O.D., Oregon Committee of Concerned Optometrists, Tr. 3227 at 3245-47.

104 Testimony of J. Harold Bailey, Executive Director, American Optometric Association, Tr. 5905 at 5995-96.

105 Supra note 103.

106 See, e.g., testimony of J. Harold Bailey, supra note 104.

107 See, e.g., exhibits to testimony of J. Harold Bailey, HX 362 - HX 366.

108 Id.

109 Testimony of J. Harold Bailey, supra note 104, at 6002.

serve many of the same purposes as advertising,¹¹⁰ and further that they clearly are not viewed as detrimental to professionalism by the optometrists who employ them.

The second premise underlying the contention that advertising will alter the doctor-patient relationship is that consumers will perceive advertising as indicative of lowered professional standards. This premise assumes first, that the current absence of information enhances consumers' trust in their doctors; and second, that the presence of increased information will impair that faith.

A study of consumer attitudes conducted for the California Citizen Action Group (CCAG) demonstrated the weakness of the first assumption. Over 40% of the respondents in the CCAG study felt that professional associations are withholding information under the guise of protecting the public.¹¹¹ Of those persons, 52% attributed the deliberate withholding of information to profit motives, 25% to a desire by practitioners to retain their professional "mystique," and 12% to an attempt to reduce competition among providers of eye care.¹¹² The results of the CCAG study show clearly that far from enhancing patient confidence in their practitioners, the withholding of information is viewed by substantial numbers of consumers as a calculated effort by professionals to obscure their economic motivations.

A separate study of consumer attitudes commissioned by the California Optometric Association effectively refuted the contention that increased information in the form of advertising will lower consumer trust in their practitioners. Almost 70% of consumers in that survey disagreed with the notion that advertising would lower the professional image of eye care providers.¹¹³

Thus, the assumptions underlying the frequently-voiced concern among optometrists that advertising will interfere with the

¹¹⁰ For example, The AOA Planner, a public relations manual for state and local optometric associations, recognizes as one of the goals of its outlined public relations program the "economic rewards" to be enjoyed by individual practitioners. Exhibit IV to testimony of J. Harold Bailey, HX 364, at p. 8 of Planner.

¹¹¹ Paul A. Fine Associates, Study on Eye Care and Eye Services, HX 280, at Table 14.

¹¹² Id. at Table 15.

¹¹³ Dr. Harvey Adelman, Lawrence S. Chuba and Associates, Survey on Consumer Attitudes toward Purchase of Eyeglasses, HX 245, at p. 2.

relationship between patients and practitioners appear to be unfounded. The contention that a lowered self-image will ensue from the advertising of eye care goods and services, and that practitioners will respond to an "unprofessional" climate by reducing their own standards of care, is not substantiated by the evidence in the record. Moreover, the premise that a lack of information enhances consumer trust in that relationship and that the public equates advertising with "unprofessionalism" is refuted by the above-mentioned studies of actual consumer attitudes.

The second untoward consequence of a lowered professional image is that, according to some optometrists, the profession will fail to attract persons of intelligence and social commitment to its ranks in the future. The argument, as stated by Alden N. Haffner, Dean of the State University of New York's College of Optometry, is as follows:

As a health care profession increasingly growing in respect, optometry has been able to attract well-qualified and highly educated applicants to its schools and colleges. The same high calibre science oriented student would tend not to be attracted to the profession were it forced to enter a marketplace environment dedicated to profit-making as opposed to the public health.¹¹⁴

Dr. Haffner buttressed his contention with the results of a nationwide survey he conducted of 1,549 optometry students. The 55-question survey questionnaire asked students to respond to 24 multiple-choice questions regarding the possible effects of advertising on their personal career aspirations, on the profession in general, and on consumers. In answer to a question as to whether price advertising among optometrists would attract a "lower caliber science oriented student," 53% of the students agreed that it would.¹¹⁵ Forty-eight percent of respondents agreed with the proposition that optometry would attract "a less socially committed person" if optometrists price-advertised.¹¹⁶ A third question asked the students whether, if price advertising had been permitted at the time they considered entering the field

¹¹⁴ Testimony of Alden N. Haffner, O.D., Ph.D., Tr. 2035 at 2052. See also testimony of Chester H. Pheiffer, O.D., Ph.D., Dean, College of Optometry, University of Houston, Tr. 5243.

¹¹⁵ Exhibits to testimony of Alden N. Haffner, HX 178 and HX 179.

¹¹⁶ Id.

of optometry, they would: (a) still have entered optometry (52% who had an opinion said yes); (b) have considered other occupational options as well as optometry (36% agreed); or (c) not have considered optometry (12% agreed).¹¹⁷

The survey appears to affirm that approximately half of the optometry students concur in Dean Haffner's belief that optometry schools will attract lower-caliber applicants if advertising is permitted. It also shows that more than half of the presumably high-caliber optometry students currently enrolled would definitely enter the profession even if advertising existed, and only 12% would completely reject the profession because of advertising. Thus, the results are mixed, at best, and fail to show that the current high quality of entrants to the field would be substantially reduced by the effects of advertising.

Further, the evidence cited above in support of the propositions that advertising will lead neither to diminished professional standards, nor to consumer disenchantment in their eye care providers, would seem to augur well for the continued ability of optometry to recruit well-qualified entrants. Since, in staff's view, professionalism and consumer confidence in their practitioners would not be eroded with the advent of advertising, it seems unlikely that the general public--including potential optometry students--would view the profession as any less honorable in the future than they do today. In fact, studies of current consumer attitudes such as those described above indicate that the image of the profession might well be enhanced by the increased dissemination of information which the recommended Rule would make possible.

Thus, staff concludes that the promulgation of the recommended Rule would not result in a lowered professional image, an alteration of the doctor-patient relationship, or a reduction in the abilities or social commitment of future optometrists. The director of the Governor's Consumer Protection Division of Louisiana offered perhaps the soundest analysis of the potential impact of advertising on professionalism:

I have always believed that professionalism is a term used to designate the attitude and the performance of individual professionals. I do not believe that laws and licenses can withdraw genuine professionalism where it truly exists or confer it where it fails to exist.¹¹⁸

¹¹⁷ Id.

¹¹⁸ Testimony of Charles W. Tapp, Tr. 4200 at 4206.

C. Effects of Advertising on Quality of Ophthalmic Goods and Services

The major argument advanced by opponents of the proposed rule was that the advertising of ophthalmic goods and services would lead to a deterioration in the quality of those commodities. The theory underlying this argument is that practitioners, by lowering their prices to survive in the more competitive marketplace which advertising would engender, would be forced to provide inferior goods and reduce the quantity and quality of services offered.¹¹⁹ Thus, while conceding that the proposed rule would indeed have the effect of lowering prices, industry members argued that it would also reduce quality levels. A fundamental assumption on which this argument rests is that the prices of eye care goods and services are directly related to their quality.

In this section we will examine these contentions and review the evidence in the record in terms of the following questions:

1. Are prices directly related to quality in the retail ophthalmic market?
2. Will the removal of advertising bans cause a deterioration in the quality of ophthalmic goods and services?

1. Are Prices Directly Related to Quality in the Retail Ophthalmic Market?

Virtually all of the opponents of the proposed rule who raised the quality argument relied on the assumption that the

¹¹⁹ 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, Tr. 660 at 664; testimony of Leonard J. Schmidt, O.D., Vice-President, Pennsylvania Optometric Association, Tr. 2235 at 2271; comment of William C. Ezell, O.D., attachment to letter from Joseph W. Jenkins, Executive Director, South Carolina 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.

prices of ophthalmic goods and services are positively related to their quality.¹²⁰ Industry members apparently view it as axiomatic that lowered prices will necessarily lead to the provision of inferior eye care goods and services. Thus, although this contention was propounded by nearly every optometrist and optician who predicted that advertising would lead to a deterioration in quality, no serious effort was made to empirically substantiate the claim.

The scant evidence presented in support of the notion that low cost is indicative of low quality in the current eye care market consisted primarily of anecdotal testimony alleging that certain discount optical establishments provide inferior goods and services.¹²¹ In spite of the fact that advertising and

120 See, e.g., letter from Robert R. Kimbro, Executive Director, New Mexico Optometric Association, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3148; letter from Karl D. Morrison, O.D., Executive Director, Florida Optometric Association, to FTC (Oct. 28, 1975), Exhibit IV-60, at R. 3087; letter from Norman G. Goss, O.D., Executive Secretary, Oregon Board of Optometry, Exhibit IV-59, at R. 3037; letter from Leonard C. Swinsick, Jr., President, Michigan Society of Ophthalmic Dispensers, to FTC (Oct. 20, 1975), Exhibit IV-62, at R. 3476; letter from J.M. Hatcher, President, Tennessee Dispensing Opticians Association, to FTC (Oct. 21, 1975), Exhibit IV-62, at R. 3485; letter from J.A. Miller, Executive Director, Opticians Association of America, to FTC (Oct. 30, 1975), Exhibit IV-55, at R. 2910.

121 See, e.g., testimony of Robert K. Shannon, O.D., Texas Optometric Association, Tr. 5296 and HX 396; testimony of Mark Robin, O.D., California Optometric Association, Tr. 3543 at 3546; testimony of George L. Haffner, President, Florida Optometric Association, Tr. 201 at 249-A, and HX 15; testimony of Charles Hughes, O.D., Arkansas Optometric Association, Tr. 4795 at 4801.

The owner of one large discount optical company objected to such charges, pointing out that allegations concerning another company had been used to disparage all discount outlets:

To date, there has been no empirical evidence presented that even attempts to prove that advertising is related to quality of product or service. We do not believe that the continued references to the Lee Optical-Daltex chain and the acts and practices which that firm may or may not have committed are
(Continued)

lower prices currently exist in several regional ophthalmic markets, the industry chose not to empirically test their assumptions regarding the relationship between price and quality in those areas.

Other participants in this proceeding did attempt to measure the relationship between the prices and quality of ophthalmic goods and services. Three separate studies found that the prices paid for eye examinations and eyeglasses bear no direct relationship to the quality of those services and commodities. A fourth study of examination services provided by low-cost optometrists showed a relatively weak correlation between the price and the accuracy of the prescription rendered, although a stronger relationship was found to exist between the price and the number of tests performed in an examination. A discussion of each of these studies follows.

Two separate studies were conducted on behalf of San Francisco Consumer Action (SFCA). The first study, conducted in Alameda County, California in 1975, compared prices with the quality of both eye examinations and eyeglasses.¹²² In the services component of the survey, the subject obtained 11 eye examinations from three ophthalmologists and eight optometrists practicing in a variety of modes and locations--from "professional" office building locations to "commercial" locations such

121 (Continued)

meaningful in terms of an overview of the entire industry and all ... who deliver ophthalmic goods and services other than in a "professional" optometrically oriented atmosphere. I suspect that our company, if we were inclined to make reports on every inferior product which we see and have been told comes from an optometrist who claims to be a "professional," could fill a number of pages with such anecdotes equal to the number of pages which presently constitute the record of these proceedings.

Rebuttal submission of Stanley C. Pearle, Chairman, Opticks, Inc., Exhibit IX-161, at R. 16377.

122 Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (March 1976), Exhibit II-65.

as a discount optical chain and a department store. The examination fees ranged from \$12.50 to \$35.¹²³

The survey found that the quality of the eye examinations--in terms of the accuracy of the prescriptions rendered and the numbers and kinds of tests conducted--was independent of the prices charged for those examinations. The surveyors drew the following conclusion from the results of the services portion of the study:

[M]uch of what goes on in an exam room depends, in the last analysis, on the conscientiousness and efficiency of the individual doctor. Little if anything, is directly affected by the fees charged for such exams or whether the doctor advertises, is located in a professional building, or practices in a discount store. . . . [T]he evidence gathered here does not support the claim that low cost or quickie examinations, or those performed by certain kinds of doctors or doctors in specific locations . . . tend to produce more "erroneous" examination results, as is so often charged.¹²⁴

The SFCA survey of lens quality produced similar results. Fourteen pairs of lenses¹²⁵--obtained from the examining practitioners who dispensed eyeglasses, a variety of opticianries, and a nationally-known laboratory--were examined independently by two laboratories. The lenses were tested for adherence to standards developed by the American National Standards Institute (ANSI), and for conformance to the practitioners' prescriptions. The laboratory analysis found that while 12 of the 14 pairs of lenses did not meet the ANSI Z-80 standards, there were wide variations in quality among the pairs. The prices of the eyeglasses, which ranged from \$20 to \$37,¹²⁶ were found to be unrelated to their quality. The surveyors found that:

123 Id. at 1654-56. One examination was obtained at no cost, because the subject was a member of the health plan clinic which was part of the survey.

124 Id. at 1658-59.

125 The subject presented similar frames to each dispenser, to be fitted with the prescribed lenses.

126 Id. at 1663-66. Wholesale prices for the three pairs obtained from a laboratory ranged from \$9.37 to \$11.18.

[P]oor quality, as defined under the Z-80 Standards and applied by the two testing labs employed here, has no direct relation to the prices charged for the lenses or to the mode or location of the dispenser's practice.¹²⁷

The second SFCA study, conducted in Phoenix, Arizona, took a format similar to the California study and yielded similar results.¹²⁸ Sixteen eye examinations, ranging in price from \$14 to \$35, were purchased from a mix of ophthalmologists and optometrists practicing in both "professional" and "commercial" outlets. Eighteen pairs of lenses, costing from \$24.15 to \$43.90, were obtained from a variety of dispensing locations which were representative of the modes of practice found in the Phoenix area. The study found that the prices charged for examinations and eyeglasses were not indicative of their quality. The authors summarized their findings as follows:

The investigation regarding the quality of goods and services purchased in Arizona indicates, once again, that the quality of an eye exam or that of optical materials is not necessarily tied to price or mode of practice. One is as apt to find a good quality pair of glasses in a corporate outlet, an independent opticianry, or a professional optometrist's office. One, however, is also equally apt to find poor quality merchandise in any of these locations.¹²⁹

A third study was conducted in five New Jersey counties by Adam K. Levin, of the New Jersey Division of Consumer Affairs.¹³⁰ The purpose of the study, according to Mr. Levin, was to get "a handle on the question that is foremost in all our minds: Is there a meaningful correlation between price and quality?"¹³¹ Mr. Levin purchased 22 eye examinations and 44 pairs of eyeglasses

127 Id. at 1667.

128 Delia Schletter, There's More Than Meets the Eye, San Francisco Consumer Action (August, 1976), HX 397.

129 Id. at 203-4.

130 Adam K. Levin, A Survey on the Quality of Eye Care and Eye Wear in New Jersey as it Relates to Price, HX 167.

131 Id. at 1.

from equal numbers of optometrists and opticians. The eye examinations ranged in price from \$10 to \$21, and the eyeglasses from \$21 to \$48. The three experts who were retained to appraise the accuracy of the examinations and the quality of the eyeglasses found wide variations in the quality of both the goods and services provided. However, as in the two studies described above, Mr. Levin found that there was "scant correlation" between the prices and the quality of the goods and services he purchased:

[M]any of the more expensive pairs of glasses purchased from the optometrists raised the same questions as some of the less expensive pairs and many of the less expensive pairs were as good a quality as some of the more expensive pairs.¹³²

A somewhat different study was conducted by the New York City Department of Consumer Affairs.¹³³ The survey was confined to eye examinations given by 16 "low-cost" optometrists in New York City. Since the study was not primarily concerned with the relationship between quality and price, and the sample consisted solely of low-cost optometrists, the range of prices was relatively narrow. Except for one practitioner who charged \$10 for his examination, the fees ranged from \$3 to \$7. Within that limited price range, the investigators found that the accuracy of the examination was related to some degree to its price, and that there was a definite correlation between the number of tests performed and the examination fee.

The Commissioner of the Department of Consumer Affairs pointed out that:

[T]he cost of the examination did not bear the same relationship to its accuracy. Five stores offering examinations ranging in price from \$3 to \$10 all yielded correct results for each of the subjects examined in the establishments. Apparently, "rock-bottom" prices do not necessarily mean poor quality examinations.¹³⁴

She concluded, on the basis of the data, that "quality is not necessarily related to higher costs."¹³⁵

132 Testimony of Adam K. Levin, Tr. 1905 at 1918.

133 New York City Department of Consumer Affairs, Survey of Optometric Establishments, January, 1976 - June, 1976, HX 173.

134 Testimony of Elinor Guggenheimer, Tr. 1963 at 1966. (Emphasis in original.)

135 Id. at 1967.

The important difference between the New York study and those described above is that it did not provide quality comparisons among the various price levels at which eye care services are available. By excluding all practitioners who charged more than \$10, it focused solely on "commercial" practitioners whose examination fees differed only slightly. The question of how the quality of those examinations would compare with those rendered by medium- and high-priced sellers was left unanswered by the New York survey.¹³⁶

The collective results of the studies concerning the relationship between price and quality in the retail ophthalmic market show that--contrary to the hypothetical suppositions of many of the proposed rule's opponents--prices of eye care goods and services are not positively related to their quality. This finding calls into question the assumption that widespread advertising, and the concomitant lower prices which it would presumably bring, would lead to a deterioration in the quality of eye examinations and eyeglasses. If low prices are not indicative of inferior goods and services in the current eye care market, it may be inferred that the level of quality would not necessarily change as advertising and lower prices become more widespread.

2. Will the Removal of Advertising Bans Cause a Deterioration in the Quality of Ophthalmic Goods and Services?

Before addressing the question of whether the removal of restrictions on price advertising would lead to a lower level of quality in the retail ophthalmic market, it is important to explore the presumed relationship between the existing bans and current quality levels. The implied assumption of those who argue that the removal of the advertising restraints would cause a deterioration in quality is that those restraints currently contribute to the maintenance of high quality levels in the eye care goods and services market. If that were indeed the case, one would expect that the quality of such commodities would be higher in states which prohibit advertising than in states which permit it.

136 Presiding Officer Cabell made the following observations about the New York survey:

As the prices charged for the examination varied so little and since the places visited were all commercial establishments, ... it is difficult to draw any conclusion other than that low cost vision care be entirely satisfactory and can compare favorably with that obtained at much greater cost.

Report of the Presiding Officer, Exhibit XIII-1, at p. 105.

The only empirical study on the record which attempted to compare the quality level of an advertising state with that of a nonadvertising state found no differences in quality between the two jurisdictions. The SFCA studies described above enabled the surveyors to compare quality levels between Arizona, where price advertising is permitted, and California, which prohibited advertising by optometrists and opticians at the time the first SFCA survey was conducted. They found that:

The level of quality between our sample groups of examiners and dispensers in California and Arizona appears to be much the same.¹³⁷

The clear inference from that finding is that California's prohibition on price advertising did not have the effect of fostering higher quality eye care than that available in neighboring Arizona.

The SFCA California study and Adam Levin's New Jersey survey also raised questions about the overall quality levels within those nonadvertising states. The authors of both studies acknowledged the difficulties in measuring quality in the eye care market; the practicability of the ANSI standards and the degree of tolerable variations among "accurate" prescriptions are widely viewed as highly problematical.¹³⁸ The surveyors agreed, however, that the degrees of variance from currently available standards of workmanship in the fabrication of eyeglasses were alarmingly wide.¹³⁹

Adam Levin discounted the notion that New Jersey's advertising ban had ensured that its citizens receive high quality

137 There's More Than Meets the Eye, supra note 128, at 204.

138 See discussion at notes 142-146, 207-209, infra.

139 See testimony of Adam K. Levin, supra note 132, at 1912; Optical Illusion, supra note 122, at 1667. With regard to ophthalmic services, the SFCA survey team concluded that the acceptable range of variations in prescriptions was so large and nebulous that claims by one class of practitioners that their services were of superior quality were disingenuous:

Without being able to pinpoint a range of accepted tolerances by which to judge the prescriptions written by eye examiners, the claims that this group or that write "erroneous" prescriptions must be regarded as little else but self serving and misleading. Id. at 1660.

ophthalmic goods and services. The findings of his study, he said, "would appear to raise a serious competency question."¹⁴⁰ Levin characterized the quality argument and the implications of his survey data as follows:

[Eye care practitioners] contend that . . . advertising will irreparably damage the professional aspects of the eye care/wear field, and that presently the public gets what it pays for. They claim that advertising will usher in an era of significant deterioration in the quality of ophthalmic goods and services. Unfortunately, even cursory review of this survey would suggest the need to consider whether the often-decreed, feared deterioration in eyewear dispensing has begun already.¹⁴¹

The conclusion drawn by those who conducted the only quality studies available for nonadvertising states, then, was that the quality of ophthalmic goods and services in those states is not uniformly high.

It should be noted, however, that the evidence in the record showing that the current level of quality in the ophthalmic market is less than optimal does not mean that the public's health and welfare is seriously endangered by such shortcomings. Optical experts who testified indicated that eyeglass wearers can tolerate a relatively wide range of deviation from their "optimal" refractive status without suffering any significant decrease in visual efficiency.¹⁴²

Studies have shown that a consumer who has a vision problem is likely to receive a different prescription from every practitioner who examines his eyes.¹⁴³ Similarly, the refractive powers of the eyeglasses he receives will almost certainly vary

140 Adam K. Levin, supra note 130, at 11.

141 Id.

142 See, e.g., testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3781-82; testimony of Leonard J. Schmidt, O.D., Vice-President, Pennsylvania Optometric Association, Tr. 2235 at 2253; testimony of James E. Washington, O.D., Tr. 2591 at 2614, 2621; testimony of William T. Heimlich, Chairman, Standards Committee, Opticians Association of America, Tr. 2185 at 2194, 2220-21.

143 Optical Illusion, supra note 122; There's More Than Meets the Eye, supra note 128; Adam K. Levin, supra note 130.

from practitioner to practitioner.¹⁴⁴ However, the evidence shows that eyeglass wearers can generally tolerate deviations from their optimal corrective status which--although technically ascertainable--have little or no effect on the patient's visual comfort.¹⁴⁵ For example, the SFCA California study reported that although the survey subject received different prescriptions and lenses from each of the practitioners who were part of the survey, she "found that she could wear 13 out of the 14 pairs of glasses with equal comfort and that all of these had markedly improved her vision."¹⁴⁶ So, in spite of the fact that the eyeglasses were shown to contain wide technical variations in quality as well as variations in price, the wearer perceived no substantial differences in terms of visual performance.

Further, the record demonstrates that even those lenses which exceed the acceptable range of quality tolerances pose no serious health hazard to the wearer. The testimony of numerous witnesses and other evidence affirmed that neither incorrect prescriptions nor improperly fabricated lenses can cause permanent damage to the health of the eyes.¹⁴⁷ Ophthalmologists testified that while improper eyeglasses can affect

144 Id.

145 Id.; and sources cited in note 142, supra.

146 Optical Illusion, supra note 122, at 1668.

147 See, e.g., statement of Frank W. Newell, M.D., HX 115; testimony of David Volk, M.D., O.D., Tr. 1133 at 1152; testimony of David M. Link, Acting Director, Bureau of Medical Devices and Diagnostic Products, Food and Drug Administration, Tr. 415 at 420-21; testimony of Chester M. Pfeiffer, O.D., Ph.D., Dean, University of Houston College of Optometry, Tr. 5243 at 5274; testimony of Sylvester Bradford, O.D., Tr. 5401 at 5427; testimony of John K. Davis, Associate Professor of Physiological Optics, Pennsylvania College of Optometry, Tr. 2475 at 2490; testimony of Robert N. Kleinstein, O.D., Ph.D., School of Optometry, University of Alabama Medical Center, Tr. 6057 at 6091; testimony of Mark Robin, O.D., California Optometric Association, Tr. 2851 at 2868; testimony of Myron Shofner, O.D., Tr. 4842 at 4870; Jesse Rosenthal and William C. Folson, "Standards of Eyeglasses," Medical Care, Vol. XI, No. 3 (May-June, 1973), Exhibit VI-11, at R. 12064; letter from Steven John Fellman, Optical Manufacturers Association, and Exhibits, to FTC (November 1975), Exhibit V-51, at R. 11434; testimony of Richard A. Schubach, Standard Optical Co., Tr. 3420 at 3445.

visual performance, they cannot cause eye disease or permanently change the refractive status of the eyes.¹⁴⁸ As a leading ophthalmologist explained, lenses which cause poor visual performance are likely to be noticed by the wearer and can simply be exchanged for more appropriate spectacles:

Quite obviously, if one's vision is obscured or confused by the wrong glasses, he may have an automobile accident or fall down a flight of stairs. However, if he similarly wears too tight a pair of shoes, he may develop gangrene of the toes and require an amputation. The intelligent individual in each case removes the offending appliance.

148 Three of the four ophthalmologists who were witnesses at the hearings testified that improper lenses cause no damage whatsoever to the eyes. Statement of Frank W. Newell, M.D., supra note 147; testimony of David Volk, M.D., supra note 147; and testimony of James F. Rambasek, M.D., Tr. 1787 at 1825. The fourth physician, Dr. Robert Reinecke, disagreed with his colleagues to the extent that he felt damage to a patient's vision could occur in certain rare instances. He added, however, that it is the practitioner's professional responsibility to carefully monitor the progress of such patients, so that he saw no serious health hazard even with regard to "the handful of situations" where the potential for such damage exists. Statement of Robert D. Reinecke, M.D., HX 230, at pp. 2-3.

It should also be noted that some witnesses felt that improper fitting of contact lenses can potentially damage the eyes. See, e.g., testimony of James F. Rambasek, M.D., Tr. 1787 at 1825. Presiding Officer Cabell found, however, that the weight of the evidence in the record showed that:

[T]he eye is a soft, gooey mass, not unlike plastic,...which is hard to damage, and even the tearing, lacrimation or eyestrain caused by poor contact lenses would not result in serious permanent damage or result in aggravation of existing conditions like nearsightedness or farsightedness.

Report of the Presiding Officer, Exhibit XIII-1, at p. 116.

Comfortable and good vision is, of course, desirable. However, uncomfortable, distorted, and poor vision does not have any affect on health.¹⁴⁹

Thus, while the evidence in the record may give rise to some concern as to the current level of quality in the retail ophthalmic market, it should not be interpreted to mean that consumers are being substantially harmed by such quality variances.

In connection with the finding that the inferior commodities which are now on the market do not seriously endanger the public's health and welfare, it should also be noted that one segment of the population is being harmed--not by the quality of eyeglasses currently dispensed--but by the lack of any visual correction. The evidence discussed in Sections III and IV of this report which shows that the lack of price information in many jurisdictions has led to decreased consumption of eye care goods and services--particularly among the poor and the elderly--indicates that the visual welfare of many consumers is jeopardized because they cannot afford to purchase needed eye examinations and eyeglasses.¹⁵⁰ Thus, in assessing the relative health problems attendant to the varying quality levels manifested in both advertising and nonadvertising jurisdictions, the plight of those for whom quality is an empty issue, because they lack the resources to obtain any eye care, cannot be overlooked.

The question whether the removal of the advertising bans would lead to a deterioration of future quality levels in the ophthalmic market was, as we noted above, a major issue in the rulemaking proceeding. However, only one study was submitted in evidence to support the proposition that a cause-and-effect relationship exists between advertising and poor quality. The survey,¹⁵¹ conducted by James D. Bing, O.D.,¹⁵² attempted to compare the relative quality of 18 pairs of eyeglasses purchased

149 Statement of Frank W. Newell, M.D., supra note 147, at 10.

150 See Section III(B)(3), and Section IV(A), supra.

151 See exhibits to testimony of James D. Bing, O.D., HX 149-HX 160.

152 The survey was also designed and evaluated by Dr. Bing, and was apparently financed jointly by Dr. Bing and local optometric societies. Testimony of James D. Bing, O.D., Tr. 1679 at 1710-11, 1756-57.

from both advertising¹⁵³ and nonadvertising opticians and optometrists in the Cleveland, Ohio area.

The criteria employed by Dr. Bing to rank the spectacles in order of their relative quality did not, however, include the crucial quality variable: i.e., whether the eyeglasses conformed to the survey subject's prescription.¹⁵⁴ The reason for this omission, as Dr. Bing explained, was that upon evaluating the purchased eyeglasses, he found that the refractive powers of all but one of the 18 pairs met his standards for accuracy.¹⁵⁵ Staff therefore concludes that this survey--although it represents the single attempt by the proposed rule's critics to test the relationship between advertising and quality--failed to demonstrate that such a relationship exists.¹⁵⁶

Thus, as was the case with the contention that price and quality are positively related, those who advocated the retention of the advertising bans failed to present empirical evidence which would substantiate their assumption that advertising causes the quality of eye care goods and services to decline.

