No. 12-461

In the Supreme Court of the United States

NATIONAL ASSOCIATION OF OPTOMETRISTS & OPTICIANS; LENSCRAFTERS, INC.; EYECARE CENTERS OF AMERICA, INC., PETITIONERS,

v.

KAMALA D. HARRIS, in her official capacity as Attorney General of the State of California; CHARLENE ZETTEI, Director, Department of Consumer Affairs, RESPONDENTS.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF *AMICI CURIAE* OPTICIANS ASSOCIATION OF AMERICA; CATO INSTITUTE; KEVIN H. TRAN, O.D.; JESSICA RACHEL TOTTEN, O.D.; ANTONIO MORAN, O.D.; BEI ZHANG, O.D.; AND MEHRI MOSHTAGHI, O.D., IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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INTRODUCTION AND INTEREST OF *AMICI CURIAE*[1]

The California laws challenged in this action[2] allow in-state optometrists to sell eyewear as part of their own practices, but prohibit optometrists from affiliating with interstate retail eyewear chains. These blatantly protectionist measures have both the purpose and the effect of insulating in-state optometrists from competition from out-of-state optical stores, which often provide comparable products and services at lower prices. California's statutes and regulations thus unconstitutionally discriminate against interstate commerce and impede the "national free market" in goods and services that the Commerce Clause was intended to secure. *Wyoming* v. *Oklahoma*, 502 U.S. 437, 469 (1992).

But there is more than just abstract legal principle at stake here. Competition helps consumers, especially those least advantaged. By raising the cost of access to eye care, the challenged laws disproportionately burden underserved minority communities. These communities already face higher-than-average rates of visual impairment and have limited access to affordable health care. California's regulatory scheme pushes needed care even further out of reach. It also blocks an important gateway into the profession for newly-licensed minority optome-

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[1] *Amici* provided notice of their intent to file this brief to counsel of record for each party at least 10 days prior to the due date for filing, and all parties have consented to this filing. No counsel for a party authored this brief in whole or in part, and no person, other than the *amici* and their counsel, contributed money to its preparation or submission.

[2] Cal. Bus. & Prof. Code §§ 655, 2556, 3103; Cal. Code Regs. tit. 16, §§ 1399.251, 1514.

trists, who are statistically more likely to serve minority communities.

Founded in 1926, the Optician's Association of America is the only national organization representing opticianry's business, professional, educational, legislative, and regulatory interests.

The Cato Institute, founded in 1977, is a nonpartisan public policy research foundation dedicated to advancing the principles of individual liberty, free markets, and limited government. Cato's Center for Constitutional Studies was established in 1989 to promote the principles of limited constitutional government that are the foundation of liberty. Toward those ends, Cato publishes books and studies, conducts conferences, produces the annual *Cato Supreme Court Review*, and files amicus briefs.

The individual optometrist *amici*—Drs. Kevin H. Tran, Jessica Rachel Totten, Antonio Moran, Bei Zhang, and Mehri Moshtaghi—each devote substantial time to providing eye care and outreach services to underserved, largely minority communities in California. Their practices, which are affiliated with national retail eyewear chains, will be directly affected by the restrictive regulations being challenged in this lawsuit. Brief professional biographies of the optometrist *amici* are provided in the Appendix to this brief.

Amici believe, as did the framers of the Commerce Clause, that consumer welfare—whether in the field of eye care services or otherwise—is best promoted by robust competition in a truly national marketplace. Accordingly, *amici* urge this Court to grant certiorari to review California's impermissibly protectionist regulatory regime.

SUMMARY OF ARGUMENT

I. As Petitioners have demonstrated, the challenged laws indisputably have a discriminatory effect: They permit in-state optometrists to combine the functions of performing eye examinations and selling eyewear, but prohibit interstate optical retailers from doing the same. In addition to this discriminatory effect, it is also apparent from the record below that the laws had a discriminatory purpose, which provides an independent reason why they fall afoul of the Commerce Clause.

The legislative history shows that the central statutes at issue were enacted at the behest of in-state business interests who feared competition from out-of-state retail chains. Section 2556, which prohibits optical retailers from furnishing, employing, or maintaining optometrists at their locations, was passed as a "defense law" intended—in the words of Respondents' own expert witness—"to prevent out-of-state optical companies from coming into California and undercutting dispensing optometrists on price." A. 81–82. Section 655, which prevents various kinds of affiliations between optical retailers and eye care professionals, was described by its legislative sponsor as being introduced "on behalf of the California Optometric Association in an effort to protect California from some of the problems * * * being experienced in eastern states, where large business interests have completely taken over the optometric profession." A. 81. This kind of blatantly protectionist purpose cannot survive Commerce Clause scrutiny.