153 None of those classified as advertisers in the survey advertised the prices of eyeglasses or examinations; one optical firm in the survey advertised glasses at "half price," without quoting a specific price. Id. at 1727-28.

154 Id. at 1689.

155 Id.

156 The study contained other methodological flaws. Dr. Bing did not devise the criteria by which he would judge the relative quality of the eyeglasses until after he had made his initial evaluation (during which he discovered that none deviated significantly from the prescribed refractive power). Id. at 1690. Further, although when he made his initial evaluation the eyeglasses were not identified as to their source, he did know the source of each pair when he applied the criteria used to rank the spectacles in order of relative quality. Id. at 1694-95. As Presiding Officer Cabell observed, "the objectivity and methodology used in this survey are open to serious question." Supra note 136, at 90. Dr. Bing acknowledged that he had hoped "to prove a few things" with the survey (Tr. 1697); that his methodology suffered defects (Tr. 1690); and that a causal relationship between advertising and quality was not clearly demonstrated by his survey results (Tr. 1726-27).

Several leading optometric spokesmen acknowledged that they had no data to support their contentions,¹⁵⁷ but instead relied, as one said, on their "own professional judgment"¹⁵⁸ to conclude that advertising leads to inferior quality.

Two witnesses who had made extensive searches of the literature and surveys in the ophthalmic field testified that they found no indication that the relationship between advertising and quality had ever been tested,¹⁵⁹ despite the fact that industry members have historically opposed advertising on the basis that quality would deteriorate. Other evidence in the record also attests to the lack of substantiation of this claim.¹⁶⁰ The failure to measure the effects of advertising on quality is clearly not due to an absence of comparative information, since the current retail ophthalmic market is characterized by a mix of advertising and nonadvertising jurisdictions.

Since the crux of the resistance to the proposed rule is the argument that advertising will precipitate a deterioration in the quality of eye care goods and services, it would seem to behoove those who make that contention to provide the Commission with supporting evidence. As the head of a survey research firm, Gordon S. Black, Ph.D., testified:

In the absence of that kind of evidence, it seems to me that the burden of proof in an argument of that kind lies with the people who are making the assertion of the relationship

157 See, e.g., testimony of J. Harold Bailey, Executive Director, American Optometric Association, Tr. 5905 at 5937-38; testimony of Alden N. Haffner, O.D., Dean, State University of New York College of Optometry, Tr. 2035 at 2061; testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3614.

158 Testimony of Jesse C. Beasley, supra note 157.

159 Testimony of Gordon S. Black, Ph.D., Tr. 4518 at 4520; testimony of Roy Alper, Executive Director, California Citizen Action Group, Tr. 3733 at 3741.

160 See, e.g., "Economist Lee Benham: More Academician Than Activist," American Optometric Association News (Nov. 1, 1975), Exhibit II-73, at R. 2030; testimony of Elton Rayack, Professor of Economics, University of Rhode Island, Tr. 2275 at 2282; testimony of James J. Ryan, National Association of Optometrists and Opticians and New York State Optical Retailers Association, Inc., Tr. 2360 at 2366; rebuttal submission of California Citizen Action Group, Exhibit IX-176, at R. 17287; comment of National Council of Senior Citizens, Inc., Exhibit VII-988, at R. 13977.

[between advertising and quality] . . . who, in fact, are asserting that there will be certain kinds of consequences that will occur if these restrictions are removed, and yet I see a virtual absence of any evidence, documentation or proof to that effect.¹⁶¹

The prediction that lifting the advertising bans will cause a deterioration in quality must therefore be examined from a hypothetical standpoint, since the currently available evidence does not support such an assumption. Opponents of the proposed rule have predicted that the nationwide removal of restraints on advertising will precipitate a drastic change in the economic climate of the retail ophthalmic market, which will force practitioners to abandon their interests in their patients' welfare in favor of financial concerns. However, those same opponents consistently testified that they personally would not lower the quality of their goods and services if advertising were permitted.¹⁶² The implication throughout their testimony was that while the "ethical" majority of practitioners would not succumb to the economic pressures which advertising would purportedly foster, some nebulous subset of "borderline practitioners"¹⁶³ would dispense inferior goods and services.

The contention that advertising would lead to low quality in the ophthalmic market is thus reduced to an argument that the "commercialists" would provide the inferior care and appliances, while the "professionals" would maintain high standards in their own practices. This argument is premised on several conditions:

161 Testimony of Gordon S. Black, Ph.D., Tr. 4518 at 4521. See also testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1845.

162 See, e.g., testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3614; testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1042; testimony of Robert Hart, Society of Dispensing Opticians of New Jersey, Tr. 2442 at 2470; testimony of M. F. Keller, O.D., Montana Optometric Association, Tr. 3469 at 3513; testimony of Charles McQuarrie, O.D., President-Elect, American Optometric Association, Tr. 3838 at 3858; testimony of Lester H. Sugarman, O.D., Connecticut Optometric Society, Tr. 2876 at 2888; testimony of James E. Washington, O.D., Tr. 2591 at 2608; testimony of Jesse Johnson, Vice President, Board of Examiners in Optometry of Oklahoma, Tr. 5607 at 5621; testimony of Erwin R. Lax, O.D., Tr. 4871 at 4894.

163 See, e.g., testimony of E. Richard Friedman, O.D., President-Elect, International Association of Boards of Examiners in Optometry, Tr. 5651 at 5677.

(1) that advertising bans somehow prevent practitioners from maximizing their profits currently by providing inferior goods and services; (2) that the financial incentives of commercial optical outlets militate against the provision of high quality eye care; (3) that practitioners in general are currently operating so close to capacity that an advertising-induced increase in customers would cause the less ethical among them to reduce the quantity and quality of services provided; and (4) that "commercialists" have different sources of ophthalmic goods at the manufacturing and wholesale levels than do "professionals."

The assumption that the removal of advertising bans would induce certain practitioners to lower the quality of their goods and services ignores the fact that anyone who wishes to increase his profit margin by selling inferior eye care is free to do so regardless of advertising restrictions. Staff can see no reason why those who are inclined to lower their costs in order to increase profits are hindered from doing so in the absence of advertising. Others agreed, pointing out that, in the words of one optician, "[p]eople that want to use inferior material will continue to and people using top-notch merchandise will continue to."¹⁶⁴ As California State Assemblyman Terry Goggin observed,

The notion that price advertising alone will push professionals into selling defective goods and rendering incomplete service is counter-intuitive. Why aren't these optometrists and opticians misbehaving now? . . . The monetary incentives are even greater now than they would be under price competition.¹⁶⁵

¹⁶⁴ Testimony of Seymour Pollack, Tr. 2307 at 2316. An optometrist made a similar point:

Rules and regulations will not change the working habits of the individual practitioner . . . I know of some people that use fine quality merchandise and get a fine quality price for it. There are other practitioners that use the cheapest possible merchandise and still get a high price for it. Those predisposed to use the poor quality will continue to do so.

Testimony of Robert Sandow, O.D., Tr. 2725 at 2728.

¹⁶⁵ Testimony of California State Assemblyman Terry Goggin, Tr. 3017 at 3019. See also testimony of Elton Rayack, Professor of Economics, University of Rhode Island, Tr. 2275 at 2282.

The second assumption, that the financial incentives of commercial optical outlets would dictate the provision of sub-standard goods and services, was refuted by several firms which currently provide eye care services and appliances at discount prices. The five major retail optical chains which submitted testimony or written comments in this proceeding claimed that the provision of high quality goods and services was fundamental to the success of their businesses.¹⁶⁶ Further, those which operate in both advertising and nonadvertising states maintained that all of their outlets sell ophthalmic goods of identical quality--often produced by the same laboratories--regardless of whether the store advertises or not.¹⁶⁷

The discount optical firm spokesmen explained that they find it neither necessary nor profitable to provide inferior eye care goods and services. They are able to provide high quality materials at lower prices than their competitors because they take advantage of economies of scale made possible by their larger volumes of business. Examples of such economies were cited as volume discounts from suppliers, increased efficiency, and lower per-unit labor and overhead costs.¹⁶⁸

The large firms averred that customary market incentives to supply high quality goods and services are as applicable to the ophthalmic retail market as they are to other consumer product areas. Thus, successful optical firms must rely on consumer satisfaction and repeat business. As the chairman of a large Texas-based chain wrote,

Our own company experience emphatically demonstrates the fact that no matter how much we advertise, our business will suffer if we fail to deliver a satisfactory product and service
. . . The consuming public will not consistently

166 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 R. 14639-40.

167 Testimony of Edward E. Crittenden, supra note 166, at 6019; testimony of William A. Schwartz, supra note 166, at 347; testimony of Donald Juhl, supra note 166, at 399-400.

168 See, e.g., testimony of Edward E. Crittenden, supra note 166 at 6017-18; testimony of Donald Juhl, supra note 166, at 387-88; testimony of Jack Perry, Perry Optical Centers, Tr. 2328 at 2340.

patronize an inferior provider, be he individual or firm, whether he advertises or not.¹⁶⁹

The other large retailers agreed that consumer satisfaction was linked with their economic incentives, so that the provision of consistently high quality eye care goods and services was rewarded by increased patronage and profits.¹⁷⁰

In this connection, it is important to note the evidence in the record which shows that consumers can usually perceive whether or not the eyeglasses they purchase are satisfactory. Some participants in this proceeding have contended that consumers are unable to detect poor quality in ophthalmic goods, and will therefore unknowingly purchase and wear defective eyeglasses.¹⁷¹ However, numerous practitioners testified that wearers of improper lenses suffer quite salient symptoms such as blurred or distorted vision, nausea, and headaches.¹⁷² Eyeglass purchasers who suffer such discomforts are therefore likely to return to the dispenser and demand that the lenses be replaced. As the chairman of the University of Chicago's Ophthalmology Department observed,

Most individuals who dispense lenses prefer that they be dispensed as accurately as possible, because the recipient complains if the lenses are uncomfortable or if their vision is poor . . . or is not improved as much as the patient wished.¹⁷³

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- 169 Rebuttal submission of Stanley C. Pearle, supra note 166, at 16378.
- 170 See, e.g., testimony of William A. Schwartz, supra note 166, at 365; testimony of Edward E. Crittenden, supra note 166, at 6015-A.
- 171 See, e.g., letter from Jimmy W. McNeil, O.D., President, Texas Optometric Association, to FTC (Nov. 3, 1975), Exhibit IV-60, at R. 3239.
- 172 See, e.g., testimony of Nelson Waldman, O.D., Tr. 5458 at 5472; testimony of Alden N. Haffner, O.D., Ph.D., Dean, State College of Optometry, State University of New York, Tr. 2035 at 2098; testimony of Charles Hughes, O.D., Arkansas Optometric Association, Tr. 4795 at 4801; testimony of Robert N. Kleinstein, O.D., School of Optometry, University of Alabama Medical Center, Tr. 6057 at 6091; testimony of Charles Seger, O.D., Fellow, American Academy of Optometry, Tr. 506 at 529.
- 173 Testimony of Frank W. Newell, M.D., Tr. 1167 at 1171. See also, testimony of Donald Juhl, supra note 166, at 406-7.

Optical retailers thus have little incentive to dispense lenses of poor quality or which do not conform to the patient's prescription. Their costs will increase if such retailers must replace improperly fabricated eyeglasses in order to satisfy their customers, and their businesses will suffer from reduced patronage if they do not respond to consumer dissatisfaction.¹⁷⁴

The argument that an increased patient load necessitated by competitive pressures would force practitioners to reduce the quantity and quality of their services was made by several optometrists.¹⁷⁵ As one stated,

Professional men can work efficiently only so many hours each day so it is unreasonable to expect office hours to be lengthened in order to accommodate the additional load. The end result would be that they would simply have to see more patients in the same amount of time, thus compromising their standard of care.¹⁷⁶

As was noted above, the evidence in the record concerning the ethical standards prevalent in the profession¹⁷⁷ and the testimony of optometrists themselves¹⁷⁸ suggests that most would not

174 This point was illustrated by Stanley Pearle, currently Chairman of Opticks, Inc., who recounted the experience of another large optical retailer with which he was formerly associated. According to Mr. Pearle, that retailer--which allegedly has a reputation as a seller of lower quality ophthalmic goods--has lost revenues over the past several years as a result of that reputation. Mr. Pearle concluded that this example "tends to support the point that the public is knowledgeable and will not continue to patronize what it feels is an inferior provider." Rebuttal submission Stanley Pearle, Exhibit IX-161, at R. 16379.

175 See, e.g., statement of Nelson Waldman, O.D., HX 340; letter from Mary Ellen McCabe, for Rhode Island State Board of Examiners in Optometry, to FTC (Dec. 9, 1975), Exhibit IV-59, at R. 3040; letter from Warren V. Ales, O.D., President, Louisiana State Association of Optometrists, to FTC (Oct. 17, 1975), Exhibit IV-60, at R. 3113; letter from Robert W. McNevin, Counsel, Indiana Optometric Association, to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3100.

176 Comments of Dr. Clarence L. McEachern, attachment to letter from Joseph W. Jenkins, supra note 119, at 3197-98.

177 See subsection (B), supra.

178 See note 162, supra.

deprive their patients of the full range of vision care services under any circumstances. However, the implication is that some marginal group would provide substandard care if faced with an increased patient load.¹⁷⁹

A nationwide study of optometry manpower refutes the contention that practitioners operate to close to capacity that any increase in patients would place pressure on them to reduce their present standards of care. The 1971 survey of 2,393 optometrists practicing in all regions of the country revealed that only 7.40% felt they could care for no additional patients. Almost 22% responded that they could handle 30% or more patients above their current load, and a majority were operating at less than 85% capacity.¹⁸⁰ Similarly, in a 1975 survey of optometrists, the average practitioner said he could handle a 39.5% increase in patient load within the present organization of his practice.¹⁸¹ Thus, fears that increased competition would force practitioners to take on more patients than they could handle without reducing their services appears unwarranted, on the basis of these data.

Finally, the argument that sellers who advertise must provide lower quality ophthalmic goods assumes that clearly identifiable quality alternatives exist at the manufacturing and wholesale levels. The record suggests that while the eyeglasses currently sold at retail vary widely in quality, the nature of the production process is such that inferior quality lenses are more a result of inadvertence than design. Further, the evidence fails to show that low-priced sellers currently obtain their ophthalmic materials from different sources than do higher-priced retailers.

179 As one optometrist stated:

The competent and ethical optometrist who desires to serve the best interests of the patient would not be affected. Unfortunately, all may not have such a strong ethical concept.

Comments of Dr. William C. Ezell, attachment to letter from Joseph W. Jenkins, supra note 119, at 3192.

180 Alden N. Haffner, O.D., Ph.D., Project Director, A National Study of Assisting Manpower in Optometry, Department of Labor Contract No. 81-34-70-11 (1971), Exhibit II-17, at R. 618. See also rebuttal submission of California Citizen Action Group, Exhibit IX-176, at R. 17281.

181 "1st Annual Practice Management Survey," Optical Journal and Review of Optometry, Vol. 113, No. 2 (Feb. 15, 1976), Exhibit VI-44, at R. 12547.

Although definitions of lens quality vary, the ophthalmic manufacturers appear to produce three types of lenses. Most of the lenses produced at the manufacturing level are identified as "first quality," which signifies that they contain no physical defects and are of a design which is calculated to provide the wearer with optimal visual efficiency.¹⁸² "Second quality" lenses, which according to some sources constitute less than 10% of the manufacturers' output, are manufactured by the same process as those of first quality, but are marred by production errors.¹⁸³ Such lenses, containing defects such as chips and bubbles at the edges of the large lens blanks, are sold as "second quality," lower-priced materials to optical laboratories. The laboratories, in cutting the lens blanks to fit smaller frames, can remove such defects so that the finished lenses are of first quality.¹⁸⁴

The third category of lens quality concerns the relative sophistication of the lens design. Some manufacturers have developed technically superior lens forms, which constitute

182 See, e.g., "Standards of Eyeglasses," supra note 147, at 12059.

183 See, e.g., letter from Richard D. Holbrook, President, Shuron Division of Textron, Inc., to FTC (Apr. 28, 1976), Exhibit VI-60, at R. 12601; testimony of William A. Schwartz, supra note 166, at 372; Canadian Department of Consumer and Corporate Affairs, Material Collected for Submission to the Restrictive Trade Practices Commission in the Course of an Inquiry Under Section 47 of the Combines Investigation Act relating to the Production, Supply, Distribution and Sale of Ophthalmic Goods in Canada (July 1975), Exhibit II-33, at R. 920.

184 Id. As William A. Schwartz, Vice-President of Wall & Ochs, Inc., explained,

Frankly, the designation [of second quality] is misleading to the public. What is regarded as a second quality lens from a top manufacturer in this country may have a chip of glass out at the edge which is not going to affect visual performance. In actuality that part of the glasses will never be used. Second quality is a term that should not convince everyone that if they put them on they are going to see double. Tr. 346 at 372.

an improvement over traditional designs. Major ophthalmic producers such as Bausch & Lomb, for example, manufacture both a more expensive lens of advanced design, and a standard brand lens.¹⁸⁵ Bausch & Lomb has stated that it considers both kinds of lenses to be of "first quality."¹⁸⁶ Since both types of lenses are functional devices which enable the wearer to see properly, the differences between them are primarily a matter of practitioner and consumer choice on the basis of preference and cost considerations.

As to contact lenses, the record contains no indication that there are varying quality levels among such lenses.¹⁸⁷ Further, soft contact lenses must be approved by the Food and Drug Administration, and are required to meet the same standards as new pharmaceuticals before they are marketed.¹⁸⁸

At the laboratory level, quality standards appear to be much more variable than at the manufacturing level. Although much of the lens finishing and fabrication process is automated in most laboratories, individual craftsmanship and subjective judgment are required at certain stages of the laboratory process.¹⁸⁹ The potential for defective workmanship and the production of inferior

185 See, e.g., letter from Jerome Dienstag, Associate General Counsel, Bausch & Lomb, to FTC (Nov. 17, 1975), Exhibit V-20, at R. 7783-84; testimony of John K. Davis, Associate Professor of Physiological Optics, Pennsylvania College of Optometry, Tr. 2482; testimony of David Volk, M.D., Tr. 1133 at 1144; testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3810-11.

186 Letter from Jerome Dienstag, supra note 185.

187 See, e.g., letter from Robert E. Wall, President, UCO Optics, Inc., to FTC (May 3, 1976), Exhibit VI-60, at R. 12623. According to Mr. Wall, his company "send[s] out only 'first quality' lenses and as far as I know, there are no 'second quality' lenses in the contact lens field." See also Optical Illusion, supra note 122, at 1613.

188 See, e.g., Steve Collins, "Optical Firms Look to Rosier Future," The Commercial and Financial Chronicle (Nov. 18, 1974), Vol. 219, No. 7445, Exhibit II-6, at R. 228.

189 See Section I(B), supra.

eyeglasses is therefore greatest at the wholesale point in the ophthalmic distribution chain. Evidence in the record indicates that most of the lower quality lenses currently dispensed are the result of laboratory errors.¹⁹⁰

However, the potential for laboratory error is not as great for some types of lenses as for others. As was described in Section I of this report, the majority of lenses are finished at the manufacturing level.¹⁹¹ Since those stock lenses have already been ground to standard refractive powers by the manufacturers, and the wholesale laboratory need only cut them to fit particular frames, the potential for reducing the quality of such lenses is relatively slight.¹⁹²

Lenses manufactured as semi-finished, on the other hand, are more susceptible to laboratory error. Even semi-finished lenses, however, may not be subject to a particularly large margin of human error, since the record shows that the laboratory process of converting a semi-finished lens to a finished product is usually performed by machines.¹⁹³ Thus, the most

190 See, e.g., testimony of John K. Davis, Associate Professor of Physiological Optics, Tr. 2475 at 2506; testimony of E. Craig Fritz, President, Connecticut Opticians Association, Tr. 2827 at 2848; testimony of Jack Perry, Perry Optical Centers, Tr. 2328 at 2337-38.

191 See Section I(A) and (B), supra.

192 One witness described the fabrication process as follows:

[T]he fabrication of eyeglasses is relatively routine ... the great majority of lenses are already ... prepackaged. They talk about grinding the lens and fitting the lens ... I don't know anybody who grinds it. There is a machine and you have an implement that fits on the machine, a flywheel that's set ... [to the] precise size as the frame. You put a lens on this and turn the machine and it grinds the lens ... it's a very mechanized routine operation ... [and] not nearly as complicated as everybody would make you believe.

Testimony of James J. Ryan, National Association of Optometrists and Opticians and New York State Optical Retailers Association, Tr. 2360 at 2378.

193 See Section I(B), supra.

common points at which fabrication errors can occur appear to be when finishing machines are adjusted to specific refractive powers, when the optical centers of the eyeglasses are arranged, and when the lenses are edged to fit specific frame sizes.

The record contains no systematic evidence that laboratories intentionally produce eyeglasses of inferior quality, or that certain laboratories specialize in rendering substandard products. The wholesale laboratories, like the manufacturers, apparently endeavor to produce only high quality finished products; their lower quality lenses are the result of inadvertent fabrication errors. A group of wholesalers which was surveyed by staff as to their quality standards and grades uniformly claimed to produce only first-quality eyeglasses.¹⁹⁴

The evidence in this proceeding does show that the incidence of laboratory error is unsettlingly high, and that certain laboratories consistently produce lower quality ophthalmic goods than others.¹⁹⁵ There are, unquestionably, wide variations in quality in the eyeglasses currently sold at retail. The relationship between the varying quality levels of ophthalmic goods and their laboratory sources is not, however, as clear. There is considerable evidence that low-priced retailers currently use the same laboratories as do the high-priced practitioners.¹⁹⁶

The two San Francisco Consumer Action studies described above¹⁹⁷ demonstrated that the prices charged for ophthalmic goods at retail are not necessarily related to the laboratory sources from which they are obtained. The SFCA surveyed 106 ophthalmic practitioners in California and 113 in Arizona regarding their retail prices and their particular laboratory sources.

194 Letters in response to staff investigational inquiry (Apr. 13, 1976), Exhibit VI-60.

195 See, e.g., testimony of Ralph Stipley, Optical Wholesaler, Tr. 1764 at 1778.

196 See, e.g., testimony of William A. Schwartz, Vice-President, Wall & Ochs, Inc., Tr. 346 at 370; Exhibits to testimony of Bill Strum, HX 244; testimony of Eugene Yager, Redwood City Optical, Tr. 3578 at 3595; testimony of Douglas Hurdlebrink, Consumer Protection Center, Baton Rouge, Louisiana, Tr. 6247 at 6254; statement of Steven LaVerdiere, HX 217; testimony of J. Howard Sturman, O.D., Academy of California Optometrists, Tr. 3348-73.

197 Supra notes 122 and 128.

In both states, it was found that many of the highest- and lowest-priced sellers used the identical laboratories.¹⁹⁸ As the authors noted in the Arizona study:

As regards the claim that higher retail prices are mandated by one's choice of laboratory, our data tends not to bear this out. In response to a question on our questionnaire which asked practitioners to name the labs with whom they did business, almost all mentioned three or four of the local labs in the area . . . yet the similarity in their answers were not reflected in a corresponding similarity in their prices.¹⁹⁹

These findings seem to bear out the conclusion that the retail prices charged for eyeglasses are not determined by the quality of the laboratory which fabricated them.

Moreover, it appears that the designations of "first quality" goods are so unstandardized and undefined as to be virtually meaningless.²⁰⁰ Many witnesses testified that they relied on manufacturers' brand names and the reputations of the laboratories

198 Optical Illusion, supra note 122, at 1613; There's More Than Meets the Eye, supra note 128, at 153.

199 There's More Than Meets the Eye, supra note 128, at 153.

200 As Presiding Officer Cabell found, "[t]here is considerable amount of testimony in the record containing references to first and second quality lenses. These terms are somewhat meaningless in the absence of recognized standards." Report of the Presiding Officer, Exhibit XIII-1, at p. 70.

See also testimony of J. Howard Sturman, Academy of California Optometrists, Tr. 3348 at 3361; testimony of Bernard Englander, Cooperative Services of Detroit and Group Health, Inc., Tr. 1333 at 1350; Optical Illusion, supra note 122, at 1662-67; testimony of Sylvester Bradford, O.D., Tr. 5401 at 5426; "Standards of Eyeglasses," supra note 147, at 12060, 12062; testimony of James J. Ryan, National Association of Optometrists and Opticians and New York State Optical Retailers Association, Tr. 2360 at 2380; testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3817; letter from William Goldberg, General Manager, Union Eye Care Center, Inc., to FTC (Oct. 29, 1975), Exhibit III-7, at R. 2455.

they used to assure that they dispensed high quality ophthalmic goods.²⁰¹ Thus, in the absence of objectively defined designations of "first quality," retailers at all price levels and modes of practice appear to obtain a largely undifferentiated mix of actual quality levels.

Some industry members asserted that while current quality levels are ensured in part by the fact that 85% of the lenses consumed in the U.S. are domestically produced, if advertising were allowed the market would be flooded by imported lenses which are presumed a priori to be of inferior quality.²⁰² The authors of a definitive article on ophthalmic quality standards, however, discounted the notion that imported lenses are necessarily of lower quality than those of domestic origin:

The quality of the imports ranges from the poorest to very good, but probably none exceeds the quality of the best American made lenses. However, since the quality of domestic lenses also varies extensively, the term "American made" in itself is baseless as proof of quality.²⁰³

Further, those who argued that imported lenses are of uniformly lower quality presented no evidence to substantiate their claim. The fear that an increase in imported lenses would signal a decline in ophthalmic quality would therefore seem to be unwarranted, since there is no clear relationship between quality standards and the country of manufacture.

It is staff's conclusion that the record does not support the prediction that the quality of ophthalmic goods and services will deteriorate if the recommended Rule is promulgated. No empirical evidence was presented to substantiate the contention

201 See, e.g., testimony of Erwin Jay, O.D., Tr. 1450 at 1477-79; testimony of Richard C. Reed, Oregon Committee of Concerned Optometrists, Tr. 3227 at 3244; testimony of George Tracewell, California Association of Dispensing Opticians, Tr. 3916 at 3936; testimony of David Volk, M.D., Tr. 1133 at 1155. See also letter from Jack L. Marshburn, General Manager, City Optical Company, to FTC (Apr. 21, 1976), Exhibit VI-60, at R. 12592; testimony of Ralph Stipley, Optical Wholesaler, Tr. 1764 at 1777.

202 See, e.g., letter from Earl A. Berrigan, President, Louisiana Association of Dispensing Opticians, to FTC (Dec. 29, 1975), Exhibit VI-62, at R. 3471; testimony of Richard A. Schubach, Standard Optical Company, Tr. 3420 at 3435; testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 933 at 1006.

203 "Standards of Eyeglasses," supra note 147, at 12060.

that a cause-and-effect relationship exists between advertising and low quality in the ophthalmic market. The systematically compiled data which are in the record appear to refute that claim. Staff's examination of the hypothetical assumptions on which proponents of the quality argument relied, in the absence of empirical data, leads us to conclude that such assumptions are at best speculative, and are largely unsubstantiated by the available evidence. Thus, it is staff's view that the current advertising bans bear no relationship to the quality of ophthalmic goods and services, and that the lifting of those restrictions would not result in a deterioration of existing quality levels.

Given the professed goal of industry members to ensure that the public receives high quality eye care goods and services --and the evidence which shows that the advertising bans do not achieve that goal--²⁰⁴ it would seem that direct quality controls would be an appropriate solution. As a representative of Consumers Union stated:

[E]xisting bans on price advertising have not assured high quality in eyeglasses or eye care services. To the extent that quality has been maintained, it has been accomplished through such regulatory devices as licensing and certifying of eye care professionals and setting of standards for eye care products. To the extent that greater quality control is needed, it is appropriately accomplished by upgrading licensing and certification procedures and improving enforcement of these requirements.²⁰⁵

204 As Presiding Officer Cabell concluded:

There is no evidence in this record which establishes that a continuation of the bans on advertising by either optometrists or opticians would enhance the quality of goods and services furnished to consumers. In fact the lack of competition, which is a consequence of these and other restraints, probably results in consumers paying far too much for poor quality goods and services.

Report of the Presiding Officer, Exhibit XIII-1, at p. 109.

205 Letter from Nancy H. Chasen, Attorney, Washington Office, Consumers Union, to FTC (Nov. 14, 1975), Exhibit III-7, at R. 2452.

Numerous others agreed that direct regulatory standards constitute a more rational approach to the problem of quality control than do advertising restrictions.²⁰⁶

Formal quality standards for both eyeglasses and eye examinations currently exist. The American National Standards Institute (ANSI) quality criteria for ophthalmic materials, which were originally devised as voluntary guidelines, have been incorporated into the laws and regulations of some states.²⁰⁷ While considerable debate was heard in this proceeding as to the viability of the rigid ANSI criteria as practicable standards,²⁰⁸ the

206 See, e.g., testimony of Roy Alper, California Citizen Action Group, Tr. 3733 at 3741; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1973; testimony of Joseph Garcia, California Department of Consumer Affairs, Tr. 3962 at 3965-67; testimony of Terry Goggin, California State Assemblyman, Tr. 3016 at 3018-20; testimony of Elena Hangii, Arkansas Community Organizations for Reform Now, Tr. 4621 at 4623; testimony of Robert Hart, Society of Dispensing Opticians of New Jersey, Tr. 2442 at 2460; testimony of B. J. Kabakoff, O.D., Tr. 2671 at 2683; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1853-54; testimony of Charles W. Tapp, Director, Louisiana Governor's Consumer Protection Division, Tr. 4200 at 4205; testimony of Glenn R. Workman, Legislative Research Project for Ohio's Elderly, Tr. 1209 at 1213; testimony of William B. Haley, New York Community Service Society, Tr. 2129 at 2135.

207 The evidence in the record indicates that the ANSI standards have to date been adopted by California, Connecticut, Indiana, New Jersey, Texas, and Wisconsin. See, e.g., testimony of Joseph Garcia, California Department of Consumer Affairs, Tr. 3962 at 3967; testimony of E. Craig Fritz, President, Connecticut Opticians Association, Tr. 2827 at 2829; testimony of Robert G. Corns, O.D., Indiana State Board of Optometry, Tr. 1293 at 1305; testimony of James Washington, O.D., East Orange, New Jersey, Tr. 2591 at 2601; testimony of Nelson F. Waldman, O.D., Houston, Texas, Tr. 5458 at 5471; testimony of Donald L. Heyden, O.D., Wisconsin Optometric Association, Tr. 5852 at 5861.

208 See, e.g., testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3784-86; testimony of John K. Davis, Associate Professor of Physiological Optics, Pennsylvania College of Optometry, Tr. 2475 at 2492; testimony of William T. Heimlich, Chairman, Standards Committee, Opticians Association of America, Tr. 2185 at 2230; testimony
(Continued)

solution would seem to lie in revising and improving the criteria, rather than rejecting them because they are currently unrealistic. A member of the committee which sets the ANSI standards testified that the standards are now undergoing revisions which will render them more practicable.²⁰⁹

To date the Federal government has not found it necessary to enter the regulatory field in the area of ophthalmic goods, except to mandate impact-resistance safety standards for lenses.²¹⁰ However, the Food and Drug Administration (FDA) has been specifically empowered by recent legislation to devise and enforce performance standards for ophthalmic goods.²¹¹ The Acting Director of the FDA's Bureau of Medical Devices and Diagnostic Products testified that the agency may impose such mandatory standards in the future.²¹²

In the area of eye care services, several state laws and regulations governing optometrists delineate minimum eye examination standards.²¹³ Such requirements are designed to ensure

208 (continued)

of James J. Ryan, National Association of Optometrists and Opticians and New York State Optical Retailers Association, Tr. 2360 at 2382; testimony of Richard A. Schubach, Standard Optical Co., Tr. 3420 at 3449.

209 Testimony of John K. Davis, Associate Professor of Physiological Optics, Pennsylvania College of Optometry, Tr. 2475 at 2492.

210 See testimony of David M. Link, Acting Director, Bureau of Medical Devices and Diagnostic Products, Food and Drug Administration, Tr. 415 at 417.

211 Id. at 416.

212 Id. at 431.

213 See, e.g., testimony of Alan L. Austin, Counsel, South Dakota State Board of Examiners in Optometry, Tr. 864 at 891; testimony of William E. Johnson, Kentucky Optometric Association, Tr. 1419 at 1430; testimony of Jack Bridwell, O.D., President, Texas Optometric Association, Tr. 5212 at 5232-33; testimony of Alfred P. Rosati, President, Rhode Island Optometric Association, Tr. 2749 at 2768; testimony of Richard Schubach, Standard Optical Co., Salt Lake City, Utah, Tr. 3420 at 3447; testimony of Edward F. Stein, O.D., Pontiac, Michigan, Tr. 926 at 952; testimony of Thomas C. Wold, Counsel, North Dakota State Board of Optometry, Tr. 1377 at 1381.

that licensees perform certain batteries of tests,²¹⁴ screen for eye diseases and refer patients to physicians when necessary,²¹⁵ and possess various ophthalmic examination equipment.²¹⁶ Forty-five states also require that optometrists participate in continuing education programs as a condition of license renewal,²¹⁷ and the major national professional associations sponsor such programs for both optometrists and opticians.²¹⁸

The fears expressed by several practitioners that the ability to advertise would cause a few of their unethical colleagues to omit certain portions of the standard eye examination and fail

214 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.

215 See, e.g., Regulations of the South Dakota Board of Examiners in Optometry, Section 4.03, Exhibit IV-42. The regulations mandate that:

It is the duty of every optometrist to properly advise his patient of any apparent or suspected pathological condition coming to his notice that should have medical or other care outside the field of optometry. Id.

216 See, e.g., Rules and Regulations of the Michigan State Board of Examiners in Optometry, Section 338.262, Exhibit IV-23, which specify seven items of equipment which optometrists are required to "have and use."

217 See American Optometric Association, Bulletin from Office of Counsel, Vol. XXXV, No. 52 (Jan. 31, 1977), at p. 8.

218 See, e.g., letter from J. Harold Bailey, Executive Director, American Optometric Association, to FTC (Nov. 15, 1975), Exhibit IV-53, at R. 2564; statement of Robert C. Odom, President, Opticians Association of America, HX 308, at p. 12.

to detect ocular diseases would seem to be most aptly addressed by a strengthening of such standards and legal requirements. As the Commissioner of New York City's Department of Consumer Affairs testified:

There is a licensing authority in this state and it is my feeling that their energies could be better directed toward policing shoddy practices rather than toward enforcing an anti-advertising rule.²¹⁹

Other witnesses agreed that the quality of eye care services should be the concern of state regulatory authorities and professional associations.²²⁰

Thus, direct regulation of ophthalmic quality by the appropriate agencies appears to be the most rational approach to maintaining and upgrading standards. Since the evidence in the record points overwhelmingly to the conclusion that advertising and quality in the ophthalmic market are not related, it seems evident that direct controls are the appropriate method by which to ensure that the public receives the best possible eye care goods and services.

219 Testimony of Elinor Guggenheimer, Tr. 1963 at 1973.

220 See, e.g., testimony of California State Assemblyman Terry Goggin, Tr. 3016 at 3018-19; testimony of Roy Alper, California Citizen Action Group, Tr. 3733 at 3742; testimony of Charles W. Tapp, Director, Louisiana Governor's Consumer Protection Division, Tr. 4200 at 4205.

VI. Basis for Staff Recommendation on Advertising Restraints

A. Theory of Unfairness Under Section 5

Based on staff's analysis of the evidence in the record, it is our conclusion that the recommended Rule can be grounded in the theory of legal unfairness without regard to deception. The essence of the unfairness theory as it applies to the ophthalmic market is simply that the failure to adequately disseminate information to consumers, as well as the restraining of such dissemination of information, is unfair in violation of Section 5 of the Federal Trade Commission Act because: (1) the economic and social benefit to the public attributable to such nondissemination is substantially less than the economic and social costs engendered by such restraints and (2) it offends public policy, being contrary to clear national policy and not vital to achieve important state policy goals.

The Commission's authority to proscribe "unfair" commercial practices which are not necessarily deceptive has been utilized frequently as an independent basis for Commission action.¹ While "deception" may fairly be viewed as a major subcategory of "unfairness," it does not exhaust its content. The Commission has broad, quasi-legislative discretion to define what acts and practices constitute "unfairness" to consumers.² While its interpretations must clearly have some foundation in the commercial realities and public policy of the time, no one particular underpinning (e.g., judicial precedent) is indispensable to sustain a finding of prohibited unfairness.

The responsibility of the Commission to define practices as either competitively unfair or "unfair to the consumer" is a dynamic one.³ As in defining other fluid legal concepts a great deal of leeway must be and is given to the definer. For example, Judge Hand stated that:

1 Cf. Pfizer, Inc. 81 FTC 23 (1972), complaint dismissed; All-State Indus., 75 FTC 465 (1969), aff'd 423 F.2d 423 (4th Cir. 1970) cert. denied, 400 U.S. 828 (1970); FTC v. R.F. Keppel & Bro., Inc., 291 U.S. 304 (1934); Wolf v. FTC. 135 F.2d 564 (7th Cir. 1943); First Buckingham Community, Inc., 73 FTC 938 (1968); Chemway Corp., 77 FTC 1250 (1971).

2 The 1938 Wheeler-Lea Amendment made it clear that this authority extends to the direct protection of consumers, in addition to assuring traditional competitive practices.

3 Cf. All-State Indus., supra note 1; Pfizer, Inc., supra note 1. See also FTC v. Motion Picture Advertising Service Co., 344 U.S. 392, 396 (1953), wherein it was held:

(Continued)

The Commission has a wide latitude in such matters; its 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.⁴

The S & H case sets forth a succinct confirmation of the Commission's jurisdiction over and latitude to define unfair practices:

[T]he Federal Trade Commission does not arrogate excessive power to itself if, in measuring a practice against the elusive, but congressionally mandated standard of fairness, it, like a court of equity, considers public values beyond simply those enshrined in the letter or encompassed in the spirit of the antitrust laws.⁵

The Commission's recently recognized authority to explore the boundaries of "unfairness" is closely analogous to concepts which courts of law often deal with, such as the doctrines of "public policy" and "unconscionability." Nothing in S & H suggests that the Commission, in defining unfairness, may ignore commercial reality and such evidence of public policy and sentiment as it can discern in defining unfairness. The staff believes that the nondisclosure of material information is unfair when considered in light of current commercial reality and public policy.

3 Continued

The precise impact of a particular practice on the trade is for the Commission, not the courts, to determine. The point where a method of competition becomes "unfair" within the meaning of the act will often turn on the exigencies of a particular situation, trade practices, or the practical requirements of the business in question

⁴ FTC v. Standard Education Society, 86 F.2d 692, 696 (2d Cir. 1936), rev'd on other grounds, 302 U.S. 112 (1937).

⁵ FTC v. Sperry & Hutchinson Co., 405 U.S. 233, 244 (1972).

Analytically, it appears that two principles must be established in order to prohibit some practice as legally unfair:

FIRST: It must be determined that prohibiting the practice provides greater social or economic benefit than permitting the practice to continue. This can best be considered as a "balancing of interests" test or "marketplace fairness" test which weighs the potential costs and burdens upon vendors from imposing a standard of behavior against the potential economic losses to consumers if the standard is not imposed.⁶ To better explain this concept, the Commission, in a footnote to the Pfizer opinion, offered the following comparison:

Compare Fletcher, Fairness and Utility in Tort Theory, 85 Harv. L. Rev. 537 (1972), Reasonableness is determined by a straightforward balancing of costs and benefits. If the risk yields a net social utility (benefit), the victim is not entitled to recover from the risk-creator; if the risk yields a net social disutility (cost), the victim is entitled to recover. The premises of this paradigm are that reasonableness provides a test of activities that ought to be encouraged and that tort judgments are an appropriate medium for encouraging them. This balance admittedly gives more consideration to the producers' interests than does the test suggested by Adam Smith: '[T]he interest of the producer ought to be attended to only so far as it may be necessary for promoting that of the consumer.' Smith, An Inquiry Into the Nature and Causes of the Wealth of Nations, 624 (Modern Library Edition, 1937).⁷

This note suggests that although the weight to be given to conflicting interests may vary according to the predisposition of those who do the balancing, some such balancing is necessary. In the context of prescription eyeglasses the Commission must balance the benefits to be derived from advertising restrictions against the losses created by those restrictions.

⁶ Pfizer, Inc., supra note 1, at 60-63.

⁷ Id. at 62, n. 12.

SECOND: It must be determined that the prohibition of a practice, although the practice is to some extent "socially or economically desirable," is warranted as a legal constraint. This involves the discovery and definition, as Judge Hand has suggested, of the "conscience of the community,"⁸ or as the S & H court held, of the "public values beyond . . . the antitrust laws."⁹

While the courts have not found occasion to state explicitly the extent of the Commission's authority to define illegal unfairness to consumers, the Commission did find occasion to weave the judicial threads into its own statement in the "Statement of Basis and Purpose," accompanying its trade regulation rule for the prevention of unfair or deceptive advertising and labeling of cigarettes in 1964. The Commission stated:

No enumeration of examples can define the outer limits of the Commission's authority to proscribe unfair acts or practices, but the examples should help to indicate the breadth and flexibility of the concept of unfair acts or practices and to suggest the factors that determine whether a particular act or practice should be forbidden on this ground. These factors are as follows: (1) whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise--whether, in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers (or competitors or other businessmen). If all three factors are present, the challenged conduct will surely violate Section 5 even if there is no specific precedent for proscribing it.¹⁰

8 FTC v. Standard Education Society, supra note 4, at 696.

9 FTC v. Sperry & Hutchinson Co., supra note 5 at 244.

10 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. 8355 (1964).

This broad-gauged definition found judicial approval in the S & H case. Although the court did not explicitly affirm the sufficiency of the various criteria, it did recognize that the Commission had not committed itself to the view that all three criteria must be met.¹¹ Furthermore, if the Commission's Pfizer opinion is useful as an example of the legal theory of unfairness, it appears that the Commission need not explicitly ground its declarations of unfairness in any of the three cigarette rule criteria. Although the Pfizer opinion cited the criteria, it did not explicitly address itself to any of them.¹²

The most recent decisions by the Commission and the courts with respect to unfairness have reaffirmed the basic principles noted above. In its decision in Beneficial Corporation¹³ the Commission succinctly stated its unfairness authority:

There is no doubt at this point that the Commission may adapt the substance of Section 5 to changing forms of commercial unfairness, and is not limited to vicariously enforcing other law. Therefore, in this case, as in others, those who engage in

¹¹ "[A]ll the FTC said in the statement referred to was that '[t]he wide variety of decisions interpreting the elusive concept of unfairness at least makes clear that a method of selling violated Section 5 if it is exploitive or inequitable and if, in addition to being morally objectionable, it is seriously detrimental to consumers or others.'" 405 U.S. 233 at 245.

¹² Consideration of the criteria, however, appears implicit in the following language:

Fairness to the consumer, as well as fairness to competitors, dictates this conclusion. Absent a reasonable basis for a vendor's affirmative product claims, a consumer's ability to make an economically rational product choice, and a competitor's ability to compete on the basis of price, quality service or convenience are materially impaired and impeded. 81 FTC at 62.

¹³ In the Matter of Beneficial Corporation, et al., 86 FTC 119 (1975), aff'd in part 542 F.2d 611 (3d Cir. 1976).

commercial conduct which is contrary to a generally recognized public value are violating the Federal Trade Commission Act, notwithstanding that no other specific statutory strictures apply. (citation omitted)¹⁴

However, the most significant decision by both the Commission and the courts in relation to this proceeding is that in Spiegel.¹⁵ Initially, the Commission reiterated the factors cited in its statement of basis and purpose accompanying the cigarette rule¹⁶ as guideposts for determining whether conduct violates the unfairness standard of Section 5.¹⁷ On appeal, the Seventh Circuit Court of Appeals upheld this determination.¹⁸ The more important aspect of Spiegel, however, is its discussion of the law of unfairness vis-a-vis conduct which is sanctioned by state law. In Spiegel the defendants' conduct involved the use of Illinois' long-arm jurisdiction to sue consumer debtors. In the Commission's decision, the Commission expressed some doubt that the conduct being challenged was within the state law.¹⁹ However, the Commission noted that even if Speigel's conduct did conform to state law, this would not be a barrier to Commission action.²⁰

On appeal, the Court of Appeals noted that the Commission does possess the authority to prohibit conduct as legally unfair even though that conduct is specifically permitted by state law. In arriving at this conclusion the court noted:

¹⁴ 86 FTC at 171.

¹⁵ Spiegel, Inc. v. FTC 1976-2 Trade Cases, ¶ 61,006 (7th Cir. 1976). Initial Commission decision at 86 FTC 425 (1975).

¹⁶ See note 10, supra.

¹⁷ 86 FTC at 438.

¹⁸ Supra note 15 at 69,453.

¹⁹ 86 FTC at 444-45.

²⁰ 86 FTC at 445, n. 12:

We similarly do not believe that the Tenth Amendment forbids Commission action (RB 40 42). Even if the Commission's action is viewed as imposing a limitation on state authority to authorize suits, rather than as imposing a limitation on Spiegel's ability to abuse the judicial process, it is nonetheless well-established that the Tenth Amendment does

(Continued)

In *Federal Trade Commission v. Sperry & Hutchinson Co.* [1972 TRADE CASES ¶ 73,861], 405 U.S. 233, 92 S. Ct. 808, 31 L. Ed 2d 170 (1972), the Supreme Court left no doubt that the FTC had the authority to prohibit conduct that, although legally proper, was unfair to the public.

Previously, this Court in *Peerless Products v. Federal Trade Commission* [1960 TRADE CASES ¶ 69,863], 284 F.2d 825 (7th Cir. 1960), cert. denied 365 U.S. 844 (1960), rejected the argument that a practice, legal under local law, could not be banned under Section 5. In *Peerless* local ordinances sanctioned the use of merchandise punch-boards. The Court upheld the FTC's power to hold their use unlawful, stating:

Unless Congress specifically withdraws authority in particular areas, the Commission, upon its general grant of authority under 15 U.S.C.A. § 45(a)(6), can restrain unfair business practices in interstate commerce even if the activities or industries have been the subject of legislation by a state or even if the intrastate conduct is authorized by state law (citations omitted).²¹

Based on the foregoing legal principles and case law, staff contends that the inadequate dissemination of information by sellers and providers of ophthalmic goods and services is unfair under Section 5 of the Federal Trade Commission Act if it:

(1) Results in substantial harm to consumers. (i.e., the economic and social benefits accruing to the public because of the nondissemination of information are substantially less than the economic and social costs/losses imposed on consumers because of the absence of such information.)

20 Continued

not mean that state-authorized activity may stand in the face of duly authorized Federal Requirements Maryland v. Wirtz, 392 U.S. 183 (1968); United States v. Darby, 312 U.S. 100, 123-24 (1941).

21 Supra note 15, at 69,453.

(2) Offends public policy. (i.e., the nondissemination of information is basically contrary to clear national policy and is not vital to achieve important state policy goals.)

As the staff has described in some detail, there are large consumer losses which are directly or indirectly attributable to the restrictive nature of state laws and rules and private associational restraints.²² The evidence demonstrates that higher prices,²³ lower rates of consumption by the poor and the elderly²⁴ and lower frequency of eye examinations²⁵ are the result of the nondissemination of information in the ophthalmic market. In addition, staff's analysis of the evidence indicates that the economic and social benefits offered to justify these restraints are substantially outweighed by the costs to consumers.²⁶

The state policies and goals proffered in support of these restrictions have previously been discussed in detail.²⁷ Thus, we will not replicate that discussion herein, except to note staff's conclusion that the restrictions do not serve to achieve any of these goals. However, some further discussion of national public policy may prove enlightening.

The Commission has previously noted that public policy concerns are part of the unfairness analysis:

[W]hether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise-- whether, in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness . . . even if there is no specific precedent for proscribing it.²⁸

22 See Section III, supra.

23 Id.

24 See Section IV(A), supra.

25 See Section IV(C), supra.

26 See Section V, supra.

27 Id.

28 Pfizer, Inc., supra note 1.

That inadequate dissemination of information "offends public policy" is apparent. Competition, particularly price competition, is one of our basic national policies, as indicated by numerous statutes,²⁹ common law principles,³⁰ executive determinations,³¹ and other sources.³² Prohibitions or restrictions on information represent departures from this national economic policy. Inadequate disclosure discourages or prevents individual consumers from price shopping,³³ reduces retailers' incentives to engage in price competition, and results in higher costs to the public at large.³⁴

More specifically, the failure of ophthalmologists, optometrists, and opticians to disseminate information on goods and services offends public policy by depriving consumers of basic information they need to make intelligent purchasing decisions.³⁵ The fundamental public interest in providing consumers with basic information to make intelligent purchasing decisions has been recognized repeatedly, as, for example, in USDA Meat Grading

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- 29 The Sherman, Clayton, Truth-in-Lending, Federal Trade Commission, and Fair Packaging and Labeling Acts are a few examples. Moreover, the Comprehensive Drug Abuse Prevention and Control Act of 1970, Public Law 91-513, specifically recognizes the importance of competition by requiring that the subject regulatory action be consistent with the maintenance of "adequate competition."
- 30 See, e.g., *United States v. Addyston Pipe and Steel Co.*, 85 F. 271 (6th Cir. 1898), aff'd 175 U.S. 211 (1899).
- 31 See, e.g., Research Paper and Policy Statement of the U.S. Department of Justice Regarding State Restrictions on the Advertising of Retail Prescription Drugs, Department of Justice (1971).
- 32 Numerous textbooks and treatises expound on the virtues of competition. E.g., Adam Smith, An Inquiry into the Nature and Causes of the Wealth of Nations (Modern Library ed. 1937); J. M. Clark, Competition as a Dynamic Process (Brookings Inst. 1961).
- 33 See Section IV(B)(2), supra.
- 34 See Section III, supra.
- 35 See Section IV(B), supra.

Requirements,³⁶ the FTC Octane Rule,³⁷ and numerous other FTC Rules,³⁸ Guides,³⁹ and cases.⁴⁰ The public interest in providing consumers with accurate price information is equally well recognized in numerous Commission decisions, including Guides Against Deceptive Pricing,⁴¹ Guides concerning use of the word "free,"⁴² and in a variety of cases.⁴³ The necessity for consumers to have price information that is available and

36 7 C.F.R. § 53 (1973).

37 16 C.F.R. § 422 (1972).

38 See, e.g., TRR Relating to the Care Labeling of Textile Wearing Apparel, 16 C.F.R. § 423 (1972).

39 See, e.g., Guides for Shoe Content Labeling and Advertising-- Guide VII, 16 C.F.R. § 231.2 (1967) (shoes or slippers composed of nonleather material having the appearance of leather must bear labeling which clearly discloses (1) the general nature of the material, or (2) that the material is simulated or imitation leather); Trade Regulation Rule Regarding Misbranding and Deception as to Leather Content of Waist Belts, 16 C.F.R. § 405.4(b)(1964) (it is deceptive to sell belts which are made of nonleather material unless disclosure is made of the true composition of the product); Trade Regulation Rule Relating to Incandescent Lamps, 16 C.F.R. § 409 (1972) (requires disclosure of facts deemed necessary to properly judge the character of light bulbs-- power consumed, light output, laboratory life).

40 See, e.g., Haskelite Mfg. Corp. v. FTC, 127 F.2d 765 (7th Cir. 1972) (paper simulated wood products); Mary Muffet, Inc. v. FTC, 194 F.2d 504 (2d Cir. 1952) (rayon fabrics looked like silk); Mohawk Refining Corp. v. FTC, 263 F.2d 818 (3d Cir. 1959), cert. denied, 351 U.S. 814 (1959) (used and not crude oil was marketed).

41 16 C.F.R. § 233 (1967).

42 16 C.F.R. § 251 (1971).

43 See, e.g., Giant Food, Inc. v. FTC, 322 F.2d 977 (D.C. Cir. 1963); Harsam Distributors, Inc. v. FTC, 263 F.2d 396 (2d Cir. 1959); Dorfman v. FTC, 144 F.2d 737 (8th Cir. 1944); Niresk Indus., Inc. v. FTC, 278 F.2d 337 (7th Cir. 1960), cert. denied, 364 U.S. 883; FTC v. Mary Carter Paint Co., 60 FTC 1827 (1962), aff'd, 379 U.S. 957 (1965); and Walter J. Black, Inc., 50 FTC 255 (1953).

accessible in a manner that facilitates price comparison is also a basis for state supermarket unit pricing laws,⁴⁴ the Automobile Information Disclosure Act,⁴⁵ and the Truth-in-Lending Act.⁴⁶ With respect to the latter Act, Congress declared that "the informed use of credit results from an awareness of the cost thereof by consumers."⁴⁷ The House Report accompanying the Automobile Disclosure bill declared that "[t]he primary purpose of the bill is to disclose the manufacturer's suggested retail price of the new automobile . . . so that the buyer will know what it is. This information is not available now."⁴⁸

Thus, it is the staff's conclusion that the restraints imposed by states and private associations on the dissemination of accurate information concerning ophthalmic goods and services violate the unfairness test of Section 5 of the FTC Act. Not only do the economic and social losses caused by such restraints exceed any offsetting benefits, but the states have shown no vital link between their rightful duty to protect the public health, safety, and welfare and the restrictions and prohibitions described above. However, special factors surround state laws which permit advertising, including price advertising, but which impose certain disclosure requirements. These laws and their relationship to the Commission's law of unfairness are discussed below.

B. State Disclosure Laws

At the inception of this proceeding, only three of the states which permitted price advertising required some form of disclosures.⁴⁹ However, since that time at least three more states have adopted laws,⁵⁰ or regulations⁵¹ permitting price advertising, but requiring disclosures.

⁴⁴ See, e.g., Md. Ann. Code, Article 83 § 21(E). Other states which have mandatory unit pricing laws include Connecticut, Massachusetts, Rhode Island, and Vermont. It appears unit pricing is permitted everywhere, according to Paul Korody, Nat'l Assoc. of Food Chains.

⁴⁵ 72 Stat. 325 (1958).

⁴⁶ Consumer Credit Protection Act, Title I, 15 U.S.C. § 1601 (Supp. V. 1970).

⁴⁷ Id., Findings and Declaration of Purpose.

⁴⁸ H.R. Rep. No. 1958, 85th Cong., 2d Sess. (1958).

⁴⁹ Utah, West Virginia, and Connecticut.

⁵⁰ Massachusetts.

⁵¹ New York and Virginia.

With regard to state laws which either totally prohibit advertising, or prohibit price advertising, staff has already concluded that the nondissemination of information in accordance with those laws violates the unfairness standard of Section 5 of the FTC Act.⁵² In arriving at this determination, staff found that the justifications proffered on behalf of these restraints were either unsubstantiated by the evidence, or were not vital to achieve an important state policy goal.⁵³ Simply stated, the issue which must be addressed is this:

Does the evidence support a finding that state laws which permit advertising but require disclosures violate the unfairness standard of Section 5?

As we discussed earlier, it is staff's belief that the unfairness of the nondissemination of information in this market must be measured against two factors:

- (1) Does it result in substantial harm to consumers?
- (2) Is the nondissemination vital to achieve important state policy goals?⁵⁴

1. Does a State Requirement That Advertising Include Certain Specified Disclosures Result in Substantial Harm to Consumers?

Two separate factors must be taken into account in addressing this question. First, based on the rulemaking record does the evidence indicate that state disclosure laws are resulting in the nondissemination of information? Second, do state laws which require disclosures hold the potential for inflicting such harm?

In a previous discussion we discussed the range of disclosures required by the state disclosure laws which have been adopted to date.⁵⁵ Reference to two of those states' laws, Massachusetts and Virginia, provides a good framework for discussing the impact of disclosure laws. Under Massachusetts law, price advertisements must disclose: (1) whether the price advertised includes lenses as well as frames; (2) whether the lenses included in the advertised price are single-vision, bifocal or trifocal;

52 See subsection (A), supra.

53 See Section V, supra.

54 See note text at notes 21-22, supra.

55 See Section V(A)(3), supra.

(3) whether the lenses available at the advertised price include low, medium, or high refractive power; and (4) that the advertised price does not include an eye examination.⁵⁶ Of the state disclosure laws enacted to date, the Massachusetts law contains the fewest requirements.