The incoherence of California's regulatory scheme provides further support for finding a discriminatory purpose. As the District Court found, and the Ninth Circuit did not controvert, all of the public health problems that Respondents claim are caused by the affiliation be-

tween optometrists and optical retailers are also present when non-affiliated optometrists sell eyewear as part of their private practices. California has presented no plausible rationale—apart from naked protectionism—for permitting in-state optometrists to provide one-stop shopping, while prohibiting interstate optical retailers from doing the same.

II. California's regulations also have negative real-life effects, particularly on underserved minority communities. Minorities already face a higher incidence of visual impairments and greater barriers to eye care access. The protectionist regime challenged here exacerbates these problems by insulating the eye care market from competition by interstate retailers, who often provide goods of comparable or better quality at a lower cost to consumers. Studies show that eye care prices are higher in markets that exclude retail chains from offering one-stop shopping, and poor and minority consumers are most heavily impacted by those increased costs.

Preventing optometrists from affiliating with retail optical chains also closes an important gateway into the profession for newly-licensed minority optometrists, who are often faced with high entry and startup costs. Imposing further barriers to minority participation in the optometric profession will ultimately harm the underserved communities in which these individuals disproportionately practice.

ARGUMENT

I. The Challenged Laws Were Expressly Intended To Protect In-State Business Interests At The Expense Of Out-Of-State Competitors, In Violation Of The Commerce Clause.

As Petitioners have explained, California's prohibition on co-location has the undisputed effect of allowing in-state optometrists both to perform eye examinations and to sell eyewear to their patients, while barring national eyewear chains who compete in California from offering the same "one-stop shopping." And, as the District Court recognized, the state's purported public health concerns—which could perhaps justify a hypothetical bar on *any* optometrist selling eyewear—cannot support a discriminatory regime where in-state optometrists are allowed both to perform examinations and to sell glasses, but national retail chains are not. A. 100–101.

The result is a regulatory scheme that both the Federal Trade Commission and California's own Department of Consumer Affairs have recognized as irrational and anti-competitive. In a 1989 rulemaking proceeding, the FTC determined that the challenged restrictions "work to deprive consumers of necessary eye care, restrict consumer choice, and impede innovation in the eye care industry" without "provid[ing] offsetting quality-related benefits to consumers." 54 Fed. Reg. 10285, 10298, overturned on other grounds, *California State Bd. of Optometry* v. *FTC*, 910 F.2d 976 (D.C. Cir. 1990). It concluded that "[a] significant proportion of [eye care] costs can be attributed to the inefficiencies of an industry protected from competition by state regulation," noting that "prices for eye care are 18 percent higher in markets where chain firms are totally restricted than in markets where chain firms operate freely." 54 Fed. Reg. 10285–10286.

Similarly, in 1982, the California Department of Consumer Affairs found that the state's restrictions on co-location imposed serious costs on consumers without furthering any public health objective:

> The State on the one hand takes the extreme measure of literally banning a form of practice with clearly demonstrated and major economic benefits to consumers, and with probably health-related advantages as well; while on the other hand it does little or nothing to examine or enforce laws which would protect consumers from bad practices among the great majority of optometric licensees.

California Department of Consumer Affairs, Commercial Practice Restrictions in Optometry 24 (Dec. 1982). The Department concluded that "[i]n sum, the web of corporate practice regulations works unevenly and inconsistently; rests on premises which are unproven, demonstrably false, or are contradicted by evidence of how corporations operate in fields other than optometry; avoids known consumer abuses; and operates effectively in only one consistent way—stifling competition." *Id.* at 25.

Why would California put in place a regulatory regime that stifles competition, restricts consumer choice, raises prices, and provides no offsetting health benefits? The legislative history of the challenged laws provides an answer: They were enacted to give in-state optometrists a monopoly on one-stop shopping and thus an artificial competitive advantage over national chains in the retail eyewear market. This is precisely the kind of blatantly protectionist purpose that the dormant Commerce Clause prohibits.

A. The legislative history of the statutes reveals a discriminatory purpose.

1. "A finding that state legislation constitutes 'economic protectionism'" in violation of the Commerce Clause "may be made on the basis of either discriminatory purpose, see *Hunt* v. *Washington Apple Advertising Comm'n*, 432 U.S. 333, 352–353 (1977), or discriminatory effect." *Bacchus Imports, Ltd.* v. *Dias*, 468 U.S. 263, 270 (1984) (other citations omitted); see also *South Dakota Farm Bureau, Inc.* v. *Hazeltine*, 340 F.3d 583, 596 (8th Cir. 2003) ("[d]iscriminatory purpose is at the heart of dormant Commerce Clause analysis"). Courts regularly look to legislative history and similar sources to ascertain whether a statute was enacted for a discriminatory purpose. See, *e.g.*, *Kassel* v. *Consolidated Freightways Corp.*, 450 U.S. 662, 671 (1981) (state's asserted safety interest found to be "illusory" in context of Commerce Clause challenge); *East Kentucky Res.* v. *Fiscal Ct. of Magoffin Cty.*, 127 F.3d 532, 542 (6th Cir. 1997) ("where other sources, other than the state's own self-serving statement of its legislative intent, indicate the presence of actual and discriminatory purposes, a state's discriminatory purpose can be ascertained from sources"); *Chambers Med. Tech. of South Carolina, Inc.* v. *Bryant*, 52 F.3d 1252, 1259 & n.10 (4th Cir. 1995) (considering statements of state legislators in connection with inquiry into discriminatory purpose).