By way of contrast, Virginia law requires the following disclosures be made in at least 10 point type:

- (1) name of the manufacturer of frames
- (2) product number of advertised frames
- (3) country of manufacture of frames
- (4) material of frame (plastic, metal, or combination)
- (5) whether lenses are clear, tinted, or photochromatic
- (6) whether lenses are glass or plastic
- (7) whether price includes single-vision, bifocal (including segment size), trifocal (including segment size)
- (8) hard or soft contact lenses
- (9) ads must state that eye examinations are not included in the advertised price
- (10) ads offering discounts must state the regular price
- (11) if the lenses sold are not purchased from a manufacturer who warrants that the lenses satisfy the American National Standards Institute (ANSI) standards or if the lenses do not in fact meet the ANSI standards the advertisements must state, "Does not meet ANSI standards."⁵⁷

These two state enactments represent the two extremes in disclosure requirements. In the next section we discuss in detail the issue of whether any of these requirements could arguably satisfy the test of being "vital to achieve an important state policy goal."⁵⁸ However, to determine whether such disclosure laws have resulted in substantial injury to consumers, staff must look to the advertising which has occurred since the enactment of these laws.

In Virginia, even with the rigorous disclosure requirements, some price advertising, has occurred.⁵⁹ Many of the beneficial

⁵⁶ MASS. GEN. LAWS, Ch. 112, § 73A as amended by 1976 Mass. Acts Ch. 91, Exhibit IV-22.

⁵⁷ Virginia State Board of Examiners in Optometry, Rule 3, Exhibit IV-47.

⁵⁸ See subsection (B)(2), infra.

⁵⁹ See, e.g., Advertisement of Peoples Drug, "TV Channels Magazine," The Washington Post (Feb. 27, 1977); Advertisement of Dart Drug, Supplement to The Washington Post (February 27, 1977).

attributes of advertising have been exhibited by these advertisements. Offers of multiple pairs of eyeglasses at reduced rates,⁶⁰ offers of product guarantees,⁶¹ and vigorous price competition have occurred in the advertisements.⁶²

Thus, staff cannot conclude, based on the available evidence, that even the most rigorous disclosure law enacted to date has resulted in substantial injury to consumers. Under disclosure laws such as that in effect in Massachusetts which require fewer disclosures, the potential for discouraging advertising is even

60 See, e.g., Advertisement of Dart Opticians, The Washington Post (June 24, 1976):

A Very Special 1 cent Offer: Buy one pair of glasses at our low discount price and get a second pair for only 1 cent.

61 See, e.g., Advertisement of Dart Opticians, The Washington Post (June 24, 1976):

If the lenses of your new glasses break within the year from date of purchase, Dart will replace them FREE of charge.

See also, Advertisement of Peoples Drug, "TV Channels Magazine," The Washington Post (Feb. 27, 1977):

FREE ONE YEAR NO-FAULT INSURANCE ON FRAMES AND LENSES For one full year after you get your Peoples eyeglasses or prescription sunglasses, Peoples will replace broken lenses and repair or replace broken frames at no cost.

62 See, e.g., Advertisement of Dart Opticians, Supplement to The Washington Post (Feb. 27, 1977):

OPTICAL SPECIAL - Dart Opticians will beat the price of any advertised optical special running between February 27th and March 5th by 5%. Bring in any advertisement or coupon to the Dart Optical Center near you and we will beat the competition.

further reduced. We must note, however, that because these disclosure laws are relatively new, the potentially adverse effects of such laws remain to be determined.⁶³

While staff cannot conclude that substantial injury has occurred because of state disclosure requirements, we emphatically conclude that such disclosure requirements hold the potential for resulting in substantial injury. In staff's discussion of whether the recommended rule should require disclosures, we catalogued all of the disclosures which have been advocated.⁶⁴ Carried to the logical extreme, disclosure requirements could be used to effectively prevent all advertising. Simply by burdening advertising with sufficient content requirements, advertising could become economically infeasible. Indeed, a number of witnesses testified to their belief that state boards of optometry would use disclosure requirements to prohibit indirectly all advertising.⁶⁵

At this juncture, staff must conclude that (1) it cannot be shown on the available evidence that disclosure requirements have resulted in substantial injury; and (2) permitting states totally unfettered discretion to adopt disclosure requirements holds the potential for disclosure requirements being adopted with the effect of preventing truthful advertising.

63 For example, analysis of the advertising to date in Virginia reveals that only the larger sellers and providers have engaged in extensive advertising. In other jurisdictions, such as Maryland and the District of Columbia, where no disclosure requirements exist, numerous smaller opticians have engaged in price advertising. See, e.g., Advertisement of Accurate Optical, The Washington Post (Aug. 13, 1975), Exhibit II-49, at R. 1309. Advertisement of Sterling Optical, The Washington Post (May 25, 1975), Exhibit II-49, at R. 1309.

It appears that the advertisements found in Virginia require additional space to comply with the numerous disclosure requirements. Thus, it may be that the disclosure requirements deter smaller opticians and others from advertising. In effect this could result in competitive injury to smaller opticians, and deny consumers access to information they might otherwise obtain.

64 See Section V(A)(3), supra.

65 See, e.g., testimony of Sheldon Fantle, Chairman of the Board and Chief Executive Officer, Peoples Drug Stores, Tr. 482 at 484; testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6207a.

2. Are State Disclosure Requirements Vital to Achieve Important State Policy Goals?

In an earlier section, staff concluded that state laws which totally prohibited advertising, or prohibited price advertising, were not necessary to achieve any vital state interest.⁶⁶ One of the arguments which was rejected as unfounded was the contention that total bans were necessary to prevent deception.⁶⁷ However, this issue must be reconsidered with respect to state disclosure laws. In our discussion of the need to control deception, staff noted that numerous avenues were open to the states to control deception, short of totally prohibiting all advertising.⁶⁸ The imposition of mandatory disclosure requirements by the states arguably constitutes one such avenue.

To the extent that state disclosure requirements serve to require that advertisements include information without which those advertisements would be deceptive, the disclosure requirements may represent a cost-effective method for the state to police deception. A number of persons testified that both the states and the federal government lacked the necessary resources to police deceptive advertising on a case-by-case basis.⁶⁹ By affirmatively requiring that advertisements include information necessary to prevent deception, states might well be better able to ease their enforcement burdens.

In no sense is staff advocating the imposition of disclosure requirements by state legislatures or licensing boards. Staff reiterates our basic view that ophthalmic goods and services should not be treated differently than other consumer products. In addition, we would restate our belief that in many instances disclosure requirements are not designed nor intended to prevent deception, but rather to stifle advertising. However, staff cannot conclude that states should be prohibited from requiring disclosures in all instances.

66 See Section V, supra.

67 See Section V(A), supra.

68 Id.

69 See, e.g., testimony of R. Ted Bottiger, Counsel, Washington Optometric Association, Tr. 4047 at 4054; testimony of Robert G. Corns, O.D., Indiana State Board of Optometry, Tr. 1293 at 1299; testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5554; testimony of Erwin Jay. O.D., Tr. 1450 at 1479.

Conclusion

Accordingly, staff must conclude that some state laws which permit advertising, including price advertising, but require some form of disclosure, might not violate the unfairness standard of Section 5 of the FTC Act. In some instances, narrowly drawn disclosure requirements might not result in substantial injury to consumers. Moreover, under certain circumstances, some disclosure requirements might be "vital to achieve important state policy goals" such as minimizing the possibility of deception, or easing the state's burden of enforcing their deceptive advertising statutes.

However, at the same time the dangers inherent in permitting unlimited disclosure requirements are apparent. Both the letter and spirit of staff's recommendation could easily be circumvented by the imposition of onerous disclosure requirements. Moreover, given the intense opposition to the proposed Rule by optometric boards which in many states are empowered to impose such requirements, staff cannot dismiss the possibility that such circumvention will occur.

To accommodate all of these concerns, staff recommends the following course of action. First, staff recommends that the Commission preempt state laws which permit advertising but require disclosures.⁷⁰ Secondly, the states should be permitted to enact disclosure requirements in the limited areas specified in the recommended Rule.⁷¹ Finally, states which believe that disclosure requirements are necessary to prevent deception, in addition to those delineated by the staff, are free to petition the Commission to obtain an exemption from the Commission's Rule. This would allow all interested parties an opportunity to comment on the specific proposal.

Notwithstanding the possibility that certain disclosure laws might not violate the unfairness standard of Section 5, the Commission possesses the authority to preempt them. Pursuant to the Magnuson-Moss Federal Trade Commission Improvements Act,⁷² the Commission was authorized to prescribe rules which:

70 See § 456.3 of the recommended Rule, Section X, infra.

71 Id.

72 15 U.S.C. § 2301 (Public Law 93-637).

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70 See § 456.3 of the recommended Rule, Section X, infra.

71 Id.

72 15 U.S.C. § 2301 (Public Law 93-637).

- (1) define with specificity acts or practices which are unfair⁷³ and
- (2) include requirements prescribed for the purpose of preventing such acts or practices.⁷⁴

Under this latter category, the Commission may prohibit conduct which although not in violation of Section 5, might lead to other conduct which would violate Section 5. It is staff's conclusion that this provision of the Commission's authority directly addresses the present situation. As we previously noted, disclosure requirements hold the clear potential for effectively prohibiting advertising.⁷⁵ By burdening advertising with disclosures which are not necessary to control deception, the states could circumvent the recommended Rule if they chose to do so. Indeed, the disclosure requirements adopted in Virginia provide a clear indication that some states, particularly through their Boards of Optometry, are inclined to require disclosures which are not necessary to prevent deception.⁷⁶

At the same time, staff recognizes that the states should not have their hands tied in enforcing their deceptive advertising statutes. The testimony of the Ohio Attorney General offers a good guidepost by which to proceed:

I strongly urge that any set of regulations adopted by the Federal Trade Commission should clearly state that the states shall not be precluded from enforcement activities which do not conflict with or frustrate the purpose of the federal regulations, and that states

73 Id. Section 18(a)(1)(B) of the FTC Act as amended by Public Law 93-637 states:

The Commission may prescribe rules which define with specificity acts or practices which are unfair or deceptive acts or practices in or affecting commerce.

74 Id. In addition, § 18(a)(1)(B) of the FTC Act as amended by Public Law 93-637 states:

Rules under this subparagraph may include requirements prescribed for the purpose of preventing such acts or practices.

75 Supra notes 64 and 65 and accompanying text.

76 See Section V(A)(3) for a further discussion.

shall be encouraged to engage in enforcement activities which are in concert with and promote the regulations. This suggestion applies not only to the eyeglass industry, but to all other regulations promulgated by federal agencies.

There is a strong pattern of effective enforcement of the antitrust and consumer fraud law by the Attorney General's Office in Ohio. It would be most unfortunate if the federal government were deemed to have totally preempted these state enforcement activities. The states can provide an additional means to carry out the purposes of the regulations, and should not be prevented from doing so.⁷⁷

Staff's final recommendation includes a number of measures designed to accommodate legitimate state concerns. First, staff's recommended Rule would not preempt those state laws which apply disclosure requirements to all commodities.⁷⁸ Second, the rule permits state or local governmental units to continue to require mandatory affirmative disclosures in those limited areas in which it appears that at least a potential for deception exists.⁷⁹ The specific areas in which the states may impose disclosure requirements are clearly spelled out in staff's recommendation.⁸⁰

Finally, in those instances in which a state determines that disclosures in addition to those recommended by the staff are necessary to prevent deception, the state may petition the Commission for an exemption from the Commission's Rule. Under the Commission's authority in the Magnuson-Moss Act:

77 Text of testimony by William J. Brown, Attorney General, State of Ohio, HX 56, at p. 8.

78 See § 456.3 of the recommended Rule, Section X, infra.

79 Id.

80 Id.

Any person to whom a rule . . . applies may petition the Commission for an exemption from such rule. If . . . the Commission finds that the application of a rule . . . is not necessary to prevent the unfair or deceptive act or practice to which the rule relates, the Commission may exempt such person or class from all or part of such rule.⁸¹

⁸¹ Section 18(g)(1) of the FTC Act as amended by Public Law 93-637.

VII. Consumer Access to Ophthalmic Prescriptions

A. Background

In proposing the Rule, the Commission included the following statement concerning the release of prescriptions for ophthalmic goods:

[T]he Commission may require persons qualified to perform eye examinations to deliver written prescriptions to buyers, if evidence demonstrates that buyers are prevented from price shopping because of unavailable prescriptions. For example, such a requirement might state:

It is an unfair act or practices for any . . . person qualified pursuant to state law to perform eye examinations or refractions to fail to deliver to the buyer such complete written prescription or specifications for corrective lenses as will enable the buyer to obtain the corrective lenses from the seller or provider of the buyer's choice.¹

In its Statement of Reason for the proposed rule, the Commission expressed concern that consumers may be unable to effectively utilize increased information in the marketplace if they do not have access to their prescriptions.² To focus public comment, the Commission addressed a specific question to the public requesting comment on this issue.³ In addition, one of

¹ Notice of Proceeding and Proposed Trade Regulation Rule, 41 Fed. Reg. 2399 (January 16, 1976).

² Id. at 2400.

³ Id. at 2401. The question stated:

8. Will the requirement that a buyer be provided with a written prescription for the corrective lenses he requires:

- (a) facilitate his ability to comparison shop more effectively;
- (b) lower his costs by enabling him to have lenses provided by the dispenser of his choice; or

(Continued)

the seven issues designated by the Presiding Officer pursuant to Section 1.13(d)(1) of the Commission's Rules addressed the advisability of mandating the release of prescriptions:

Will a requirement that a buyer be provided with a copy of the prescription for corrective lenses which he requires significantly improve his ability to obtain such lenses from the seller or provider of his choice?⁴

This issue has evoked considerable comment during the various written comment periods and at the public hearings held in this matter.

The problems associated with the release of ophthalmic prescriptions have been addressed by the Federal Trade Commission on an earlier occasion. In 1962, the Commission adopted a set of voluntary industry Guides for the Optical Products Industry.⁵ Among the provisions contained in the guides was one concerning the release of prescriptions. Section 192.7(c) of the Guides states:

It is an unfair trade practice to tie in or condition eye refraction service for a patient with the dispensing of the prescribed eyeglasses or contact lenses to the patient, when such practice effects, or has a reasonable probability of effecting, substantial injury to competition or creates or tends to create a monopoly, at any competitive level in the trade area or areas where the practice is employed.⁶

3 (Continued)

(c) facilitate duplications or replacements of lenses without having to return to his ophthalmologist or optometrist to obtain a copy of his prescription.

⁴ Final Notice of Proposed Trade Regulation Rule Proceedings, 41 Fed. Reg. 14194 (April 2, 1976).

⁵ 16 C.F.R. § 192.

⁶ 16 C.F.R. § 192.7(c).

Among the types of conduct considered to be violative of this provision were the refusal to perform examinations if the patient desired to have the prescription filled elsewhere⁷ or the charging of a higher or additional fee for having the prescription filled elsewhere.⁸ However, no litigation to enforce these guides was ever undertaken.

B. Total Vision Care

In an earlier section,⁹ we discussed the professional roles, responsibilities, and functions of ophthalmologists, optometrists, and opticians. Certain differences in the roles of these professions require elaboration with regard to our discussion of the necessity and propriety of requiring the release of ophthalmic prescriptions.

In general, two somewhat distinct systems for the delivery of eye care have evolved. Patients examined by ophthalmologists are typically referred to opticians to have their prescriptions filled.¹⁰ While there is an increasing trend for ophthalmologists to become involved in the dispensing of eyeglasses,¹¹ particularly in the area of contact lenses,¹² the majority of ophthalmologists provide examination services only.

⁷ An interpretive note to Section 192.7(c) states:

To be considered as subject to the prohibitions of paragraph (c) of this section [is the] (1) Refusal of the doctor to perform refractions, or to supply prescriptions based thereon, when and because the patient desires to have the dispensing of the product done by another party lawfully qualified to dispense same.

⁸ Id. The note also states:

To be considered as subject to the prohibitions of paragraph (c) of this section [is] (2) The doctor requiring a higher fee when he does not dispense

the products he prescribes than when he does dispense such products.

⁹ See Section I(C), supra.

¹⁰ See Section I(C)(3), supra.

¹¹ See Section I(C)(1), supra.

¹² Id.

The second system for the delivery of eye care involves a concept often referred to as "total service." Total service is the short hand expression used by many, particularly within the profession of optometry, to describe their belief that vision care should be provided by a single practitioner, from examination to dispensing through the rendering of followup services.¹³ The rationale behind this concept from optometry's perspective has been succinctly stated by the American Optometric Association (AOA):

-
- 13 See, e.g., Position Statement of Michigan State Board of Examiners in Optometry, HX 315, at p.3:

Total Vision Care--A Basic Principle

Total vision care rendered by an individual, ethical doctor of optometry in a single location is a basic principle upon which the profession of optometry was founded.

My best objective is to provide for you and your family the best vision care possible.

In order to most effectively accomplish this objective, it is necessary that total vision care service, including examination, refraction, prescription and verification of lenses, selection and fitting of frames, dispensation of materials, and periodic maintenance of prescribed materials, be provided by this office, and that optometric responsibility not be divided.

See also Monroe J. Hirsch and Ralph E. Wick, The Optometric Profession (1968), Exhibit II-30, at R. 811; Harold L. Light and Jessie Rosenthal, "Pilot Study of Quality and Standards in Filling Spectacle Prescriptions," Public Health Reports, Vol. 80, No. 5, (May 1965), Exhibit VI-24, at R. 11262; letter from Indiana Optometric Association to FTC (Oct. 14, 1975), Exhibit IV-60, at R. 3098; letter from Massachusetts Board of Optometry to FTC (Nov. 6, 1975), Exhibit IV-59, at R. 2997; testimony of Jessie C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3603; testimony of Robert G. Corns, O.D., Director of Inspectors, Indiana Optometry Board, Tr. 1293 at 1305; testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1050; testimony of Jessie Johnson, O.D., Vice-President, Board of Examiners in Optometry of Oklahoma, Tr. 5607 at 5630.

There should be no breakdown in the chain of events beginning with an examination and culminating in ophthalmic materials being converted to a prescription item for an individual for the reason of protecting the health and welfare of the individual person. The general health of the individual, as used in its broadest sense, is endangered when anything disrupts complete vision care.¹⁴

However, the comments of the National Association of Optometrists and Opticians offer a different perspective:

The professionals provide what they euphemistically characterize as a "total service" to the consumer. It is unique in that by statutory definition in most states the sale of the product (ophthalmic goods) is tied to a service (ophthalmic examinations). Optometry provides this "total service" solely for the economic benefit of its members. The professionals derive a material portion of their income from the sale of ophthalmic goods.¹⁵

In support of this position, a number of resolutions adopted by the AOA in its 1954 convention are often cited. Among these were resolutions declaring "visual care" to be exclusively the domain of optometry,¹⁶ urging elimination of "unlicensed" persons

14 Comment of J. Harold Bailey, Executive Director, AOA, Exhibit VIII-160, at R. 14695.

15 Id. at 14685.

16 Testimony of Phil Watson, State Senator of Oklahoma, Tr. 4570 at 4580. Resolution 4 adopted by the AOA at their Annual Congress in 1954 states:

Resolved that it is the stated policy of the American Optometric Association in convention assembled that the field of visual care is the field of optometry and should be exclusively the field of optometry, and--"Be it further resolved that the individual state associations are recommended to make serious study of the optometry laws prevailing in their states to the end that exemptions be restricted, limited and ultimately eliminated and that encroachments by untrained, unqualified and unlicensed persons into the exclusive field of optometry be prevented through the established enforcement agencies of the respective states."

from the field of visual care,¹⁷ and opposing licensure of any additional groups in the field of visual care.¹⁸ As we previously discussed, optometry has consistently opposed attempts by opticianry to achieve licensed status.¹⁹ Thus, although spokesmen for the AOA have indicated that the positions advocated in their 1954 resolutions are no longer the formal view of the AOA,²⁰ a legitimate question arises as to whether in fact the policy embodied in those resolutions is still being pursued. Indeed, the concept of total vision care, in which the dispensing of eyeglasses is subsumed within the larger process of examination and dispensing, effectively reduces the available market for opticians. The elimination of opticianry as a viable competitor to optometry would clearly serve to enhance the financial status of optometry as a whole.

17 Id.

18 Id. At the AOA's 1954 Congress the following resolution was also adopted:

Where there is an increasing tendency for groups which are presently unlicensed to seek licensure, now therefore be it resolved that the American Optometric Association is opposed to the licensing of any new groups in the visual care field.

19 See Section I(C)(4), supra. A survey conducted by the Opticians Association of America (OAA) showed that in the past 15 years opticians' licensing bills had been defeated 125 times. 87.5% of those bills were opposed by the respective state optometric associations. See also testimony of Robert C. Odom, President of OAA, Tr. 4312 at 4321.

20 Testimony of J. Harold Bailey, Executive Director, AOA, Tr. 5905 at 5918. Mr. Bailey testified that the intent of Resolution 4 was not to drive opticianry or ophthalmology out of the eye care field. He testified that it was designed to eliminate persons who were illegally practicing optometry.

C. Availability of Prescriptions

The inclusion of the prescription section . . . is an admission by the FTC of the importance of the prescription to the whole industry. Without the prescription, nothing happens. The industry shuts down.²¹

In the past 32 years, I have seen everything imaginable done by doctors to insure that the prescription given the patient is filled at the office they own or have ownership in. I have seen some of the following things done rather than release a prescription for eyeglasses: Tear it to pieces and throw it in the wastebasket. Say that there will be an extra charge if it is taken elsewhere. Tell the patient they will not be able to check the accuracy, etc. Give the patient the prescription but only write part of the prescription on it.²²

These statements, the first by a representative of the Indiana Optometric Association and the latter by a Texas optician, are indicative of the economic importance of the eyeglass prescription to the practitioners in the eyeglass market. A brief review of the market shares presently held by each category of practitioner demonstrates this importance. It is estimated that ophthalmologists perform approximately 43% of all eye examinations performed annually²³ while optometrists account for the remaining 57%.²⁴ The statistics on dispensing indicate that ophthalmologists dispense approximately 10.3% of all eyeglasses, optometrists 49.3%, and opticians approximately 40.4%.²⁵ It is apparent that the optician is totally dependent upon the availability of prescriptions from other practitioners. As the only practitioner not qualified to perform examinations,²⁶ the optician necessarily relies on the availability of prescriptions to conduct his business.

21 Testimony of Chester Curry, O.D., Indiana Optometric Association, Tr. 993 at 1020.

22 Testimony of Berry C. Lofland, Certified Optician, Professional Eyewear, Tr. 5510 at 5513.

23 See Section I(C)(1) supra.

24 See Section I(C)(2) supra.

25 See Section I(C), supra.

26 See Section I(C)(3), supra.

Considerable testimony was given at the public hearings in this matter indicating that prescriptions are not readily available to all consumers. The practices employed to discourage consumers from taking their prescriptions elsewhere to be filled fall into three general categories:

- (1) outright refusal to release prescriptions or refusal to conduct the examination unless the patient agrees to purchase eyeglasses at the same time;
- (2) the charging of an additional fee as a condition to releasing the prescription; and
- (3) conditioning release of the prescription on the signing of a release or waiver of liability by the patient.

Each of these tactics has gained widespread use with the optometric profession and to a lesser extent in ophthalmology. A discussion of each of these practices as well as their prevalence in the retail ophthalmic market follows.

1. Refusal to Release Prescriptions

Two distinct practices are addressed within this category. Numerous persons--primarily consumers, representatives of consumer groups, and opticians--testified that many optometrists and ophthalmologists would not release prescriptions to consumers, even when requested to do so.²⁷ In a study conducted by the New York City Department of Consumer Affairs, numerous instances were

27 See, e.g., testimony of Joseph Serian, O.D., President, 20/20 Contact Lens Service, Inc., Tr. 250 at 277-78; testimony of Walter Johns, Jr., Reporter for The Cleveland Press, Tr. 1603 at 1612; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1857; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1974; testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2021; testimony of Stephen LaVerdiere, LaVerdiere's Super Drug Stores, Tr. 2573 at 2579; testimony of Robert C. Odom, supra note 19, at 4319; testimony of Lee Starr, Optician, Tr. 4412 at 4422-23; testimony of Doug Matthews, Optician, Tr. 4460 at 4473; testimony of Elena Hangii, Arkansas Community Organizations for Reform Now, Tr. 4612 at 4634; testimony of Berry C. Lofland, supra note 22 at 5513; testimony of Stanley Roberts,
(Continued)

documented in which practitioners simply refused to release prescriptions.²⁸ A similar study conducted by the New Jersey Division of Consumer Affairs yielded similar results.²⁹ The evidence demonstrates that this practice is occurring on a widespread basis.³⁰ In commenting on the reasons why his optical dispensary failed financially, one former optician stated:

27 Continued

Optician, Tr. 5839 at 5844; testimony of Phoebe T. Harris, Ph.D., Consumer Economics and Home Management, Mississippi State University, Tr. 6210 at 6221; testimony of Edward E. Crittenden, President, Eyear Optical, Tr. 6015 at 6015-C; testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6188; comment of Clara E. Strampfer, Exhibit VII-155, at R. 12840; comment of Mrs. Rozell Grey, Exhibit VII-163, at R. 12850; comment of Mrs. Otto V. Ueberroth, Exhibit VII-644, at R. 13413; letter from Renate Ruff, Exhibit II-63, at R. 1513.

28 Testimony of Elinor Guggenheimer, supra note 27:

In several instances during the course of our study, the examining doctor actually refused to furnish written prescriptions to participants who asked expressly for them. Upon questioning by one of these participants, one doctor admitted that the purpose of not providing a prescription was to prevent the subject from purchasing his glasses elsewhere. "We want to sell you the glasses," the doctor said. Id. at 1974.

29 Testimony of Virginia Long, supra note 27, at 1861.

30 Testimony was received from persons in at least 14 different jurisdictions complaining of this practice. See, e.g., Texas: testimony of Berry C. Lofland, supra note 22, at 5513; testimony of Stanley Roberts, supra note 27, at 5844; Massachusetts: letter from Kenneth C. Collinson, Jr., Kenco Optics, Inc., Exhibit IV-123, at R. 5674; Tennessee: testimony of Edward E. Crittenden, supra note 27, at 6015-C; South Carolina: testimony of Kenneth R. Davenport, supra note 27, at 6188; New York: testimony of Elinor Guggenheimer, supra note 27, at 1974; Oklahoma: testimony of Lee Starr, supra note 27, at 4422-23; testimony of Doug Matthews, supra note 27, at 4473; Arkansas: testimony of Elena Hangii, supra note 27, at 4634; Mississippi: testimony of Phoebe T. Harris, supra note 27, at 6221; Ohio: testimony of Walter Johns, Jr.,
(Continued)

you see, when you can't get prescription releases, you can't do business and my optical shop was about four miles from the nearest doctor and he happens to be an optometrist who refuses to allow prescriptions to the patients unless they buy their glasses direct from him. That's the only way they can get it.³¹

A related concern is the practice of some doctors, both ophthalmologists and optometrists, who will not conduct an examination unless the patient agrees in advance to purchase his eyeglasses from the practitioner. Consumers, opticians, and opticians' associations from a number of states testified that this practice occurs with some frequency.³² In at least one state, Michigan, it has been held that optometrists are free to condition the availability of their services upon agreement by the consumer that all goods will be purchased from the examining optometrist. In a position statement by the Michigan State

³⁰ Continued

supra note 27, at 1612; testimony of Joseph Serian, O.D., supra note 27, at 277-78; Maine: testimony of Stephen LaVerdiere, supra note 27, at 2579; New Jersey: testimony of Virginia Long, supra note 27, at 1857; testimony of Robert C. Troast, supra note 27, at 2021; New York: testimony of James J. Ryan, NAOO and New York State Optical Retailers Association, Inc., Tr. 2360 at 2381; Connecticut: letter from William A. Schwartz, Jr., Wall & Ochs, Exhibit IV-126, at R. 5702; letter from Renate Ruff, supra note 27, at 1513. See also testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4319.

³¹ Testimony of Lee Starr, supra note 27, at 4419.

³² See, e.g., testimony of Ron G. Fair, O.D., President, AOA, Tr. 4638 at 4648-49, 4727; testimony of Doug Matthews, supra note 27, at 4465; testimony of Jack S. Folline, member, South Carolina Board of Examiners in Optometry and Opticianry, Tr. 574 at 587; testimony of Robert Hart, Sr., Society of Dispensing Opticians of New Jersey, Tr. 2442 at 2447; Position Statement of Michigan State Board of Examiners, HX 315, at p. 2.

Board of Examiners in Optometry, it was held that the availability of the ultimate prescription was a matter of contract between the doctor and the patient.³³ The Board made clear its belief that this "contract" should call for the optometrist to dispense his own eyeglasses.³⁴ Consistent with this position, the Michigan Optometric Association made clear its belief that prescriptions should not be made available. The Association recommended that its members post the following notice in their offices:

Total vision care rendered by an individual, ethical doctor of optometry in a single location is a basic principle upon which the profession of optometry was founded.

My objective is to provide for you and your family the best vision care possible.

In order to most effectively accomplish this objective, it is necessary that total vision care service, including examination, refraction, prescription and verification of lenses, selection

³³ Position Statement of Michigan State Board of Examiners, HX 315. In part the Board stated:

The Michigan State Board of Examiners in Optometry does not prescribe rules for the control of the prescription of the eye physician since they are exempted from certain sections of our law. However, although no constraint of mode of practice by the ophthalmologist in the ownership of prescription is intended by this Board, we hold that the optometrists are obligated to reach an agreement with the patient as to the extent of the services to be provided. Id. at p. 1.

³⁴ Id. In part the Board stated:

Therefore, it appears mandatory that the optometrist, in order to fulfill his obligation to his patients, does clearly state the policy of his office, to wit: the patient is to be informed as to the fact that the policy of his office and his private contractual relationship with the patient, requires that all ophthalmic materials and any other materials or directions be dispensed or administered by his office and that any other arrangement, contrary to or modifying, be requested by the patient and agreed upon by the examining (and prescribing) optometrist if any option is to be exercised by the patient in this regard. Id. at p. 2.

and fitting of frames, dispensation of materials, and periodic maintenance of prescribed materials, be provided by this office, and that optometric responsibility not be divided.

Therefore, it is my policy, consistent with the ethical and moral precepts of my profession, not to release ophthalmic prescriptions for servicing at locations other than this office unless special circumstances prevail, and unless there is prior agreement for release of the prescription.³⁵

Thus, the evidence demonstrates that the practice of practitioners either refusing to release prescriptions, or conditioning the availability of examinations on "in-house" dispensing, is a serious and pervasive problem. Moreover, the practice appears in some instances to have become institutionalized through policies such as that followed in Michigan.

A final variation on this theme involves the practice of releasing unsigned copies of prescriptions to consumers when asked for a copy of the prescription.³⁶ Many persons testified that this device was being used to prevent meaningful access to the prescription as the optician cannot fill the prescription unless signed.³⁷

2. Charging of Additional Fees

By far, the most frequent practice employed to discourage consumers from shopping elsewhere is the charging of a fee for the prescription in addition to that charged for the examination, if the consumer requests his prescription so that he can shop elsewhere. In one survey conducted in Mississippi, approximately 25% of the optometrists surveyed charged a higher price to consumers who requested copies of their prescriptions.³⁸ A similar

35 Id. at p. 3.

36 See, e.g., testimony of Robert C. Odom, supra note 19, at 4319.

37 Id.

38 In a survey of 23 optometrists, six or 26%, charged an additional fee. Testimony of Phoebe T. Harris, Ph.D., supra note 27, at 6222.

pattern developed in a survey conducted on behalf of the NAOO.³⁹ Opticians' associations in numerous states⁴⁰ testified that member opticians had encountered serious difficulty in obtaining customers' prescriptions without the customer incurring an additional charge. In addition, numerous individual opticians and others confirmed this finding, citing instances in which an additional fee had been charged.⁴¹ The nature and amount of the

39 In a survey of 12 optometrists, three, or 25%, charged additional fees. Statement of R. Burr Porter, Ph.D., on behalf of NAOO, HX 390, at p. 18.

40 See, e.g., testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5551 (Texas); testimony of Kenneth R. Davenport, supra note 27, at 6188 (S.C.); testimony of Billie J. Odom, Vice President, Opticians' Association of Northern Virginia, Tr. 55 at 61 (Va.); testimony of Ralph J. Rubinoff, Executive Director, Massachusetts Association of Registered Dispensing Opticians, Tr. 2532 at 2538 (Mass.); testimony of Robert Hart, Sr., supra note 32, at 2449 (N.J.); testimony of E. Craig Fritz, President, Connecticut Opticians Association, Tr. 2827 at 2832 (Conn.); testimony of Stephen Lee Adams, President, Tennessee Opticians Association, Tr. 6015 at 6015-C (Tenn.). See also testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4319.

41 See, e.g., testimony of Joseph Serian, O.D., supra note 27, at 266; testimony of Kent Wilcox, Deputy Director, Michigan Consumers Council, Tr. 973 at 976; testimony of Donald Juhl, President, Jack Eckerd Corporation, Tr. 379 at 394-95; testimony of Jerry Burger, O.D., Tr. 1056 at 1097-98; testimony of Robert C. Troast, supra note 27, at 2021; testimony of John Collins, Health Care Task Force, New Jersey Federation of Senior Citizens, Tr. 2430 at 2439; testimony of James E. Washington, O.D., Tr. 2591 at 2618; testimony of Walter Johns, Jr., supra note 27, at 1612; testimony of Charles W. Tapp, Director, Governor's Consumer Protection Division, State of Louisiana, Tr. 4200 at 4227-28; testimony of Elena Hangii, supra note 27, at 4634-35; testimony of James Elless, O.D., Tr. 5363 at 5384-85; testimony of Chester H. Pheiffer, O.D., Ph.D., Dean, College of Optometry, University of Houston, Tr. 5243 at 5289-90; testimony of Jerry K. Humphrey, M.Ed., F.N.A.O., Certified Optician, Tr. 5884 at 5894; testimony of Phoebe T. Harris, Ph.D., supra note 27, at 6222; testimony of Douglas Hurdelbrink, Consumer Protection Center, Baton Rouge, Louisiana, Tr. 6247 at 6255; comment of Leonard Kleist,
(Continued)

fees vary, although generally the amounts charged are not large, usually \$5 to \$10.⁴² In the context of the eyeglass purchase, an additional fee of this amount may well be sufficient to deter or discourage the consumer from obtaining his prescription and shopping for the best buy.

The nature of the fee charged may also vary. In some instances, it appears that the additional fee charged is considered a "verification fee."⁴³ Verification usually involves a process of comparing the written prescription against the correction which has been ground into the lenses.⁴⁴ The significant

41 Continued

Exhibit VII-65, at R. 12739; comment of Mrs. M. L. White, Exhibit VII-134, at R. 12817; comment of Sheila Vanlue, Exhibit VII-270, at R. 12972; comment of Miles J. Murphy, Exhibit VII-338, at R. 13048; comment of Mr. & Mrs. William Bates, Exhibit VII-437, at R. 13162; Article by Walter Johns, Jr., Cleveland Press. (Dec. 26, 1975), Exhibit VII-1032, at 14043; Delia Schletter, Optical Illusion: A Consumer View of Eye Care, San Francisco Consumer Action (1976), Exhibit II-65, at R. 1620; unsigned letters from consumers: Exhibit III-6, at R. 2470, 2472; letter from Mrs. James H. Robertson to FTC, Exhibit III-6, at R. 2476; letter from Mary H. Clayton to FTC, Exhibit III-6, at R. 2477; letter from Judy Eyer to FTC, Exhibit III-6, at R. 2478; list of names submitted by E. Floyd Gurley, Oklahoma Optical Supply Co., of patients charged an additional fee for release of their prescriptions, Exhibit III-6, at R. 2480-85; statement of Bernice Carter, Office of Consumer Protection, Baton Rouge, Louisiana, Exhibit V-86, at R. 11923.

42 See, e.g., article by Walter Johns, Jr., supra note 41, at 14043 (\$5-\$10); comment of Mr. & Mrs. William Bates, supra note 41, at 13162 (\$8); testimony of Jerry Burger, Tr. 1056 at 1098 (\$5); letter from Mary H. Clayton, supra note 41, at 2477 (\$6); letter from John Price to FTC, Exhibit III-6, at R. 2480 (\$10).

43 See, e.g., testimony of Norman G. Michaud, O.D., New Hampshire Optometric Association, Tr. 2789 at 2818.

44 See, e.g., A Task Analysis of the Dispensing Optician, HX 309, at pp. 24-25.

point to note about the imposition of "verification fees" does not lie in the propriety of verifying lenses or charging a fee for doing so. The "verification fees" which have been objected to are those imposed prior to the time the verification is performed. In some instances, it has been alleged that optometrists and ophthalmologists use this "verification fee" to dissuade patients from taking their prescriptions elsewhere.

3. Waivers of Liability

One practice occurring with increasing frequency involves the practice of conditioning the release of a consumer's prescription on the signing of a waiver of liability. There are many examples of such waiver forms found in the Record. In the most extreme case, the waiver form purports to relieve the examining optometrist not only from defects which are attributable to the practitioner who dispenses the eyeglasses, but also for the accuracy of the examination itself. An official of one large Florida chain of eyeglass dispensaries cited an example of such a waiver form:

We strongly believe optometric care can best be rendered when all services concerning visual care are originated and supervised through this office. We want our patients to fully understand that by taking this prescription to another optometrist, ophthalmologist, or optician for its completion, we are absolved of any responsibility for its correctness, effectiveness, value, or comfort. Further should any difficulties arise such as headaches, double vision, sight loss, et cetera all expenses and liabilities involved in reexamination, change in lens design, et cetera, will be the responsibility of the patient and the party who accepts the responsibility of filling this prescription.⁴⁵

45 Testimony of Donald Juhl, President, Jack Eckerd Corporation, Tr. 379 at 395. Another variation of this type of disclaimer states:

It is the policy in our office to provide the highest quality visual care available. We strongly believe that the best needs of the patient are met when all services are rendered under the direct supervision of the prescribing doctor, only he has the full knowledge of your visual needs. Should difficulty arise with any prescription filled in our office, we feel a responsibility to our patients to re-examine and

(Continued)

Prior to obtaining the prescription, the consumer was required to sign his name to the above disclaimer.⁴⁶ For purposes of this discussion, the enforceability of such a waiver is unimportant. The disclaimer has a significant impact on the consumer's decision whether to take his prescription elsewhere. Not only does the form attempt to disclaim responsibility for the examination for which the patient has paid, but it also makes a blatant attempt to frighten the consumer by raising the prospect of visual difficulty or even blindness if the prescription is taken elsewhere.

45 Continued

charge the prescription at no additional charge. It should be understood that by taking the prescription to another party for fabrication the patient is removing himself from the care and responsibility of the prescribing doctor. Should any difficulty arise (blurred vision, double vision, eye discomfort, headache, nausea, etc.) all expenses for professional services to re-evaluate, change lenses or frames, etc. must be considered the responsibility of the patient and/or the party filling the prescription.

I UNDERSTAND THE FULL IMPLICATIONS OF THIS RELEASE
AND ACCEPT THESE RESPONSIBILITIES AS STATED.

Patient's Signature

Optician's Signature

Statements submitted by Michael Zagorac, Jr., Vice President, Jack Eckerd Corporation, HX 198, Statement #2.

See also prescription signed by Lowell B. Zerbe, O.D., (Jan. 22, 1973), Exhibit II-63, at R. 1519; prescription of Paul Van Arsdall, O.D., Exhibit II-63, at R. 1520; rebuttal submission of Gaynell H. Owens, President, Certified Ophthalmic Dispensers of Kansas, Inc., Exhibit IX-175, at R. 17267.

46 Testimony of Donald Juhl, supra note 45, at 396.

A second type of disclaimer employed seeks only to waive responsibility for the accuracy of the eyeglasses themselves in the event the consumer chooses to obtain them elsewhere. Numerous examples of this type of disclaimer are found in the record.⁴⁷

It has been argued that forms such as this, which purport to disclaim only responsibility for the eyeglasses themselves, are employed to deceive consumers into believing that other, alternative dispensers, are not qualified to dispense the eyeglasses.⁴⁸

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- 47 Statements submitted by Michael Zagorac, Jr., supra note 45, statement #1. This form is not only used by individual practitioners, but also by some large optical chains. For example, Texas State Optical uses the following disclaimer:

We cannot be responsible for the accuracy or the quality of your glasses unless they are made by Texas State Optical.

Copies of prescriptions written by T. D. Little, O.D., HX 349. See also copies of prescriptions with the same disclaimer by Texas State Optical and M & M Optical Co., HX 344.

- 48 Testimony of E. Craig Fritz, supra note 40, at 2832. Mr. Fritz stated:

Too often, as president of the Connecticut Opticians Association, stories have been heard at Board meetings from our membership, that "doctor so-and-so," be he optometrist or ophthalmologist, frightened, cajoled or implied that he and he alone had the training and experience to assure his patient of proper fit and correct prescription. Nothing could be farther from the case. Likewise, opticians frequently are asked why optometrists require extra or additional charges when prescriptions are requested by their patients to be taken outside the optometrist's office, or why patients are refused their prescriptions entirely. Such situations are little better than those where an ophthalmologist or optometrist states to a patient that he is "not responsible for a prescription" once it leaves his office, leaving a clear impression that other dispensers are unqualified to serve the public. Id.

See also testimony of Robert C. Odom, supra note 19, at 4319; testimony of John H. Burns, Optician, Fort Worth, Texas, Tr. 5582 at 5584.

However, a number of optometrists voiced concerns which lend some legitimacy to the use of forms which disclaim only the accuracy of the ultimate product. First, some optometrists indicated that it was necessary to insure that the patient understands that the person dispensing the eyeglasses is responsible in the event that difficulties not associated with the examination occur.⁴⁹ Moreover, some optometrists stated a fear that they would be legally liable for the acts of the dispensing optician.⁵⁰ However, there appears to be no recorded instances in which an ophthalmologist or optometrist has been held liable for either the services or goods provided by an independent dispensing optician.

While the two preceding forms of waivers are the most prevalent, other notations are often placed on prescription forms in an effort to dissuade the consumer from shopping elsewhere. For example, the record contains some examples of prescriptions bearing notations concerning verification such as the following:

The above prescription must be returned to the doctor for verification or the prescription is null and void.⁵¹

In other instances, the prescription contains a statement indicating that the patient should return for verification.⁵² It appears that the use of disclaimers and waivers, such as those described above, is not unique to optometry. The record reflects that these practices have been used on occasion by dispensing ophthalmologists as well.⁵³

49 See, e.g., "Defensive Dispensing Outlined," AOA News (Feb. 1, 1977), at p. 14.

50 Id.; testimony of Chester Curry, Indiana Optometric Association, Tr. 993 at 1023.

51 See, e.g., testimony of Robert C. Odom, supra note 19, at 4319; prescription signed by Lowell B. Zerbe, O.D., supra note 45, at 1519.

52 See, e.g., testimony of Jessie C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3604.

53 See, e.g., testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5564.

D. Necessity for a Rule Requiring Release of Prescriptions

In part, the preceding discussions have touched on the issue of prevalence. However, in determining the extent to which consumers are being denied access to their prescriptions, an interesting dichotomy arises. Many optometrists,⁵⁴ optometric associations,⁵⁵ and ophthalmologists⁵⁶ have stated their belief that their patients are entitled to unconditionally obtain their prescriptions. Yet, the evidence reflects the fact that consumers are encountering considerable difficulty in obtaining their prescriptions, either because of additional fees, use of waiver forms, or outright refusals. In virtually every instance in which practicing optometrists were surveyed, it was found that in excess of 50% imposed some restriction on the availability of the patient's prescription. For example, the Certified Ophthalmic Dispensers of Kansas submitted one such survey:

54 See, e.g., testimony of B. J. Kabakoff, O.D., Massapequa, New York, Tr. 2671 at 2681; testimony of N. Robert Sandow, O.D., Sandow Opticians, Tr. 2725 at 2727; testimony of Herman Gould, O.D., Tr. 4749 at 4770; testimony of Bradford Sylvester, O.D., Austin, Texas, Tr. 5401 at 5430-34; testimony of Robert N. Kleinstein, O.D., M.P.H., Ph.D., School of Optometry, University of Alabama Medical Center, Tr. 6057 at 6094; testimony of Joseph Serian, O.D., supra note 27, at 277.

55 See, e.g., testimony of Bernard A. Morewitz, O.D., President, Virginia Optometric Association, Tr. 160 at 177; testimony of Glen J. Shanahan, Counsel, Kansas Optometric Association, Tr. 4237 at 4270-71; testimony of Jesse Johnson, O.D., supra note 13, at 5630-31; testimony of Jack Bridwell, O.D., President, Texas Optometric Association, Tr. 5212 at 5229; testimony of Norman G. Michaud, O.D., supra note 43, at 2818; testimony of Roy Ebihara, O.D., Lorain County Optometric Society, Tr. 1235 at 1243-44; objection of the Wyoming Optometric Association, HX 252, at p. 7.

56 See, e.g., testimony of David Volk, M.D., Ophthalmologist, Tr. 1133 at 1137. See also testimony of Robert C. Odom, supra note 19, at 4325. Mr. Odom quotes from an American Medical Association Judicial Council Opinion that states:

"A patient is entitled to a copy of his or her prescription for glasses, drugs or appliances and he has the privilege of having the prescription filled wherever he wishes." Id.

Of thirteen optometrists surveyed in Topeka, six charge the patient from \$5.00 to \$12.50 extra for a written copy of his prescription. Two stated they do make a charge but would not quote a price; one stated positively he would not give a written prescription, and three stated there was no extra charge.⁵⁷

As was previously mentioned, two different surveys of optometrists in Mississippi found that the majority of consumers were unable to obtain their prescriptions without paying an additional fee or signing a waiver form.⁵⁸ One survey which included both ophthalmologists and optometrists, indicated that consumers encounter fewer difficulties in obtaining prescriptions from ophthalmologists.⁵⁹ However, one witness testified that dispensing ophthalmologists, particularly those who dispense contact lenses, are withholding prescriptions on a massive scale. The Vice President of the Northern Virginia Optician's Association testified:

Five years ago in Northern Virginia, most opticians filled the ophthalmologists' prescriptions for contact lenses. Today, opticians have been put out of the contact lens business by the ophthalmologists refusing to examine

57 Rebuttal submission of Gaynell H. Owens, President, Certified Ophthalmic Dispensers of Kansas, Inc., Exhibit IX-175, at R. 17266, 17271.

58 Testimony of Phoebe T. Harris, Ph.D., supra note 27, at 6221. In a survey of 23 optometrists, five refused outright to release prescriptions, six charged additional fees, and eight would release the prescription only if the patient insisted, or if the patient signed a waiver form. Only four of the 23 released the prescription as a matter of course. Id. In a second study by Dr. R. Burr Porter, associate professor of finance at Southern Methodist University, entitled The Price of Ophthalmic Goods and Services, Comparison, Mississippi and New York, out of 12 optometrists surveyed, three charged additional fees for release of the prescription, one required the signing of a waiver form, and four refused to release prescriptions. Statement of R. Burr Porter, Ph.D., supra note 39, at 18.

59 Testimony of Phoebe T. Harris, Ph.D., supra note 27, at 6222. Of 26 ophthalmologists surveyed, all released the prescription without charge, although in two instances some difficulty in the form of pressure was encountered.

the patients and allowing them to purchase their contact lenses as provided by the State Board of Opticians of Virginia.⁶⁰

Opticians and their associations from numerous states testified that their patients were encountering significant difficulties in obtaining prescriptions.⁶¹ In addition, numerous state officials⁶² and individual consumers⁶³ related experiences substantiating that finding. The evidence on the record supports the conclusion that consumers are being deterred from selecting the dispenser of their choice because of their inability to obtain their prescriptions.

60 Testimony of Billie J. Odom, supra note 40, at 63.

61 See, e.g., Id., at 61 (Va.); testimony of Donald Juhl, supra note 41, at 394 (Fla.); testimony of James J. Ryan, supra note 30, at 2380-81 (N.Y.); testimony of Robert Hart, Sr., supra note 32, at 2447 (N.J.); testimony of Ralph J. Rubinoff, supra note 40, at 2538 (Mass.); testimony of Stephen LaVerdiere, supra note 27, at 2579 (Maine); testimony of E. Craig Fritz, supra note 40, at 2832 (Conn.); testimony of Doug Matthews, supra note 27, at 4973; testimony of Lee Starr, supra note 27, at 4423 (Okla.); testimony of Berry C. Lofland, supra note 27, at 5513; testimony of E. Logan Goar, supra note 53, at 5564; testimony of John H. Burns, supra note 48, at 5584 (Texas); testimony of Stephen Lee Adams, supra note 40, at 6045 (Tenn.); testimony of Kenneth R. Davenport, supra note 27, at 6188 (S.C.). See also testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4319.

62 See, e.g., testimony of Douglas Hurdelbrink, supra note 41, at 6255; testimony of Charles W. Tapp, supra note 41, at 4227; testimony of Virginia Long, supra note 27, at 1861; testimony of Elinor Guggenheimer, supra note 27, at 1974-75; Minutes of Meeting of the Arkansas Consumer Advisory Board (Dec. 5, 1975); Exhibit IV-134, at R. 5785.

63 Testimony of Kent Wilcox, supra note 41, at 976; testimony of Walter Johns, Jr., supra note 27, at 1612; testimony of John Collins, supra note 41, at 2439; testimony of Elena Hangii, supra note 27, at 4634; testimony of Phoebe T. Harris, Ph.D., supra note 27, at 6221-22; comment of Leonard Kleist, Exhibit VII-65, at R. 12739; comment of Mrs. M. L. White, supra note 41, at 12817; comment of Mrs. Rozell Grey, supra note 27, at 12850; comment of Sheila Vanlue, supra note 41, at 12972-75; comment of Miles J. Murphy, supra note 41, at 13048; comment of Mr. & Mrs. William Bates,

(Continued)

An issue which received considerable attention throughout this proceeding concerned the ophthalmic prescription itself: what exactly constitutes a prescription? The varying views of the three affected professions as to what elements are necessary in an ophthalmic prescription appear to be predicated on each profession's assessment of the functions and services it is qualified to perform.

In an earlier discussion, we noted that optometry generally adheres to the concept of total vision care.⁶⁴ In this view of the delivery of eye care, the optometrist performs all services and provides all necessary products from the initial eye examination through the dispensing of the eyeglasses. Consistent with this view, a number of optometrists testified that an ophthalmic prescription must contain all of the elements necessary for the laboratory to prepare the final product. For example, a spokesman for the Indiana Optometric Association offered this definition of an ophthalmic prescription:

A prescription, as noted above, is a work order with which an ophthalmic laboratory can produce a unique pair of glasses. Included in this work order are spherical and cylindrical components, cylinder axis, amount and direction of prism, decentration of optical centers of each lens, the individual's pupillary measurement at distance and near, the design and characteristics of the multifocal lenses with its centering, height and sag drop, the lens manufacturer and which quality this manufacturer shall utilize, the type and degree

63 Continued)

supra note 41, at 13162; article by Walter Johns, Jr., supra note 41, at 14043; Complaint and related documents in Arkansas Community Organizations for Reform Now, et al. v. Arkansas State Board of Optometry, Arkansas Optometric Association, et al., U.S. District Court, Eastern District of Arkansas, Western Division, with ACORN Comparison Price Survey of Optometric Goods and Services, Exhibit IV-91, at R. 4983; Delia Schletter, Optical Illusion, supra note 41, at 1620; unsigned letters from consumers, supra note 41, at 2470, 2472, 2473; letter from Mrs. James H. Robertson, supra note 41, at 2476; letter from Mary H. Clayton, supra note 41, at 2477; letter from Judy Eyer, supra note 41, at 2478.

64 See subsection (B), supra.

of light absorption, the kind of tempering that the lens should have, the manufacturer and the name of the frame chosen to hold the lenses, the color of the frame, the eyewire size, the kind of temples to be used, and the size of the temples.⁶⁵

This view of the ophthalmic prescription appears to have achieved favor among some optometric educators. For example, an instructor at The Ohio State University College of Optometry offered this view of a "prescription":

[W]hat I could describe as a complete prescription involving not only the lens formula but involving specific curvatures and thicknesses and so forth is promulgated very strongly by the college of optometry to its students

In other words, they do not write out just a power formula. They write out the complete design for those lenses, which is then forwarded to the laboratory, and the laboratory must fabricate those lenses on that basis.⁶⁶

Many of the items specified in the above definitions of the ophthalmic prescription are elements normally associated with the dispensing of eyeglasses as opposed to the eye examination itself.⁶⁷ For example, opticians claim that members of their profession are qualified to perform the measurements necessary to determine pupillary distance, lens design, segment characteristics in multifocal lenses, and vertex (i.e. distance between the lenses and the eye).⁶⁸ In addition, frame selection and other information specified in the IOA "prescription" are also tasks typically performed by dispensing opticians.⁶⁹ Thus, the definition of the term "prescription" proffered by many optometrists, such as the IOA testimony, does not distinguish between the information gathered in the examination process and the dispensing process.

65 Testimony of Chester Curry, O.D., supra note 13, at 1022.

66 Testimony of Marvin H. Whitman, O.D., Tr. 1518 at 1522-23.

67 See, e.g., A Task Analysis of the Dispensing Optician, prepared for OAA, HX 309. Many of the factors specified in this "prescription" are cited as tasks of the dispensing optician. Id.

68 Id. at pp. 7-12.

69 A Task Analysis of the Dispensing Optician, supra note 67.

The views of those practitioners who do not engage in the dispensing of eyeglasses reflect a distinctly different view of what elements are necessarily included within the prescription. For example, a faculty member at one optometric school was asked whether most ophthalmologists specify the complete design for the glasses in their prescriptions:

Q. Do you have an opinion as to what percentage of ophthalmologists in Ohio follow this definition?

A. I have an opinion. From my experience in the few prescriptions that I have seen from ophthalmologists, in my own office, a very small percentage of ophthalmologists do this. I generally find only a formula.

In many cases, the formula is there alone without even such an item as a pupillary distance measurement, leaving the discretion of fulfilling that prescription very, very wide open to the dispenser.⁷⁰

The issue of the qualifications of opticianry vis-a-vis optometry and ophthalmology to dispense eyeglasses has been previously discussed.⁷¹ It is important to note here, however, that a comparatively nominal amount of an optometrist's training is devoted to the functions associated with dispensing.⁷² On the other hand, opticians are unlicensed in 31 states, so that anyone, regardless of training can hold himself out as an optician in those states.⁷³ As was noted earlier, opticianry claims that it is qualified to determine vertex, decentration, pupillary distance, segment characteristics, and lens design.⁷⁴ In contrast, some optometrists expressed their belief that these functions should be performed by the examining practitioner.⁷⁵

70 Testimony of Marvin H. Whitman, supra note 66, at 1523.

71 See Section I(C)(4), supra.

72 See, e.g., testimony of Chester H. Pheiffer, supra note 41, at 5281. Dr. Pheiffer testified that only four out of 130 hours in his school's curriculum concern dispensing.

73 See Section I(C)(3), supra.

74 A Task Analysis of the Dispensing Optician, supra note 67.

75 See, e.g., testimony of Ron G. Fair, supra note 32, at 4747.

For purposes of this discussion, however, two distinct questions arise. First, in light of the controversy surrounding the qualifications possessed by opticians, should the Federal Trade Commission adopt a requirement that would facilitate competition by opticians? Secondly, what elements should be included in the prescription if it is to be released?

The evidence indicates that opticians are qualified to engage in those functions associated with the dispensing of eye-glasses. Numerous optometrists, ophthalmologists, and opticians testified to that effect.⁷⁶ The traditional practice of ophthalmology of specifying only the lens formula and deferring to the optician to perform the remaining functions⁷⁷ is perhaps the best evidence of the qualifications of opticianry as a profession. However, it is staff's belief that the applicable state law is dispositive of this question. The provision recommended by the staff⁷⁸ would not alter or change state law determining those persons who shall be permitted to dispense ophthalmic materials. Thus, the permissible activities of opticianry would continue to be controlled by the laws in effect in the states.

76 See, e.g., testimony of Robert C. Troast, supra note 27, at 2012; testimony of Robert C. Odom, supra note 19, at 4312-15; testimony of Doug Matthews, supra note 27, at 4465; testimony of Billie J. Odom, supra note 40, at 66; testimony of Frank W. Newell, M.D., Chairman, Department of Ophthalmology, University of Chicago, Tr. 1167 at 1205; testimony of David Volk, supra note 56, at 1139; testimony of Earl Hendrix, Hendrix & McGuire Dispensing Opticians, Tr. 3995 at 3999; testimony of Donald Juhl, supra note 41, at 397-98; statement of L. Murray Doody, Jr., counsel, Society of Dispensing Opticians, Inc., of New York State, Guild of Prescription Opticians of New York State, Inc., & Contact Lens Society of New York State, Inc., HX 225, at p. 1; statement of George Tracewell, California Association of Dispensing Opticians, HX 286, p. 3; comment of Reginald L. LaVerdiere, President, LaVerdiere's Super Drug Stores, Exhibit VII-188, at R. 12879; letter from E. H. Blankenship, President, Virginia Society of Prescription Opticians, Inc., to Roanoke Academy of Medicine (Nov. 25, 1974), Exhibit IV-115, at R. 5473.

77 Supra at note 70.

78 See § 456.4 of the recommended Rule, Section X, infra.

The second question concerning the contents of the prescription itself should be dealt with in much the same manner. In certain states, such as Idaho, state law stipulates what elements must be contained in an ophthalmic prescription.⁷⁹ In most states, however, no requirements are established for the content of such a prescription, except that it be signed by the examining ophthalmologist or optometrist.⁸⁰ At a minimum, an ophthalmic prescription must contain the lens formula⁸¹ and be signed by the examining ophthalmologist or optometrist.⁸²

E. Basis for Staff Recommendation

Based on the evidence in the record, which was discussed above, it is the staff's recommendation that the Commission promulgate a rule provision insuring consumers unconditional access to their ophthalmic prescriptions. Staff predicates its recommendations on two bases:

- (1) Unconditional access to ophthalmic prescriptions is necessary to effectively implement the right to engage in truthful advertising and to use the information provided by that advertising.
- (2) The refusal to release prescriptions, or conditioning the release of prescriptions, constitutes an unfair act or practice.

In many respects, these two bases are not totally independent. In part, both involve a denial of the ability to comparison shop to consumers. However, in terms of the Commission's rulemaking authority they are distinct, independent bases for Commission action.

1. Unconditional Access to Ophthalmic Prescriptions Is Necessary to Effectively Implement the Right to Engage in Truthful Advertising

78 See § 456.4 of the recommended Rule, Section X, infra.

79 See note 137, infra.

80 See, e.g., testimony of Robert C. Troast, supra note 27, at 2021; testimony of Robert C. Odom, supra note 19, at 4319.

81 See § 456.1(g) of the recommended Rule, Section X, infra.

82 Id.

In recommending that the Commission preempt state laws and regulations which prohibit truthful advertising, the staff concluded that the nondissemination of material information concerning ophthalmic goods and services in conformance with state law, was in violation of the unfairness standard of Section 5 of the Federal Trade Commission Act. Pursuant to the Magnuson-Moss--FTC Improvements Act,⁸³ it is clear that the Commission possesses the legal authority to promulgate rules which include requirements designed to prevent practices which violate Section 5.⁸⁴

To effectively implement the right to engage in truthful advertising as well as the right of consumers to utilize this information, it is necessary that consumers have unconditional access to their ophthalmic prescriptions. The relationship between the availability of the prescription and advertising is succinctly stated in the following testimony:

Needless to say, an advertising law would be useless and futile if the patient were not allowed to have his prescription so that with the prescription in hand and the knowledge of what was available to him he could make a better selection.

Presently, in Oklahoma, optometrists examine 75% of all the eyes examined and it's difficult, if not impossible, to get your prescription from an optometrist in Oklahoma. This, along with the restraint of advertising provides a very effective way of controlling the market.⁸⁵

There are two separate components to this argument. First, if consumers do not have the ability to obtain their prescriptions, they will not be able to make use of the increase in information in the market which will be generated by advertising. Numerous persons testified throughout this proceeding that

83 15 U.S.C. § 2301 (1975).

84 Id. Section 202(a) of the Act amended the Commission's authority. It states:

The Commission may prescribe . . . (B) rules which define with specificity acts or practices which are unfair or deceptive acts or practices in or affecting commerce. Rules under this subparagraph may include requirements prescribed for the purpose of preventing such acts or practices. (Emphasis added.)

85 Testimony of Doug Matthews, supra note 27, at 4461-62.

guaranteeing consumers access to their prescriptions would greatly facilitate comparison shopping.⁸⁶ With prescription in hand, consumers would be free to seek out the price, quality, and other features which best suit their needs and capabilities. In this regard, the President of the Opticians Association of America stated:

By providing the eye wear customer with a choice, opticians furnish the competitive factors in the delivery system which are in the best interests of the public.

However, in order to capitalize on this competitive factor for the benefit of the public, it is necessary for the customer to have a copy of the prescription which gives him the right and

⁶ See, e.g., testimony of William Bloss, North Carolina Public Interest Research Group, Tr. 124 at 131; testimony of John Collins, Chairman, Health Care Task Force, North Jersey Federation of Senior Citizens, Tr. 2430 at 2433; testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1975; testimony of Terrance J. Hamilton, Counsel, Massachusetts Consumer's Council, Tr. 2625 at 2637; testimony of Earl Hendrix, Hendrix & McGuire Dispensing Opticians, Tr. 3995 at 3997; testimony of Donald Juhl, President, Jack Eckerd Corporation, Tr. 379 at 386; testimony of Michael Magura, Ph.D., Professor of Economics, University of Toledo, Tr. 1261 at 1264; testimony of Billie J. Odom, Vice President, Opticians Association of Northern Virginia, Tr. 55 at 62; testimony of Seymour Pollack, New Jersey optician, Tr. 2307 at 2313; testimony of Donald on Aging, DHEW, Tr. 111 at 116; testimony of Eric Reisfeld, Maryland Citizens' Consumer Council, Tr. 284 at 285; testimony of Stanley Roberts, optician, Tr. 5839 at 5839; testimony of Ralph J. Rubinoff, Executive Director, Massachusetts Association of Registered Dispensing Opticians, Tr. 2532 at 2535; testimony of Kent Wilcox, Deputy Director, Michigan Consumers' Council, Tr. 973 at 976; testimony of Glenn R. Workman, Legislative Research Project for Ohio's Elderly, Tr. 1209 at 1211; comment of Nancy Chasen, Consumers Union, Exhibit VII-1007, at R. 14014; letter from Kenneth C. Collinson, Jr., Kenco Optics, Inc., to FTC, Exhibit IV-123, at R. 5674; letter from J. A. Miller, Executive Director, Opticians Association of America, to FTC, Exhibit IV-55, at R. 2912; statement of George Tracewell, California Association of Dispensing Opticians, HX 286, at p. 3.

ability to select the eye wear of his choice based on his personal requirements. Without a copy of this prescription, this advantage is lost.⁸⁷

Secondly, if consumers cannot easily obtain their prescriptions there is little or no incentive for dispensers to engage in advertising. The market shares of the three groups of practitioners are vitally important in this regard. As we previously noted, only ophthalmologists and optometrists are qualified to perform eye examinations.⁸⁸ Thus, from the vantage point of the dispensing optician, the market is limited to those persons who are examined by nondispensing refractionists and those who are able to obtain their prescriptions from refractionists who do dispense. If all ophthalmologists and optometrists dispensed their own eyeglasses, opticians could effectively be driven from the market. Staff is not suggesting ophthalmology and optometry as professions, or even that the majority of their members would strive to accomplish such a result. However, the record does contain instances of opticians being driven from the market because of their inability to obtain customers' prescriptions.⁸⁹

A representative of a Tennessee Optician's Association testified concerning the relationship between the release of the prescription and the utility of advertising:

Without that requirement, advertising would be ridiculous. What would it accomplish if the drug stores advertised drugs if the doctors refused to allow their patients the right to take their prescriptions to the druggist?

Without this requirement the consumer will continue to be entrapped and at the mercy of the optometrist or ophthalmologist and would be tantamount to all doctors refusing patients the right to frequent drug stores while selling drugs themselves. The consumer's interest will suffer

87 Testimony of Michael Zagorac, Vice President, Jack Eckerd Corporation, Tr. 379 at 413.

88 See Section I(C), supra.

89 See, e.g., testimony of Edward Crittenden, supra note 27, at 6045; testimony of Lee Starr, supra note 27, at 4419. See also testimony of Stephen LaVerdiere, supra note 27, at 2579.

immensurably if this requirement is not incorporated into the rules, and if it is not done, nothing else can be accomplished with advertising or otherwise.⁹⁰

It is a well-settled fact that dispensing ophthalmologists, dispensing optometrists, and opticians, are competitors for the dispensing market.⁹¹ If the Commission does not act to guarantee consumers their prescriptions, consumers may be unable to take full advantage of this competition. Particularly in smaller communities, where the number of optometrists and ophthalmologists may be limited, such practitioners could easily defeat the intent of the advertising provisions of the rule by simply refusing to release prescriptions.

Thus, it is staff's belief that in view of the economic realities of the ophthalmic market, adoption of a rule mandating the release of prescriptions is imperative if the full potential of increased information is to be achieved.

2. The Refusal to Release Prescriptions, or Conditioning the Release of Prescriptions, Constitutes an Unfair Act or Practice

Many of the factors cited above are also the basis on which staff concludes that the refusal to release prescriptions, or the conditioning of the release of prescriptions, are unfair acts or practices in violation of Section 5 of the Federal Trade Commission Act.

In our discussion of Section 5 unfairness with respect to the restrictions on advertising, we noted that the Commission measures unfairness against a three-part standard:

(1) whether the practice, without necessarily having been previously considered unlawful, offends public policy as it has been established by statutes, the common law, or otherwise--whether, in other words, it is within at least the penumbra of some common law, statutory, or other established concept of unfairness; (2) whether it is immoral, unethical, oppressive, or unscrupulous; (3) whether it causes substantial injury to consumers (or competitors or other businessmen). If all three factors

⁹⁰ Testimony of Stephen Lee Adams, supra note 40, at 6039.

⁹¹ See, e.g., Southern Research Institute, The Advertising of Ophthalmic Goods and Services: An Economic and Statistical Review of Selected FTC and Related Documents: Report to the American Optometric Association, Project 3692 (June 25, 1976), HX 356, at p. 4.

are present, the challenged conduct will surely violate Section 5 even if there is no specific precedent for proscribing it.⁹²

Our discussion in the preceding section contained a more complete analysis of the Commission's authority with respect to Section 5 "unfairness."⁹³ Applying this test to the practice of refusing to release prescriptions, or conditioning the release of prescriptions, leads staff to conclude that a violation of Section 5 exists.

Before discussing each of the three parts of the unfairness test, the effect of the availability of prescriptions should be noted. The most pervasive impact lies in the diminished ability of opticianry to compete.⁹⁴ As competitors of other dispensing practitioners, opticians are competitively injured through the creation of an artificially restricted market. Not only are opticians unable to compete for the patronage of every potential eyeglass customer, but the consumer as well is restricted in his purchase alternatives.⁹⁵ As was noted above, some opticians have been forced out of business because of their inability to obtain prescriptions. For example, a representative of one state optician association testified that he had "seen businesses literally fold and go into bankruptcy because doctors have ceased to release their prescriptions."⁹⁶ As the record reflects, this has happened on more than one occasion.⁹⁷

Thus, there is little doubt that opticianry is suffering competitive injury as a result of these practices. As we indicated earlier, conditioning the release of prescriptions through

92 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. 8355 (1964). See Section VI, at note 10, supra.

93 See Section VI(A), supra.

94 See, e.g., testimony of Robert C. Odom, supra note 19, at 4319.

95 As opticians cannot dispense without a prescription, a patient who does not have his prescription cannot patronize an opticianry.

96 Testimony of Edward E. Crittenden, supra note 27, at 6015-B.

97 See, e.g., testimony of Lee Starr, supra note 27, at 4419.

the charging of an additional fee, or requiring that a waiver form be signed, operate to achieve the same end--that the consumer not take his prescription elsewhere.⁹⁸

From the perspective of the consumer, significant injury is occurring as well. The ophthalmic prescription is the means by which consumers can comparison shop.⁹⁹ In our discussion of the economic impact of advertising restrictions, we noted that wide variations in eyeglass prices exist within the market.¹⁰⁰ Without the ability to unconditionally obtain their prescriptions, consumers are unable to utilize the information which does exist to seek out the mixture of quality and price which best satisfies their needs.¹⁰¹

Thus, it is staff's conclusion that the refusal to release ophthalmic prescriptions,¹⁰² and the various methods by which the release of prescriptions is conditioned,¹⁰³ result in substantial injury to consumers and to the competitors of dispensing ophthalmologists and optometrists.

Applying the Commission's unfairness standard to these practices leads the staff to the conclusion that they violate the Section 5 unfairness standard. In our previous discussion

⁹⁸ See subsection (C), supra.

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⁹⁹ See, e.g., testimony of Terrance J. Hamilton, Counsel, Massachusetts Consumers' Council, Tr. 2625 at 2637; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1861-62; testimony of Paul E. Alony, owner of six optical stores in Western Massachusetts, Tr. 2544 at 2547-48; testimony of Melanie Scheller, North Carolina Public Interest Research Group, Tr. 129 at 130.

¹⁰⁰ See Section III(A), supra.

¹⁰¹ See, e.g., testimony of Elinor Guggenheimer, Commissioner, New York City Department of Consumer Affairs, Tr. 1963 at 1974-75:

I believe that signed, written prescriptions should be available routinely, whether or not the consumer makes an explicit request for them. Clearly, the practice of refusing to give such prescriptions hinders the consumer's ability to shop for price and quality in ophthalmic goods.

¹⁰² See subsection (C)(1), supra.

¹⁰³ See subsections (C)(1) and (2), supra.

of unfairness¹⁰⁴ we noted that not all three of these standards need be met to establish unfairness.¹⁰⁵ However, in this instance, there is little difficulty in satisfying each of the three.

There can be little doubt that the aforementioned practices concerning the release of prescriptions fall within the "penumbra of some common law, statutory, or other established concept of unfairness." Competition, particularly price competition, is a basic national policy as reflected in numerous laws and other sources.¹⁰⁶ In addition, the practices offend the frequently expressed public policy in favor of comparison shopping through the provision of the necessary information and tools to make such comparisons meaningful.¹⁰⁷ Accordingly, staff must conclude that the refusal to release prescriptions and other associated practices offend clearly established public policy.

Similarly, there is little doubt that these restrictive practices are "unethical, oppressive or unscrupulous." Indeed, even within the professions of ophthalmology and optometry leading spokesmen testified that the consumer has a right to his prescription. Such is embodied in the official positions of the American Medical Association¹⁰⁸ and others.¹⁰⁹ Finally, the requirement that the practice cause substantial injury is clearly satisfied. We noted above the adverse impact on both consumers and competitors arising out of the refusal to release prescriptions and related practices.¹¹⁰

Thus, it is staff's conclusion that the refusal to release ophthalmic prescriptions, and the conditioning of the release of prescriptions is violative of Section 5 of the FTC Act.

104 See Section VI, supra.

105 Id. at note 11.

106 Id. at notes 29-32.

107 Id. at notes 28-31.

108 See, e.g., testimony of J. A. Miller, Executive Director, Opticians Association of America, Tr. 4312 at 4325.

109 See, e.g., testimony of Bernard A. Morewitz, President, Virginia Optometric Association, Tr. 160 at 173; testimony of Glen J. Shanahan, Counsel, Kansas Optometric Association, Tr. 4237 at 4270-71.

110 See subsection (C), supra.

In addition to the preceding discussions of the general importance of promulgating a prescription delivery requirement, it is necessary to explain the basis for the particular provisions recommended by the staff. A number of specific arguments in opposition to a requirement mandating release of prescriptions as well as arguments advocating a Rule stronger than that recommended by the staff will be addressed.

The most basic issue involves the recommended Rule's requirement that the prescription must be delivered to the patient regardless of whether the patient has requested it.¹¹¹ The record clearly shows that many ethical practitioners already permit their patients access to their prescriptions upon request by the patient.¹¹² However, the major difficulty with adopting a provision which would only require release of the prescription upon request is the consumers' lack of awareness that the purchase of eyeglasses need not necessarily be a unitary process. As was previously noted in some detail, optometry adheres to the concept of "total vision care."¹¹³ This principle involves the examining optometrist also being the person who dispenses the

111 See § 456.4(a) of the recommended Rule, Section X, infra.

112 See, e.g., testimony of Sylvester Bradford, O.D., Tr. 5401 at 5431; testimony of Jack Bridwell, O.D., President, Texas Optometric Association, Tr. 5212 at 5229; testimony of Roy Ebihara, O.D., Lorain County Optometric Society, Tr. 1235 at 1243; testimony of Herman Gould, O.D., Tr. 4749 at 4770; testimony of Phoebe T. Harris, Ph.D., Consumer Economics and Home Management, Mississippi State University, Tr. 6210 at 6210; testimony of Jesse Johnson, Jr., O.D., Vice President, Board of Examiners in Optometry of Oklahoma, Tr. 5607 at 5608; testimony of B. J. Kabakoff, O.D., Tr. 2671 at 2681; testimony of Robert N. Kleinstein, O.D., M.P.H., Ph.D., School of Optometry, University of Alabama Medical Center, Tr. 6057 at 6094; testimony of Adam Kenneth Levin, Director of Special Projects, New Jersey Division of Consumer Affairs, Tr. 1905 at 1927; testimony of Norman C. Michaud, O.D., New Hampshire Optometric Association, Tr. 2789 at 2817; testimony of Bernard A. Morewitz, O.D., President, Virginia Optometric Association, Tr. 160 at 173; testimony of David Volk, M.D., Tr. 1133 at 1137; testimony of Stanley A. Anderson, O.D., Oregon Committee of Concerned Optometrists, Tr. 3192 at 3207; statement of John R. Smyth, Attorney for the Wyoming Optometric Association, HX 252, at p. 7.

113 See notes 9-20 and accompanying text, supra.

necessary ophthalmic goods. As a result of this practice, consumers do not clearly differentiate between the process of examination and the process of dispensing.

The clearest evidence of the phenomenon is found in a survey conducted by California Citizen Action Group.¹¹⁴ In that study CCAG concluded:

Sizeable numbers [of consumers] do not differentiate between the process of an eye exam and filling the prescription. We knew from the groups that many people 'go to my doctor to get my glasses,' not for an exam and a prescription as in the case of, for example, general practice in medicine.¹¹⁵

The survey data clearly support this conclusion. For example, when asked why they purchased their glasses from the same persons who examined their eyes over 44% responded that they had never thought about going somewhere else.¹¹⁶ Almost 20% did not know that they could go somewhere else.¹¹⁷

Aside from these considerations, two additional factors make affirmative release of the prescription necessary. First, almost 50% of those surveyed by CCAG did not receive a prescription from their "eye doctor" when that person also dispensed eyeglasses.¹¹⁸ In almost 40% of the cases, the consumer was simply billed for the entire cost of the exam and the eyeglasses,¹¹⁹ without being made aware of the breakdown between examination and dispensing.

All of these factors demonstrate the pervasiveness of the problem of consumers' lack of awareness. Staff does not take the position that the concept of "total vision care" is improper. If the consumer desires to obtain both his examination and his eyeglasses from the same source, the consumer is free to make this decision. However, because consumers have been deprived of adequate information concerning their eyeglass purchases, they

114 Outline of testimony of Paul A. Fine, California Citizen Action Group, HX 276.

115 Id. at 10.

116 Fine computer printout and definitions, HX 280, table 29.

117 Id.

118 Id., table 92.

119 Id., table 93.

harbor numerous misconceptions about the delivery of eye care.¹²⁰ From a policy perspective, the most effective way to educate the consumer about his purchase alternatives is to put into the consumer's hands the vehicle by which he can exercise those alternatives, the prescription.

By requiring the release of the prescription in every case the public will have a clear, absolute right to their prescriptions. That right would be readily enforceable by the Commission. In the event that compliance investigations are necessary, the only issue to be ascertained would be whether the prescription was delivered to the consumer. The right of the consumer to his prescription would be rendered immune from evidentiary squabbles as to whether a consumer actually requested 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 case.

At the present time, some state laws require refractionists to release prescriptions upon request if the patient has paid all of the necessary examination fees.¹²¹ It has been argued that refractionists should be able to condition release of the prescription on the patient's fulfillment of all financial obligations.¹²² In part, staff has attempted to accommodate this concern. The provision recommended by the staff would allow refractionists to condition the release of the prescription on the satisfaction of the patient's financial obligations, but only when a similar requirement is imposed on all persons who are examined by the refractionist but do not purchase eyeglasses from the refractionist.¹²³ Thus, the Rule would require that refractionists not discriminate in their payment policy between persons

¹²⁰ See Section IV(B), supra.

¹²¹ For example, Rule 21 of the Rules of the Delaware State Board of Examiners in Optometry (revised 1974), states:

It shall be the obligation of a registered optometrist in the State of Delaware to tender to a patient his complete prescription and ophthalmic or contact lens specification upon request from the patient if all financial obligations to the Doctor have been satisfied.

¹²² See, e.g., testimony of J. Howard Sturman, Academy of California Optometrists, Tr. 3348 at 3366.

¹²³ See § 456.4(a) of the recommended Rule, Section X, infra.

who wish to take their prescription elsewhere and those persons whose examinations reveal that do not require eyeglasses. In both cases the refractionist has performed all of the services for the patient that he will perform. Thus, in terms of the refractionist's ability to collect outstanding indebtedness, the two groups occupy the same position. Staff concludes that any attempt to require payment in full from patients desiring to purchase their ophthalmic goods elsewhere, while not at the same time requiring payment from all others similarly situated, constitutes an attempt to deter the patient from shopping elsewhere. Accordingly, under the provision recommended by the staff, all practitioners would be free to establish the payment policy and credit terms they choose; but they cannot discriminate against those who wish to avail themselves of the benefits of comparison shopping.

Under the rule provision recommended by the staff, it would be an unfair act or practice to impose additional charges on a patient who desires to take his prescription to another seller or provider of ophthalmic goods.¹²⁴ Earlier we noted that numerous practitioners add a surcharge to their customary examination fees for patients who request copies of their prescriptions, in an attempt to dissuade the consumer from purchasing his eyeglasses elsewhere.¹²⁵ It appears that the fee charged for releasing the prescription usually falls into the \$5 to \$10 range.¹²⁶ Standing alone, these fees may not seem particularly onerous. However, in the context of the eyeglass purchase, they are indeed significant. First, the additional fee being charged is not compensation for services actually performed by the refractionist. The examination fee fully compensates the practitioner for all services rendered. Staff concludes that the intent behind the imposition of additional fees of this nature is to provide the refractionist with a form of compensation for "lost opportunity." That is, the additional fee partially recoups the income lost by the practitioner because he was not able to dispense the ophthalmic goods:

One of the frequent causes of complaints is the request by the patient for a copy of his prescription. The patient's position is that since he has been charged for the examination, he is entitled to the records of the results thereof, and whether he procures his glasses from the examining optometrist or someone else is irrelevant. The optometrist's position, although rarely articulated, is

124 Id. at § 456.4(c).

125 See notes 38-44 and accompanying text, supra.

126 Supra note 42.

that he really expects to receive some of his financial benefits from the dispensing of the glasses and if the patient goes to someone else, he is being underpaid.¹²⁷

Secondly, additional fees for release of the prescription are a significant deterrent to effective comparison shopping. If the eyeglasses the consumer ultimately purchases from a source other than the refractionist cost \$50 to \$100, the prescription surcharge of \$5 to \$10 represents as much as a 20% increase in the total cost to the consumer. Permitting refractionists to exact this fee from their patients would effectively negate the price savings which might arise from increased information. Many consumers simply may be unwilling to pay such a surcharge merely to obtain the ability to comparison shop.

Finally, any Rule provision which did not prevent the imposition of such additional fees could easily be circumvented by refractionists who were so inclined. By simply imposing a sufficiently large additional fee for releasing the prescription refractionists could effectively deny consumers meaningful access to their prescriptions. Particularly in those communities in which there are a limited number of refractionists, the imposition of a surcharge could effectively prevent consumers from price shopping by limiting their alternatives for obtaining the prescription.

One very significant problem concerns the relationship between the contents of the ophthalmic prescription and the prescription surcharge. Though not specifically raised by the industry during these proceedings, staff would state the issue as follows:

Where state law requires that ophthalmic prescriptions contain information normally determined during the dispensing process, should the refractionist be permitted to impose an additional charge for performing the services necessary to determine the additional information?

As we noted in our previous discussion of the contents of the ophthalmic prescription,¹²⁸ the professions of optometry and

127 Seymour L. Coblens, B.S.S., M.A., J.D., Adjunct Professor of Optometric Jurisprudence at Southern California College of Optometry, Optometry and the Law, St. Louis, Missouri: American Optometric Association (1976), at p. 66.

128 Supra notes 64-81 and accompanying text.

ophthalmology seem to vary considerably in their positions as to what information must be included within the prescription. Ophthalmologists and nondispensing optometrists seem to include only the refractive power, axis, and prism within the prescription.¹²⁹ On the other hand, dispensing optometrists perceive the prescription as a laboratory work order¹³⁰ containing all of the information necessary to order the final product. Indeed, it appears that some optometric schools instruct their students to prepare the prescription as though it were a laboratory work order.¹³¹ This view of the ophthalmic prescription is consistent with the expressed view of many optometrists that the examination and dispensing processes should not be separated.¹³²

Coupled with this view of the prescription is the difference between the billing practices of most optometrists and opticians. Many if not most practicing optometrists advocate that optometrists should provide ophthalmic goods at cost to the consumer, and charge a dispensing fee to compensate the optometrist for his professional services associated with dispensing.¹³³ This view is shared by the American Optometric Association in many of its publications.¹³⁴ Most opticians, however, simply "mark-up" the goods they dispense, much as any other retail seller.¹³⁵

129 Supra note 70.

130 Supra notes 65-66 and accompanying text.

131 Supra note 66.

132 Supra note 14.

133 See, e.g., testimony of Alan L. Austin, Counsel, South Dakota State Board of Examiners in Optometry, Tr. 864 at 879; testimony of Robert G. Corns, O.D., Indiana State Board of Optometry, Tr. 1293 at 1298; testimony of Jesse C. Beasley, O.D., President, California Optometric Association, Tr. 3598 at 3640; testimony of R. Ted Bottiger, Counsel, Washington Optometric Association, Tr. 4047 at 4056; testimony of James W. Clark, Jr., Executive Director, Kansas Optometric Association, Tr. 4272 at 4294.

134 See, e.g., AOA Bulletin dated March 19, 1976, setting forth the Code of Ethics, Rules of Practice, and Standards of Conduct, HX 368.

135 See, e.g., testimony of Eugene Yager, Redwood City Optical, Tr. 3578 at 3589; testimony of Donald Juhl, President, Jack Eckerd Corporation, Tr. 379 at 396.

A Rule provision calling for the release of the prescription, without controlling the content of the prescription itself, may be inadequate to achieve the desired result of permitting consumers to comparison shop for the dispensing services. If a refractionist prepared and released prescriptions which included all of the measurements determined during both the examination and dispensing processes, the refractionist would be able to receive compensation for his dispensing services even though he is ostensibly releasing the prescription to allow the consumer to obtain the dispensing services elsewhere.

Thus, it is an almost inescapable possibility that refractionists who are inclined to do so could negate the desired effects of the mandatory release of prescriptions by simply fusing the examination and dispensing services into one unit.

This problem is complicated somewhat by state law. In at least four states, optometrists are required to include in ophthalmic prescriptions information normally associated with dispensing. For example, under regulations promulgated by the Idaho Board of Optometry every prescription written by an optometrist must contain the refractive power and axis, the position of the optical centers, segment characteristics, tint, coating, and whether the lenses are to be glass or plastic.¹³⁶ Alaska, New Mexico, and Texas impose similar requirements.¹³⁷ In addition, the regulations promulgated by the Idaho Board of Optometry specify additional requirements for the content of prescriptions for contact lenses.¹³⁸ In none of these states

136 Rules of the Idaho State Board of Optometry, Rule 16(A), Exhibit IV-13.

137 See, e.g., New Mexico Statutes, Chapter 67, § 67-1-2(c), Exhibit IV-32; Alaska Administrative Code, Part I, Title 12, Chapter 48, § 12 AAC 48.080(7), Exhibit IV-2; Texas Optometry Act, § 5.12, Exhibit IV-44.

138 Rules of the Idaho State Board of Optometry, Rule 16(B), supra note 136, states:

B. All prescriptions for contact lenses shall contain at least the following information:

1. Base curve.
2. Peripheral curve or curves including widths.
3. Overall diameter.
4. Optical zone diameter.
5. Power.
6. Center thickness.
7. Color.

are ophthalmologists required to include similar information in the ophthalmic prescription. Thus, the anomalous situation arises that if an optometrist writes a prescription it must include certain information normally determined during the dispensing process; however, if an ophthalmologist performs the examination, the prescription need not include this information. Thus, the state has not made a determination that opticians in that state are not qualified to perform the tests and measurements associated with the additional prescription content.

To accommodate all of these concerns and still insure the consumer unburdened access to his prescription, staff's recommendation would require refractionists to release an ophthalmic prescription containing all of the elements which any applicable state law may require. In the absence of any state requirement as to prescription content, refractionists would simply be required to provide a prescription which would enable the consumer to obtain his ophthalmic goods from any other seller. Thus, the provision recommended by staff relies on state law to determine the minimum content of the prescription.¹³⁹ Thus, using Idaho as an example, staff's recommendation would not alter the state regulations on what optometrists must include in the prescription.

The issue of whether a refractionist may charge an additional fee for performing services normally associated with dispensing presents different considerations. It is staff's conclusion that refractionists should be permitted to impose additional fees where state law or regulations require all refractionists--i.e., both optometrists and ophthalmologists, to perform additional services. The general requirement incorporated in the recommended Rule is that a refractionist may not charge a patient who desires to take his prescription elsewhere more than he would have been charged had the examination determined that the patient did not require any ophthalmic goods.¹⁴⁰ However, if the state determines that the prescription must contain information in addition to the lens formula, axis, and necessary prism, the refractionist may charge for those services if the statutory or regulatory prescription requirement applies

139 See § 456.1(g) of the recommended Rule, Section X, infra.

140 Id. at § 456.4(c).

to all ophthalmologists and optometrists.¹⁴¹ The states would therefore remain free to define the proper functions of opticians. If a state, either legislatively or through the regulatory bodies governing both classes of refractionists decides that certain dispensing measurements must be performed by the refractionist rather than the dispensing optician, then the refractionist should be free to receive compensation for performing those services.

By requiring that all refractionists be required to perform these services before additional charges can be made for those services, staff seeks to prevent what could become a serious weakness in the Rule. Some state boards of optometry have publicly stated their views that optometrists should not release prescriptions,¹⁴² or have found that it is "ethical" to impose additional fees for releasing prescriptions.¹⁴³ Thus, if the Commission were to adopt a requirement that allowed optometrists to charge additional fees for services required by regulations promulgated by the respective boards of optometry, a board could readily redefine all of the dispensing services into prescription content requirements. In this manner, the goal of facilitating access to prescriptions would be defeated.

¹⁴¹ For example, Hawaii Department of Regulatory Agencies, Title VII, Chapter 16, Part I, Section 1.2, Exhibit IV-12, states:

The term 'prescription' means an order or formula written out in full, given by a licensed physician or optometrist, setting forth refractive powers for the grinding of any lens which has a spherical, cylindrical prismatic power or value or any combination thereof.

In this instance the regulation specifies prescription content for both physicians and optometrists. Thus, if Hawaii were to impose additional prescription content requirements such as segment characteristics or pupillary distance for both physicians and optometrists, such persons could impose an additional charge.

¹⁴² See, e.g., "Who Owns Optometric Prescriptions?," Optical Journal Review (Dec. 1, 1967), HX 315.

¹⁴³ See eyeglasses price survey conducted by Bernice Carter, Office of Consumer Protection, Office of the Governor, Baton Rouge, Louisiana (May 1975) Exhibit V-86, at R. 11923.

In summary, the recommended Rule would require practitioners to release ophthalmic prescriptions which contain all of the information necessary to permit consumers to obtain their ophthalmic goods from the seller or provider of their choice. The refractionist would not be permitted to charge the consumer any additional fees for simply releasing the prescription. If all refractionists were required by state law or regulation to include in the prescription information normally determined during the dispensing process (i.e., information in addition to the lens formula, axis, and necessary prism), the refractionist could impose an additional fee for performing those services. However, if only one class of refractionists were required by the state to include this additional information, they could not impose an additional fee for doing so.

Finally, in relation to the charging of additional fees, staff has included a provision designed to make clear our intent that a refractionist may charge an additional fee for verifying the lenses dispensed by another seller or provider.¹⁴⁴ Earlier we noted that while many optometrists believe that they are better qualified than opticians to verify ophthalmic lenses, most opticians disagree.¹⁴⁵ For purposes of this provision that dispute need not be resolved. Some state laws require that the refractionist verify lenses dispensed by another seller or provider on that refractionist's prescription.¹⁴⁶ To accommodate the state laws and to permit such practitioners to obtain compensation for performing the verification service, the Rule

144 See § 456.4(c) of the recommended Rule, Section X, infra.

145 See Section I(C)(3), supra.

146 See, e.g., Rules of the Idaho State Board of Optometry, supra note 136. Rule 15 states:

XV. Release of Prescriptions -- If an optometrist writes a prescription for the purpose of its being presented outside of his office for filling or in order to enable the patient to secure any ophthalmic materials at a location other than his office, the prescription must have recorded on the face of the written prescription, the words: "Since errors in workmanship may occur in filling a prescription, these spectacles must be returned to his office so that the accuracy of the work performed as directed in the prescription may be verified."

147 See § 456.4(c) of the recommended Rule, Section X, infra.

specifically allows the refractionist to impose an additional fee for verification.¹⁴⁷ However, to insure that the additional fee is not imposed to discourage the consumer from taking his prescription elsewhere, the rule only allows the practitioner to impose the verification fee at the time the verification is performed.

The recommended Rule also addresses the problem of waiver forms. First, as to those waivers which purport to absolve the refractionist for liability for the accuracy of the examination if the patient purchases his eyeglasses elsewhere, there appears to be little doubt that the intent behind these forms is to discourage or dissuade consumers from taking their prescriptions elsewhere. Whether the waiver is enforceable is immaterial for purposes of this discussion. The waiver of the accuracy of the exam is designed to deter the patient from exercising his ability to comparison shop. Accordingly, the rule would prohibit such waivers.¹⁴⁸

A second type of waiver involves a statement that the refractionist is not responsible for the accuracy of goods dispensed by other sellers and providers.¹⁴⁹ While these waivers are somewhat less objectionable than the former category, they frequently raise the spectre of blindness or other debilitating injury or infirmity if the patient takes his prescription elsewhere.¹⁵⁰ It is staff's conclusion as was discussed in the foregoing subsection, that these waiver forms often have the effect of intimidating the consumer and thereby prevent him from purchasing necessary goods elsewhere.

The record supports a finding that substantial numbers of consumers are not aware that examination and dispensing are not necessarily a unitary process.¹⁵¹ Frequently consumers are not aware that they can request a prescription to shop elsewhere.¹⁵² Accordingly, some participants in this proceeding argued that the Commission should require a disclosure on the prescription form itself, informing the consumer of his right to take his prescription to any ophthalmologist, optometrist, or optician.¹⁵³

148 See § 456.4(d) of the recommended Rule, Section X, infra.

149 Supra notes 45-48 and accompanying text.

150 Id.

151 Supra notes 114-117 and accompanying text.

152 Supra note 117.

153 See, e.g. testimony of Earl Hendrix, Hendrix & McGuire Dispensing Opticians, Tr. 3995 at 4002.

While staff recognizes that consumers are generally unaware of either their right to their prescriptions, or of their purchase alternatives, we believe that such a mandatory disclosure is unnecessary. It is our belief that the most effective means to remedy this lack of knowledge is through advertising. For example, one optician testified that he had included in his advertisements information designed to alert the consumer to his right to his prescription:

We pointed out that you don't have to purchase your eyeglass where you have your eyes examined (a common misconception). Your prescription for

corrective lenses is your property to be filled at the place of your choice. The results: For the first time in our community people are asking for their eyeglass prescriptions from their doctors and are comparing goods and services. This, of course, reinforces the competitive marketplace.¹⁵⁴

It is the staff's belief that if consumers are provided with an absolute right to their prescriptions, opticians will possess considerable incentives to educate the public. As the only seller or provider of ophthalmic goods not capable of performing eye examinations, the very livelihood of opticianry is dependent on securing as many prescriptions as possible. Thus, it is staff's conclusion that no such mandatory disclosure is necessary.

Contact Lenses

An issue which has been raised by a number of optometrists concerns the release of prescriptions for contact lenses. The precise issue was stated by the President of the American Optometric Association:

. . . my personal belief is that a patient should not have access to a written prescription for a contact lens because of the risk inherent in the damage to the patient should the wrong lens be applied to the eye. I personally care for every patient, see the lens on the patient, know that the lens that was put on is the lens that is verified to be the lens ordered, and I like to follow that lens and any replacement lens through very careful and cautious examination to determine that there are no abrasions, no rough edges, no problems, no interference with the oxygenation of the cornea, the physiology of the corneal

154 Testimony of Stephen LaVerdiere, LaVerdiere's Super Drug Stores, Tr. 2573 at 2575.

integrity is not compromised and certainly especially in cases where you deal with eyes that have been diseased by keratoconus or in the aphakic patient who is wearing either a soft or a hard contact lens. These are not ordinary things. These are extraordinary. The risk of eyesight is at stake, and there's no way to compromise. So my personal opinion is that no prescription for a contact lens in any form should be given to a patient.¹⁵⁵

The record in this proceeding is not conclusive on the issue of whether opticians are qualified to dispense contact lenses. Virtually every optician who testified on this subject stated his belief that opticians are qualified to dispense contacts.¹⁵⁶ One of the country's leading ophthalmologists, the Chairman of the University of Chicago's Department of Ophthalmology agreed that opticians are qualified to dispense contact lenses.¹⁵⁷ One point which should be made, however, is that neither optometrists nor opticians are qualified to treat a patient should corneal abrasion or similar difficulties occur.¹⁵⁸

However, for purposes of the recommended Rule this issue does not need to be resolved. The Rule recommended by the staff does not alter in any manner the functions which optometrists or opticians or ophthalmologists may perform under state law. Thus, if state law permits opticians to dispense contact lenses, the refractionist must release a prescription containing all of

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- 155 Testimony of Ron G. Fair, O.D., President, American Optometric Association, Tr. 4638 at 4648.
- 156 See, e.g., testimony of Stephen Lee Adams, President, Tennessee Dispensing Opticians Association, Tr. 6035 at 6052; testimony of Kenneth R. Davenport, President, South Carolina Association of Opticians, Tr. 6182 at 6192; testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5571; testimony of Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4320; testimony of Robert C. Troast, President, New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, Tr. 2007 at 2012; testimony of Jack S. Folline, South Carolina Board of Examiners in Optometry and Opticianry, Tr. 574 at 585.
- 157 Testimony of Frank W. Newell, M.D., Chairman, Department of Ophthalmology, University of Chicago, Tr. 1167 at 1196.
- 158 See, e.g., testimony of Stephen Lee Adams, supra note 156, at 6052.

the information necessary to permit the patient to obtain those lenses from any seller or provider permitted to dispense them. However, if state law does not permit opticians to dispense contact lenses, nothing contained in this Rule creates or conveys such a right. The fact that a state does not permit an optician to dispense contact lenses does not relieve the refractionist of his obligation to deliver to the patient a copy of his prescription. The evidence indicates that the prices of contact lenses vary considerably among ophthalmologists and optometrists.¹⁵⁹ Thus, to insure that consumers will be able to comparison shop for contact lenses, they must be provided with their prescription to enable them to seek out the qualified seller or provider of their choice.

Findings of the Presiding Officer

In his report, the Presiding Officer strongly supported the inclusion in the final rule of a provision requiring release of ophthalmic prescriptions without charge or the signing of any type of waiver of liability.

[T]he proposed rule should be amended to require that persons performing eye examinations or refractions deliver a written prescription to the buyer and that such persons be forbidden to impose any charge for such prescription and forbidden to place any sort of disclaimer on the prescription or to require that the buyer execute any release or other document as a prerequisite to obtaining the prescription. It is further concluded that, absent these requirements, a consumer's ability to price shop or to purchase ophthalmic materials from the seller or provider of his choice would be for all practical purposes impossible.¹⁶⁰

As evidenced by the aforementioned staff recommendations, staff's analysis of the rulemaking record is consistent in all respects with the findings of the Presiding Officer. If consumers are not guaranteed access to their prescriptions, any Commission action permitting truthful advertising would be a futile gesture.

159 More Than Meets the Eye, San Francisco Consumer Action, HX 397, Table 12.

160 Report of the Presiding Officer, Exhibit XIII-1, at p. 150.

VIII. Economic Impact on Small Businesses

In assessing the impact of staff's recommended final Rule on small businesses, the two major subject matter areas addressed by the Rule must be considered somewhat separately. The impact of the Rule provision requiring unconditional release of the ophthalmic prescription may be significantly different than that attending staff's recommendation that advertising be permitted. In his report, the Presiding Officer concluded the following in relation to the impact of the proposed Rule on small businesses:

The precise economic effect of the rule on small businesses, as typified by the ophthalmologist, the optometrist and the optician, cannot be determined with any degree of precision. There are other variables which may operate to enhance or mitigate the economic effect of the rule. These include the presence or absence of other restraints on competition in the relevant market-place. The evidence supports the conclusion that the rule will not result in driving the small businessman from the ophthalmic market-place.¹

To a large degree, the staff concurs in the finding of the Presiding Officer. However, for the reasons set out below, staff believes that the Rule may at least increase the potential for greater industry concentration at the retail level, and may provide some stimulus for increased vertical integration.

Delivery of Prescription

Staff's recommendation that consumers be provided with a copy of their ophthalmic prescription² will undoubtedly have a significant impact on small businesses. As we noted in our discussion of the ophthalmic industry,³ opticians operating independent outlets⁴ dispense only about 40% of the ophthalmic goods sold annually.⁵ In our discussion of the devices by which consumers are denied effective access to their prescriptions,

¹ Report of the Presiding Officer, Exhibit XIII-1 at p. 126.

² See § 456.4(a) of the recommended Rule, Section X infra.

³ See Section I(C)(3) supra.

⁴ Id. Not included in this calculation are opticians employed by optometrists and ophthalmologists.

⁵ Id. at note 78.

we noted that many small opticians and optical dispensaries have been placed at a competitive disadvantage⁶ or completely driven from the market because of their inability to obtain customer's ophthalmic prescriptions.⁷

There would appear to be little doubt that insuring consumers unconditional access to their prescriptions will increase competition among optometrists, ophthalmologists and opticians.⁸ Indeed, the free availability of prescriptions may well serve to stimulate the growth of small businesses, particularly opticianries. A representative of a Tennessee Opticians Association testified on this issue:

[With the] availability of service advertising [and the] patient's right to their prescription, the small business optician will thrive and eventually accomplish what the FTC seeks--lower prices to consumers while maintaining quality and service through competition.⁹

Opticianry, as the only eye care profession which cannot generate its own clientele by performing eye examinations, is wholly dependent upon the availability of prescriptions for its very survival. Staff's recommended Rule would insure the availability of prescriptions and thereby assure opticianry unfettered access to all potential eyeglass purchasers in the market.

Advertising

The precise impact advertising would have on small sellers and providers of ophthalmic goods is somewhat difficult to predict. A survey conducted by the Opticians Association of America typifies the ambivalence on this issue. In their testimony the OAA offered this view on the impact on small businesses of price advertising.

⁶ See Section VII(E)(2), at notes 94-97 infra.

⁷ Id.

⁸ See, e.g., testimony of J. A. Miller, Executive Director, Opticians Association of America and Robert C. Odom, President, Opticians Association of America, Tr. 4312 at 4313; Dispensing of Eyeglasses by Physicians: Hearings before the Subcommittee on Antitrust and Monopoly of the Senate Committee on the Judiciary, 89th Cong. 1st Sess. (1965), Exhibit II-26, at R. 770.

⁹ Testimony of Stephen L. Adams, President, Tennessee Dispensing Opticians Association, Tr. 6035 at 6038.

An OAA survey conducted in December of 1975 revealed that some 35% of the respondents expect that elimination of price advertising restrictions will decrease their volume of business; 14.5% expect that price advertising will lead to an increase in their business; 50% of the opticians feel that price advertising will have no appreciable effect on their volume of sales . . . it would be unfortunate if [the small business optician] were to 'go down the drain' as a result of a rule which misjudged the applicability of price advertising to optical dispensing products and services or the unfair economic pressures which might be generated by such a rule.¹⁰

The record evidence presents an uncertain case as to the economic impact of advertising on small businesses. Numerous persons testified that price advertising would not competitively injure small businesses,¹¹ while many persons took precisely the opposite view.¹²

¹⁰ Testimony of J. A. Miller and Robert C. Odom supra note 8, at 4324.

¹¹ See, e.g., testimony of Stephen L. Adams supra note 9, at 6038; testimony of Roy Alper, California Citizens Action Group, Tr. 3733 at 3793; testimony of Wilbur Gulley, Director, North Carolina Public Interest Group, Tr. 124 at 134; testimony of John H. Burns, Optician, Tr. 5582 at 5586-87; testimony of Edward E. Crittenden, President, Eyear Optical, Tr. 6015 at 6015-B; testimony of E. Logan Goar, Vice President, Certified Ophthalmic Dispensers Association of Texas, Tr. 5550 at 5562; testimony of William B. Haley, Acting Director, Department of Public Affairs, New York Community Service Society, Tr. 2129 at 2133; John F. Cady, "A Statement to the Federal Trade Commission Regarding the Proposed Rules Concerning Prescription Drug Price Disclosure" (January 1976), Exhibit V-80, at R. 11741.

¹² See, e.g., testimony of William T. Heimlich, Chairman, Standards Committee, OAA and Guild of Prescription Opticians, Tr. 2185 at 2196; testimony of David C. Hendershot, Executive Director, Ohio Optometric Association, Tr. 660 at 663; testimony of Erwin Jay, O.D., Tr. 1450 at 1459; testimony of M. F. Keller, O.D., Chairman, Legislative Committee, Montana Optometric Association, Tr. 3469 at 3476; testimony of Jerry M. Leach, Optician, Tr. 5846 at 5847; testimony of Berry C. Lofland, Certified Optician, Professional Eyewear, Tr. 5510
(continued)

From a theoretical standpoint, advertising holds the potential for increasing the level of concentration at the retail level. In its testimony, the Southern Research Institute stated the theoretical base for this belief:

If, indeed, it develops that price advertising does reduce prices, either in the short - or long-run, firms (or professional offices) that do not counter-advertise will either have to reduce prices to hold their shares of the market, probably at higher prices than heretofore. Some will probably be driven out of business.

To the extent that prices do decline as a result of price advertising and of the exploitation of economies of scale, the distribution of market shares is likely to be altered in favor of the new, larger-scale advertisers. Thus, what may have started as an intention to increase competitiveness may end as a movement toward oligopoly and, ultimately, higher prices, with numerous small firms in local markets continuing to operate under a high-price umbrella of a handful of larger suppliers.¹³

It would be naive to dismiss the possibility that advertising might tend to increase concentration at the retail level in the ophthalmic market. At the manufacturing level, a very high degree of concentration already exists. Staff estimates that the six largest manufacturers of lenses and frames account for 85% of the industry output of \$550 million annually.¹⁴ Two of these firms, American Optical and Bausch & Lomb account for 80% of all lens production in the United States.¹⁵

(12 continued)

at 5512; outline of testimony of L. Murray Doody, Jr., Counsel to New York Society of Ophthalmic Dispensers, HX 225; statement of Michael Magura, Professor of Economics, University of Toledo, HX 120.

¹³ Southern Research Institute, The Advertising of Ophthalmic Goods and Services, HX 356, at p. 21.

¹⁴ See Section I(A) supra.

¹⁵ Id.

At the wholesale level, there are approximately 500 firms which operate optical laboratories.¹⁶ The degree of concentration at the wholesale level appears to be much less than at the manufacturing level. Of the approximately 1500 optical laboratories,¹⁷ American Optical and Bausch & Lomb operate a total of approximately 378,¹⁸ or 25%. In addition, there are at least eight other independent firms which operate 50 or more laboratories.¹⁹ Thus, while the optical laboratory market is somewhat concentrated, the degree of concentration is relatively slight in comparison to the manufacturing level.

As we previously noted, many of the economies of scale associated with the ophthalmic industry are located at the manufacturer to wholesaler level of purchase.²⁰ Volume discounts on ophthalmic lenses are significant at this point in the distribution chain. The pressure generated by increased advertising may encourage many retail dispensers to seek to take advantage of these economies of scale by integrating backward into the wholesale laboratory level.²¹ A representative of the California Optical Laboratory Association testified that this phenomenon may place some small optical laboratories under severe competitive pressure.²²

Thus, at least the potential exists for increased concentration at the retail level, and increased vertical integration. It is important to note though, that little evidence exists that vertical integration can or will occur through all three stages, manufacturing, wholesaling, and retailing. In a series of consent decrees, the Justice Department divested the major optical manufacturers of all interests in the retail ophthalmic market.²³ Staff believes that the likelihood of future vertical integration through all three stages of delivery is not a likely prospect.

16 See Section I(B) supra.

17 Id.

18 Id.

19 Id.

20 See Section III, at notes 157-160 supra.

21 See, e.g., testimony of J. Howard Sturman, Academy of California Optometrists, Tr. 3348 at 3364-65.

22 Testimony of Roy Marks, California Optical Laboratory Association, Tr. 3778 at 3780-82.

23 See, e.g., United States v. Bausch and Lomb Optical Company, Civ. No. 46 C 1332, (N.D. Ill., filed May 5, 1951), p. 4-7.

However, the overall impact of the recommended Rule is difficult to assess. Numerous state laws control access or entry into the market for corporate entities.²⁴ Similarly, some states prohibit branch operations or the use of mercantile locations.²⁵ Clearly these items impact on a firm's operational size. If a firm cannot expand beyond one outlet, it is virtually impossible to dominate a market. Thus, the ability of firms to dominate a market is, among other things, dependent upon other state restrictions.

Finally, even assuming a potential for greater concentration and possible vertical integration, it does not necessarily follow that the public will suffer. In its comments, the Southern Research Institute equates oligopoly power with increased consumer prices.²⁶ It must be noted that there is no evidence in the record which indicates that oligopoly has been achieved even in markets where advertising is permitted. Secondly, the conduct of the so-called "small business" optometrists contains attributes of oligopoly power. The absence of price competition, concerted withholding of relevant information from the public, and increased prices, are all evils attributed to market concentration and the exercise of oligopoly power. Yet, these same attributes have become the hallmark of the ophthalmic industry. Staff would simply raise the question whether through the use of professional associations and association domination of state licensing boards the ophthalmic market is not already operating as an oligopoly.

24 See Section II(B)(3) supra.

25 Id.

26 Southern Research Institute supra note 13, at p. 21.

IX. Suggested Additions to the Rule

A number of substantive additions to the proposed rule have been suggested by consumer groups, as well as by the Presiding Officer in his report. These suggested additions fall into two general categories:

(1) The rule should be expanded to include the advertising of information related to eye examinations.

(2) The rule should be expanded to require the affirmative dissemination of information through required telephone disclosures, mandatory posting of prices, and the itemization of bills for vision care services.

For the reasons set out below, staff has rejected each of the suggested additions.

A. The Rule Should Be Expanded to Include the Advertising of Information Related to Eye Examinations

From the very inception of this proceeding, the issue whether the rule should be expanded to include the advertising of information related to the eye examination has been squarely before the public. In the Initial Notice of Rulemaking, the Commission specifically solicited views on this issue.¹ In addition, one of the designated issues stated:

Would the failure to change the definition of "ophthalmic services" in § 456.1(d) of the proposed rule, so as to include examinations and refractions prerequisite to a prescription for ophthalmic goods, result in substantial harm to consumers' interests because they would not otherwise be provided with adequate information respecting the cost of ophthalmic goods and services.²

¹ Notice of Proceeding and Proposed Trade Regulation Rule, 41 Fed. Reg. 2399 (Jan. 16, 1976). Contained in that notice was the following question:

7. Should the definition of "ophthalmic services" be altered to include examinations and refractions leading to dispensing when such services are provided by the same individual?

² Final Notice of Proposed Trade Regulation Rule Proceedings, 41 Fed. Reg. 14194 (Apr. 2, 1976).

From a procedural standpoint, staff believes that the public was sufficiently on notice that such a requirement could be included in staff's recommended Rule. However, staff has decided not to recommend such a provision for reasons other than the procedural considerations.

In his report, the Presiding Officer strongly recommended adoption of a requirement that ophthalmologists and optometrists be permitted to advertise their professional services:

A failure to include in the rule a provision which would eliminate the existing restrictions on the advertising of examinations and refractions prerequisite to a prescription for ophthalmic goods would seriously reduce the effectiveness of the rule.³

However, the Presiding Officer's recommendation would not permit ophthalmologists and optometrists to engage in all forms of "service advertising." Rather, his recommendation would only permit the advertising of examination fees.⁴

The case against permitting the advertising of professional services, in this instance eye examinations, was summarized by the American Optometric Association:

The optometrist diagnoses and treats various conditions of the vision system, and the treatment does not always involve a prescription for lenses. In general, fees charged by an optometrist for different professional services tend to vary, depending on the nature of a particular patient's condition, the nature and extent of the tests needed, and the treatment required. An optometrist generally does not know the fees that a particular patient will pay, at least until he examines the patient and diagnoses his problems. Accordingly,

³ Report of the Presiding Officer, Exhibit XIII-1, at p. 168.

⁴ Id. at 170. In his report the Presiding Officer stated:

[T]he [recommended] provision would not authorize advertisements of the skills or qualities of either the practitioner or the excellence of the examination and refraction. It would authorize only advertisements of the prices at which such services can be obtained.

an advertisement of the fee for a so-called "eye examination" or "réfraction" would not inform many patients of the fees they would actually pay, nor does it advise them as to the nature of the professional services included or whether additional charges will be required.⁵

The position of the AOA can be broken down into two major components. First, the cost of an examination varies substantially from patient to patient depending on the nature and scope of the professional services performed. Secondly, advertising would not inform the consumer of the "quality" or the completeness of an advertised examination.

The available evidence paints a different picture than that found in the AOA's position. Most of the optometrists and ophthalmologists who testified indicated that they charge a fairly standardized examination fee. In many instances, they charged a flat fee for the basic eye examination.⁶ In other cases, the examination fee varied within a very narrow range (\$3 to \$5 variation), depending upon whether a tonometry test for glaucoma was performed.⁷ Indeed, some practitioners testified that their examination fees did not vary with the amount of time spent with the patient.⁸ Prepaid vision care plans, and state funded Medicaid plans typically set a fixed rate for examinations.⁹

5 Comment of J. Harold Bailey, Executive Director, American Optometric Association, Exhibit VIII-160, at R. 14741.

6 See, e.g., testimony of J. R. Hale, Washington State Board of Optometry, Tr. 3006 at 3033; testimony of Paul S. Hornick, O.D., Tr. 1355 at 1361; testimony of Erwin Jay, O.D., Tr. 1450 at 1469; testimony of Mark Robin, O.D., California Optometric Association, Tr. 3543 at 3557.

7 See, e.g., testimony of Roy Ebihara, O.D., Tr. 1235 at 1242 (\$24 - \$30); testimony of Donald L. Heyden, Wisconsin Optometric Association, Tr. 5852 at 5879 (\$23 - \$28); testimony of Stanley A. Anderson, O.D., Oregon Committee of Concerned Optometrists, Tr. 3192 at 3208; testimony of Alan L. Austin, South Dakota State Board of Examiners in Optometry, Tr. 864 at 920; testimony of Jesse C. Beasley, O.D., California Optometric Association, Tr. 3598 at 3637.

8 See, e.g., testimony of James Elless, O.D., Tr. 5363 at 5383.

9 See, e.g., Medical and Related Services--Schedule of Maximum Allowances, HX 295, at p. 2.

Thus, despite the potential variations in the examination, most practitioners charge either a standard fee, or a narrow range of fees. Given this narrow range of fees, price advertising of examination fees would not appear to be inherently deceptive.

Addressing the "quality" argument, the relationship between the quality of an eye examination and the ability of an optometrist or ophthalmologist to advertise is unclear. The quality argument concerning the advertising of examination fees and other services does not differ substantially from the issue posed by the advertising of ophthalmic goods. If an optometrist chooses to perform substandard examinations, an advertising ban serves as no deterrent. At most it can be argued that a person who already engages in such practices will be able to increase his opportunity to reach more patients by advertising his availability.

It is the staff's belief that there are direct means to control the problem of poor quality eye examinations. Some states have adopted minimum eye examination requirements to insure that all examinations achieve a minimum level of quality. For example, the Texas Optometric Association testified that Texas' minimum quality standards for eye examinations substantially alleviated the problem of "quicky" or incomplete examinations.¹⁰ They noted that the offending optometrists were apparently unwilling to risk their licenses by offering incomplete examinations.¹¹ It is somewhat revealing that while some persons in the optometric field "support" such requirements, when faced with the opportunity to make them a reality, their support in some instances has faded.¹²

The AOA and many of its members argue that advertisements of eye examinations would not inform the consumer of the thoroughness of the examination.¹³ However, consumers have no means at

¹⁰ Deposition of Dr. Robert K. Shannon, HX 396, at pp. 41-43.

¹¹ Id.

¹² See, e.g., testimony of Terry Freeman, Administrative Aide to Ohio Senator Anthony O. Calabrese, Tr. 1543 at 1547. Mr. Freeman testified that the Ohio Optometric Association specifically rejected efforts to enact minimum examination requirements. Yet, in its testimony the Ohio Optometric Association indicated that it supported minimum examination requirements. Tr. 660 at 755.

¹³ See, e.g., comment of the AOA supra note 5, at R. 14741.

present for ascertaining the accuracy or quality of eye examinations being offered. The consumer must necessarily rely on the integrity of the optometrist or ophthalmologist to insure that a quality examination is performed.¹⁴ This basic fact would not be altered by permitting the advertising of examination fees.

Finally, elsewhere in this report, we have discussed those studies which sought to assess the relationship between the cost of an eye examination and the accuracy of that examination.¹⁵ The evidence failed to demonstrate that there is a direct correlation between the price charged for an examination and the resultant quality.

Accordingly, staff does believe that the evidence supports the lifting of bans which prohibit the price advertising of eye examinations. However, this is only a portion of a larger issue. Many of the issues connected with service advertising have not been sufficiently developed in the record. For example, the advertising of professional credentials, practice specialties, and related information is an important facet of service advertising. Moreover, an issue exists as to what conditions or possible disclosures should accompany service advertising. Staff believes that it would be unwise to carve out the narrow field of examination fees for separate treatment. Rather, we believe it to be the more responsible approach to consider the entire question of service advertising in a separate proceeding. To that end, staff recommends that this issue be actively pursued in the context of the Commission's continuing investigation into commercial restraints in the retail ophthalmic market.¹⁶ On the available evidence, staff finds that there is reason to believe that these restraints should be removed.

B. The Rule Should Be Expanded to Require the Affirmative Dissemination of Information through Required Telephone Disclosures, Mandatory Posting of Prices, and the Itemization of Bills for Vision Care Services.

¹⁴ See, e.g., testimony of Roy Alper, CCAG, Tr. 3733 at 3735; testimony of Bernard Englander, Cooperative Services of Detroit and Group Health, Inc., Tr. 1333 at 1349; testimony of Kristin K. Graves, Director, Davis Consumer Affairs Bureau, Tr. 3825 at 3828.

¹⁵ See Section V (C) supra.

¹⁶ The Commission announced by press release dated Jan. 20, 1976, that the Commission staff was conducting an investigation into other restraints in the ophthalmic market.

A number of persons, particularly consumers and consumer groups, have advocated the imposition of a number of affirmative disclosure requirements. The three major provisions advocated would require practitioners to provide consumers with price information over the telephone,¹⁷ to post prices in their places of business,¹⁸ and to itemize their bills so as to clearly differentiate the examination process from the dispensing of the resultant goods.¹⁹

In each of these cases, the process of consumer search would be greatly facilitated were these to be adopted. Comparison shopping would be considerably less burdensome if price information were made readily available. Staff wholly supports the theoretical bases on which these suggestions rest. The recommended Rule taken as a whole is predicated on the finding that consumers need additional information to make rational purchase decisions. However, the need for mandating the affirmative release of information does not appear to be as critical in the ophthalmic market as it is in some other markets, such as the funeral industry. In an industry such as the funeral industry, the purchase decision must necessarily be made within a relatively short time frame. However, the ophthalmic purchase is one which lends itself more readily to longer term comparison shopping through the use of media advertisements.

Staff is concerned that a requirement that information be affirmatively disclosed represents a significantly different approach than that contained in the proposed rule. The proposed rule was designed to permit advertising, not require it. Thus, staff believes that because of the fundamentally different approach which mandatory requirements for telephonic disclosure,

17 See, e.g., testimony of Edith Barksdale-Sloan, Director, District of Columbia Office of Consumer Affairs, Tr. 609 at 613; testimony of William Bloss, North Carolina Public Interest Research Group, Tr. 124 at 131; testimony of Virginia Long, Director, New Jersey Division of Consumer Affairs, Tr. 1843 at 1865; testimony of Donald F. Reilly, Deputy Commissioner on Aging, HEW, Tr. 111 at 124.

18 See, e.g., testimony of Roy Alper, CCAG, Tr. 3733 at 3747; testimony of Edith Barksdale-Sloan supra note 17, at 613; testimony of Glenn R. Workman, Legislative Research Project for Ohio's Elderly, Tr. 1209 at 1218.

19 See, e.g., testimony of Roy Alper supra note 14, at 3745.

posting of prices, and itemization of bills represent, additional information and comment should be received before any action is taken.

For example, if a mandatory posting requirement were to be recommended, issues concerning the type and format of the information to be posted would arise. The record simply does not contain the necessary evidentiary base on which to predicate requirements of this nature.

If, after adoption of the recommended Rule, it were found that consumers still were unable to obtain the necessary information on which to base their purchase decisions, adoption of such a requirement might become necessary. At that time, the Commission could obtain the necessary evidence and comment to make an informed decision on the question of affirmative disclosure.

X. The Rule

§ 456.1 Definitions

(a) A "buyer" is any person who has had an eye examination.

(b) The "dissemination of information" is the use of newspapers, telephone directories, window displays, signs, television, radio, or any other medium used to communicate to the public any accurate information concerning ophthalmic goods and services, including, but not limited to, the price or availability of those goods and services.

(c) 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) "Ophthalmic goods" consist of eyeglasses, or any component of eyeglasses, contact lenses, and any other device used for or incident to the correction of any visual anomaly.

(e) "Ophthalmic services" are the measuring, fitting, and adjusting of ophthalmic goods to the face subsequent to an eye examination.

(f) A "person" means any party, other than a state, over which the Federal Trade Commission has jurisdiction. This includes individuals, partnerships, corporations, and professional associations.

(g) 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. The prescription shall also include all of the information specified by state law, if any.

(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.

§ 456.2 Private Restraints

It is an unfair act or practice under § 5 of the Federal Trade Commission Act for any seller or group of sellers, including any professional or trade association, or any person engaged in the manufacturing or wholesaling of ophthalmic goods, to prohibit, limit or burden the dissemination of information by any other

seller. The conditioning of membership in a professional or trade association of sellers by such an association on a requirement that members or prospective members of that association not engage in the dissemination of information shall be deemed to prohibit, limit or burden the dissemination of information.

§ 456.3 Public Restraints

It is an unfair act or practice under § 5 of the Federal Trade Commission Act for any seller to reduce, limit, or burden the dissemination of information concerning the sale or offer for sale of ophthalmic goods and services in order to comply with any law, rule, regulation, or code of conduct of any non-federal 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 requires that the following items be included within any dissemination of information, 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; and
- (3) whether an advertised price for ophthalmic goods includes an eye examination.

PROVIDED FURTHER: 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), such a law, rule, or regulation shall not be considered to prohibit, limit, or burden the dissemination of information.

§ 456.4 Release of Prescriptions

In connection with the performance of eye examinations, it is an unfair act or practice under § 5 of the Federal Trade Commission Act 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: If a refractionist requires all buyers to pay for their eye examinations immediately after they are performed, the refractionist may refuse to give the buyer a copy of the buyer's prescription until payment is made;

(b) condition the availability of an eye examination to any person on a requirement that that person agree to purchase any necessary ophthalmic goods from the refractionist;

(c) charge the buyer any fee in addition to the fee which would have been charged the buyer if the eye examination determined that no ophthalmic goods were required. PROVIDED: Where state law, rule, or regulation requires all refractionists to include in the prescription information other than the refractive power, axis, and prism, the refractionist may charge an additional fee therefor. PROVIDED FURTHER: A refractionist may charge an additional fee for verifying ophthalmic goods dispensed by another seller where the additional fee is imposed at the time the verification is performed; and

(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 or quality of the ophthalmic goods or services dispensed by another seller.

§ 456.5 Declaration of Commission Intent

(a) It is the purpose of this part to allow retail sellers of ophthalmic goods and services to disseminate accurate information concerning those goods and services to prospective purchasers. This part is intended to eliminate 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 or local laws, rules, or regulations that are repugnant to this part, and that would in any way prevent or burden the dissemination of accurate information by retail sellers of ophthalmic goods and services to prospective purchasers. It is further the intent of this part to preempt all state or local laws, rules, or regulations which burden the dissemination of information by requiring affirmative disclosures, except to the extent specifically permitted by this part.

Finally, it is not the intent of this part to preempt those state and local laws, rules, or regulations which require affirmative disclosure of information in all advertising of all consumer products.

(b) 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 who truthfully advertises. In addition, this part may be used as a basis for declaratory, injunctive, or other relief against the threatening of bringing of an action against a seller who truthfully advertises.

(c) It is not the Commission's intent to compel any seller of ophthalmic goods and services 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 who are disposed 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.

(d) In prohibiting the use of waivers and disclaimers of liability in § 456.4(d), it is not the Commission's intent to impose liability on a refractionist for the ophthalmic goods and services dispensed by another seller pursuant to that refractionist's prescription.

(e) In this part, the Rule, each proviso, and the Declaration of Commission Intent and their application are separate and severable.

XI. Section-by-Section Analysis

This section comprises a detailed analysis of the recommended Rule. Included within this analysis is an explanation of the changes in the recommended Rule from the text of the originally proposed rule.

One change, however, relates to the entire Rule. Staff has endeavored to draft the Rule in a more readable form than was found in the proposed rule. To that end staff has deleted long lists of synonyms where a larger generic category was sufficient to convey the intended meaning. In addition, each of the definitions was written in clear, concise, sentence form. The definitions have also been placed into alphabetical order.

Section 456.1 - Definitions

Paragraph (a) - "Buyer" is intended to cover those persons who have undergone eye examinations performed by an ophthalmologist or an optometrist.

The term "buyer" was § 456.1(f) in the proposed rule. The simplification in the definition is not intended to limit the scope of the definition.

Paragraph (b) - "Dissemination of information" is defined by the Rule to include the use by a seller of any and all means of communication to bring to the attention of the public any accurate information, including price information, which the seller desires to disseminate concerning ophthalmic goods and services.

The term "dissemination of information" was § 456.1(e) in the proposed rule. Staff has eliminated many of the redundant or nearly synonymous terms to make the definition more readable. Each of the deleted terms falls within the phrase "or any other medium." Thus, staff believes it unnecessary to cite each specific example.

Paragraph (c) - "Eye examination" is intended to cover those tests and measurements performed by a refractionist which are used to determine the refractive state of the patient's eyes. Since the definition addresses those tests which are used to determine the patient's refractive status, the definition would include an examination designed to determine whether any pathology was present in a patient's eyes, where that examination either results in, or could result in the prescribing of ophthalmic goods.

The term "eye examination" was not defined in the proposed rule.

Paragraph (d) - "Ophthalmic goods" is defined broadly to include any eyeglasses or other ophthalmic devices or any accessories incident thereto, which are dispensed only upon the prescription of a licensed practitioner authorized by law to prescribe such devices. It is intended that lenses, frames, and all other component parts of either eyeglasses or contact lenses fall within the scope of this definition, including frames and accessories that are purchased without prescription.

The term "Ophthalmic goods" was § 456.1(c) in the proposed rule. Staff has deleted many of the repetitive terms which fall within the larger category of "any component of eyeglasses." Staff has also deleted references to nonprescription eyewear. The reference to nonprescription eyewear is unnecessary since state laws do not prohibit the advertising of such devices.

Paragraph (e) - "Ophthalmic services" is intended to cover the activities of the seller or provider of ophthalmic goods which are related to the dispensing of such goods. These services include, but are not limited to, measuring, adapting, fitting, adjusting, and dispensing of the frames and lenses. These activities would include the taking of measurements such as the pupillary distance, vertex, or measurements associated with the dispensing of contact lenses.

Paragraph (f) - "Person" refers to every party other than a state over which the Federal Trade Commission has jurisdiction; it includes, but is not limited to, individuals, groups, organizations, partnerships, corporations, trade associations, professional societies, and those state boards which are not in fact state instrumentalities. While the definition specifically excludes a "state," state boards governing ophthalmologists, optometrists, or opticians are within the Commission's jurisdiction and the application of the Rule insofar as they are not in fact state instrumentalities. The determination of this depends upon a weighing of several factors relative to each state board. Factors considered by the courts include the statutory or other language which establishes the agency; the methods by which its members are chosen; the accountability and supervision of members by state officials; and the purposes and activities of the agency. See Asheville Tobacco Board of Trade Inc. v. Federal Trade Commission, 263 F.2d 505 (4th Cir. 1959) and Kudner v. Lee, 7 So.2d 110 (Fla. 1949) en banc. Staff concludes that most state boards governing ophthalmologists, optometrists, and opticians are probably state instrumentalities and thus not directly subject to Section 456.2 of the recommended Rule. Section 456.3 of the recommended Rule would nonetheless preempt any offensive board regulations or state statutes without the need for making the states directly subject to Commission litigation under the Rule. (See discussion of Section 456.3 below.)

The term "person" was formerly defined as "person, partnership or corporation" in § 456.1(a) of the proposed rule. The language of the definition has been simplified to make the definition more readable. In addition, staff has chosen to define the term "person" instead of "person, partnership or corporation" to make the balance of the rule easier to read.

Paragraph (g) - "Prescription" encompasses a number of concepts. First, the prescription means the written document which contains the specifications for the ophthalmic lenses as determined by the eye examination. Second, the ophthalmic prescription must contain every element of information which applicable state law requires be contained in the prescription so as to allow the patient to obtain the necessary ophthalmic goods from any other seller or provider. Thus, in a state where an optician cannot fill a prescription which does not contain the date or the signature of the refractionist, the prescription must contain those elements.

The term "prescription" was not defined in the proposed rule.

Paragraph (h) - "Refractionist" is intended to cover ophthalmologists, optometrists, or any other persons qualified under state law to perform eye examinations.

The term "refractionist" was not defined in the proposed rule.

Paragraph (i) - "Seller" is intended to cover any person, partnership, or corporation or any employee, agent, or servant thereof, who sells or otherwise provides eyeglasses or component parts or accessories directly to the public. It is therefore intended that any ophthalmologist, optometrist, or optician who dispenses to consumers ophthalmic goods and services would fall within this definition.

The term "seller" was formerly defined as "seller or provider" in § 456.1(b) of the proposed rule. The language has been redrafted to make the provision easier to read. Instead of using "seller or provider" in each instance, staff has chosen to define a "seller" as anyone who sells or provides ophthalmic goods.

Section 456.2 Private Restraints

This section makes it an unfair act or practice for any seller or group of sellers, or any manufacturer or wholesaler of ophthalmic goods, to engage in any activity which has the effect of prohibiting, limiting, or burdening the dissemination of information concerning the sale or offer for sale of ophthalmic goods and services. The purpose of this section is to remove private impediments imposed by individuals, groups, professional associations, and others to the dissemination of information by retail

sellers of ophthalmic goods and services. This section does not create a duty to disseminate information, but seeks to allow those sellers who so choose to do so freely. The elimination of private restraints, in conjunction with Section 456.3 of this Part, is necessary to enable the Commission to free the market so that information necessary to consumer purchase decisions regarding ophthalmic goods and services can be more readily and freely made available.

Section 456.2 was formerly § 456.2(a) in the proposed rule. Staff has reorganized the Rule to assign separate status to each of the major operative provisions. In addition, staff has deleted the terms "hindering, restricting, reducing, altering, changing, or impairing." In doing so, staff does not intend to reduce the scope of the prohibited activities. Rather, staff believes that each of the deleted words is subsumed by the words which remain in the text of the recommended Rule.

Section 456.3 Public Restraints

This section makes it an unfair act or practice for any seller to reduce, limit, or burden the dissemination of information concerning the sale of ophthalmic goods and services in order to comply with the provisions of any nonfederal law, rule, regulation, or code of conduct, which would have the effect of prohibiting, limiting, or burdening that dissemination of information. The purpose of this section is to create a duty on the part of sellers not to be influenced, by, inter alia, state laws, regulations of state boards, or professional association codes in making decisions on whether and how to advertise ophthalmic goods and services. By forcing a conflict between this federally-created duty and existing state law, this section, together with the Declaration of Commission Intent (§ 456.5), seeks to preempt repugnant state law by providing sellers who wish to advertise with a valid federal defense to any formal or informal actions brought against them under color of nonfederal laws, regulations, or restraints.

The Commission by promulgating the Rule would be defining federal law. The Rule would become the supreme law of the land on the matters it covers, by virtue of the supremacy clause of the United States Constitution. This section of the Rule imposes the duty on each seller not to give consideration to any non-federal regulation relating to the dissemination of accurate information pertaining to the sale or offer for sale of ophthalmic goods and services, except as specified in the Rule. If a seller were to be prosecuted by a state for violating state law inconsistent with this Rule, the seller would be able to raise this Rule as an absolute defense against the state suit. Further, if a seller were to be adversely affected by a private association for exercising his duty under this Rule, e.g., if an optometric association seeking to enforce a code of ethics

were to bring disciplinary actions,¹ the retail seller could use this Rule as a defense. In addition to defensive uses, retail sellers could use the Rule affirmatively to seek declaratory judgments, injunctions, or other relief against the threatening or bringing of any such proceeding.

There now exist many state statutes and regulations and private restraints (see Section II of the Staff Report) which prohibit the dissemination of information concerning prescription eyewear and services. At present, an ophthalmic practitioner must weigh and consider the possible repercussions of violating these laws and private restraints if he wishes to advertise information relating to the cost or availability of his goods and services. The duty created by this Part of the Rule is for the seller to proceed as if there were no non-federal requirements governing the dissemination of information regarding ophthalmic goods and services other than the Rule. He must make his decision to disseminate information totally independently of the consideration of state or private restraints, the failure to do so being an unfair act or practice under Section 456.3 of the Rule.

There are, however, two specific exceptions to this provision. First, where state or local laws or regulations require ophthalmic advertisements to disclose:

- (a) whether an advertised price includes single-vision or multifocal lenses;
- (b) whether an advertised price for contact lenses refers to soft and/or hard contact lenses; and
- (c) whether an advertised price for ophthalmic goods includes an eye examination;

the seller must disclose these items in any dissemination of information. The Rule explicitly permits the states to impose disclosure requirements in these three limited areas.

Secondly, the Rule permits state or local governmental bodies to impose additional disclosure requirements on ophthalmic advertising where the laws or regulations are of general applicability. Thus, if a state law requires all advertisements to state the duration of an advertised offer, all ophthalmic advertising must comply with that enactment. However, to impose requirements such as this, the state or local law or regulation must apply to all consumer products, not only ophthalmic goods.

¹ Such disciplinary actions are also directly violative of § 5 of the Federal Trade Commission Act under § 456.2 of

Section 456.3 was § 456.2(b) in the proposed rule. As with the prior section, staff has deleted many of repetitive terms contained in the proposed rule. "Alter, change, and impair" have been deleted to make the section easier to read. Staff believes that each of these terms is subsumed by the terms "reduce, burden, or limit" which are retained in the provision.

Section 456.4 Release of Prescriptions

This section makes it an unfair act or practice to fail to deliver to the patient a copy of his ophthalmic prescription immediately upon conclusion of the eye examination. This provision contains a number of important features. First, the refractionist must deliver the prescription to the patient even if the patient does not make a specific request for it. Thus, every patient examined by a refractionist must be given a copy of his prescription. If the examination reveals that the patient does not need any corrective lenses there can be no ophthalmic prescription. By definition, the ophthalmic prescription contains the written specifications for the preparation of ophthalmic lenses. Accordingly, if a patient does not require any ophthalmic lenses there can be no prescription prepared or delivered. However, if the patient who is examined already uses ophthalmic goods and the examination reveals that no new or additional ophthalmic goods are required, the refractionist must nonetheless prepare and release to the consumer a copy of the prescription containing the results of that examination.

Second, nothing in this Rule provision is designed to prevent the refractionist from dispensing the ophthalmic goods to the patient if the patient so chooses. However, the refractionist must give the prescription to the patient in every case, irrespective of whether the patient buys his eyewear from the refractionist or chooses to obtain his eyewear elsewhere.

In addition, this Rule provision controls the timing of the release of the prescription. The general requirement is that the prescription must be given to the patient at the conclusion of the examination. The term "immediately after the eye examination is completed" has been employed to make it clear that the prescription must be delivered to the consumer before that consumer leaves the practitioner's establishment. However, the Rule contains one exception to this general requirement. The refractionist may withhold the patient's prescription until the patient has paid for the examination, if the refractionist imposes a similar requirement on his patients who it is determined do not require any corrective lenses. Thus, any refractionist is free to establish whatever payment policy he chooses. He is not free, however, to impose a condition of prepayment only upon those persons desiring to take their prescription to another seller.

Section 456.4(b) makes it an unfair act or practice for a refractionist to refuse to perform an eye examination if a patient desires to take his prescription to another seller or provider to obtain any necessary ophthalmic goods. This provision is intended to cover any attempt to condition the availability of examination services on prior agreement that necessary ophthalmic goods will be provided by the refractionist.

Section 456.4(c) makes it an unfair act or practice for a refractionist to impose any additional fee on a patient if the patient chooses to take his ophthalmic prescription to any other seller or provider. The general rule imposed by this section is that the refractionist cannot charge the patient more than he would have charged for the examination had the examination determined that no corrective lenses were required. This provision contains a number of important conditions. First, this provision does not in any way prevent a refractionist from charging an additional fee for verifying the lenses dispensed by another seller or provider. The refractionist is free to charge whatever fee he chooses to compensate him for the performance of that professional service. However, such a fee cannot be charged or imposed prior to the time that the service is performed. Thus, at the time the lenses are verified, the refractionist may charge a fee for that service; but the verification fee cannot be imposed at the time the eye examination is performed.

In addition, refractionists are free to impose an additional fee where applicable state law or regulation requires all refractionists in the state to include additional items of information in the ophthalmic prescription. For example, if state law requires that all prescriptions specify the pupillary distance, tint, segment height or characteristics, or other information normally associated with the dispensing of ophthalmic goods, the refractionist may charge an additional fee for performing such services. However, such an additional fee can only be imposed if all prescriptions in the state are required to contain this information. Thus, no charge can be imposed for the performance of such services unless both ophthalmologists and optometrists are required to include such information in the prescriptions they write. If state law or regulation requires prescriptions written by optometrists to include a specification for tint, pupillary distance, segment height, vertex, or other similar items, but does not require prescriptions written by ophthalmologists to include those items, no charge can be imposed for performing those services.

Section 456.4(d) makes it an unfair act or practice to attempt to employ certain types of waivers and disclaimers of liability. The Rule prohibits refractionists from placing on the ophthalmic prescription any words disclaiming the liability of the refractionist. In addition, the rule prohibits refractionists from delivering to the patient or requiring the patient

to sign any form whatsoever disclaiming the refractionist's liability for the accuracy of the examination or the accuracy of the goods dispensed by another seller or provider. This Rule provision is not intended to make refractionists liable for the ophthalmic goods dispensed by other sellers and providers of ophthalmic goods.

Section 456.5 - Declaration of Commission Intent

This section seeks to specify and make apparent that the Commission, by the promulgation of this Rule, intends to allow the dissemination of accurate information by sellers and providers of ophthalmic goods and services to prospective consumers of such goods or services and to eliminate all restraints on such dissemination by nonfederal law and by private, state, and local governmental action. Further, this section makes it clear that the Commission intends that this Rule will preempt all nonfederal laws, ordinances, or regulations that are repugnant to this Rule that would frustrate the purpose of this Rule, that would in any way prevent or burden any dissemination of accurate information by sellers and providers of ophthalmic goods and services to prospective purchasers, or that would impose standards for such dissemination except to the extent specified in the Rule.

This section makes it clear that the Commission intends that this Rule may be used as a defense in legal or administrative proceedings, or affirmatively for declaratory, injunctive, or other relief. This section makes it apparent that it is not the Commission's intent to compel any seller or provider of ophthalmic goods and services to provide or disseminate information with respect to those goods or services, but that this section is intended solely for the protection of those sellers or providers who are disposed to disseminate certain pertinent information but have been restrained or prevented from so doing due to the prohibitions of both nonfederal laws and private, state and local governmental action.

Finally, the Rule requirements and Declaration of Intent are separate and severable, so that if any provisions or the application thereof to any person, partnership, or corporation, are held invalid, the remainder of the provisions or their application to any other person, partnership, corporation, shall not be affected thereby.

APPENDIX A

FEDERAL TRADE COMMISSION
WASHINGTON, D. C. 20580

BUREAU OF
CONSUMER PROTECTION

Dear

The Federal Trade Commission has proposed a trade regulation rule which would allow sellers or providers of ophthalmic goods and services to engage in truthful advertising of such goods and services, notwithstanding state laws and regulations to the contrary. In addition, private restrictions on such accurate advertising would also be prohibited.

In addition to the proposed Rule, the Commission has indicated that if the evidence generated during the course of the hearings demonstrates that buyers are prevented from price shopping because of unavailable prescriptions, it may also require persons qualified to perform eye examinations to deliver written prescriptions to their patients.

The Commission has reason to believe that state laws and regulations, associational codes of conduct, and other private restrictions on advertising, inhibit healthy competition and artificially inflate the prices consumers must pay for ophthalmic goods and services. The Commission also has reason to believe that such laws and restrictions are not supported by any vital state interest in the public health, safety and welfare.

Because this proposal affects state laws and regulations in this area, we actively encourage the participation of state officials by the submission of written views or oral testimony at the public hearings to be held on this matter. It would be particularly helpful if you would comment on whether state laws and regulations which prohibit or restrict the disclosure of accurate information are vital to achieve important state policy goals, the nature of those goals, and whether such goals can be achieved by other means.

The Commission has determined that the Staff Report accompanying the proposed rule should be made public. A copy of that Report along with a copy of the Federal Register notice are enclosed for your use. Copies of these documents are being sent to the Governor, Attorney General, presiding officials of each chamber of the state legislature, interested state professional associations, and the appropriate state board of each state.

Instructions for submitting written comments on the proposed rule are contained in the last page of the Federal Register notice. A later Federal Register notice will set forth the hearing sites and the dates therefor. Tentatively, hearings are scheduled for Washington, D.C., New York, Cleveland, Dallas and San Francisco. If you desire more information, please address your inquiries to Room 474, Federal Trade Commission, 6th and Pennsylvania, Ave., N.W., Washington, D.C., 20580.

Sincerely,

Joan Z. Bernstein
Acting Director
Bureau of Consumer Protection

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