Here, the legislative history of sections 2556 and 655 of the California Business & Professions Code—the statutory bases of the retail chain affiliation ban challenged in this lawsuit—shows that those laws were passed at the behest of interest groups seeking to protect the one-stop shopping monopoly enjoyed by in-state optometrists. Indeed, the California Legislature was never presented

with evidence of any harm to consumers or patients that would necessitate the challenged prohibitions.

2. Section 2556 prohibits optical companies from furnishing, employing, or maintaining optometrists or ophthamologists on their premises. Cal. Bus. & Prof. Code § 2556. That law was enacted in 1939 in the wake of the entry into the California marketplace of Kindy Optical, an out-of-state retail eyewear chain—an event that "shocked" California optometrists. Richard Kendall, *Optometry's Expanding Scope*, Cal. Optometry (March/April 1999). Kindy—like today's retail eyewear chains affected by the challenged regulations—partnered with optometrists to provide customers with eye examinations at the same locations where it sold eyeglasses. The company was eventually charged with, and convicted of, violating the state's Optometry Act and driven from California. *California Optometrists Win Two-Year Legal Battle*, Optical J. & Rev. of Optometry 36 (Aug. 15, 1938).

In response to this episode, the Los Angeles County Association of Optometrists asked the state legislature to enact a "defense law." *Ibid.* The following year, section 2556 was enacted to prohibit interstate retailers from challenging in-state optometrists' monopoly on one-stop shopping. As the District Court noted, Respondents' own legislative history expert conceded below "that section 2556 was enacted as part of an effort to prevent out-of-state optical companies from coming into California and undercutting dispensing optometrists on price." A. 81–82.

3. Section 655, enacted in 1969, prohibits opticians and optical companies from having "any membership, proprietary interest, co-ownership, landlord-tenant relationship, or any profitsharing arrangement in any form, directly or indirectly" with ophthalmologists or optometrists. Cal. Bus. & Prof. Code § 655. That section, too, was

enacted at the behest of in-state interest groups seeking to preserve their monopolies over one-stop shopping by excluding national retailers from the California market. As the District Court explained:

> Section 655 was introduced in the California Legislature in 1969 "on behalf of the California Optometric Association in an effort to protect California from some of the problems * * * being experienced in eastern states, where large business interests have completely taken over the optometric profession."

A. 81 (quoting letter from California State Senator Lewis F. Sherman, the legislation's chief sponsor, to Governor Ronald Reagan, dated August 11, 1969). The bill's sponsor made clear that the law was not intended to prohibit one-stop shopping altogether, but only for out-of-staters: "[i]t was not our intention to harm any existing relationships between California optometrists, therefore we have excluded these groups by a careful amendment." Letter from Lewis F. Sherman to Ronald Reagan (Aug. 11, 1969).

In-state business interests also rebuffed more recent efforts to repeal section 2556 and 655. Petitioners' expert witness presented unrebutted evidence to the District Court that State Senator Joseph Montoya, in opposing repeal, "raised the specter of competition from 'low income states' and 'foreign manufacturers' noting 'statistics have shown that for every twelve pairs of eyeglasses going out of state for manufacture, one Californian loses his or her job.'" Declaration of Robert Pitofsky in Opposition to Defendants' Motion for Summary Judgment at ¶ 25 (Dist. Ct. Dkt. Doc. 281).

4. The District Court correctly found the evidence "quite strong" that the challenged regulations "were en-

acted with a purely protectionist purpose." A. 101. In short, the legislative history of the challenged laws—which was unrebutted before the District Court and largely unaddressed by the Ninth Circuit—supports a finding of discriminatory intent. See, *e.g.*, *Hunt*, 432 U.S. at 352 (invalidating protectionist apple labeling regulation which had been proponed by local apple-growing interests); *McNeilus Truck & Mfg., Inc.* v. *Ohio*, 226 F.3d 429, 433 (6th Cir. 2000) (discriminatory intent evident from "several letters by in-state dealers and remanufacturers to the Ohio legislature seeking" the challenged legislation).

B. The incoherence of the statutory scheme supports a finding of discriminatory purpose.

Moreover, there was no evidence below that the California statutes at issue do anything to prevent harm to the public or to protect the practice of optometry from improper commercial pressures.

The District Court found, and the Ninth Circuit did not controvert, that Respondents had "fail[ed] to present any evidence which compares the quality of care between dispensing optometrists and optometrists who work for optical chains." A. 107. To the contrary, it found that Petitioners had "set forth sufficient facts which reveal that the same problem practices which [Respondents] allege are prevalent in the corporate setting, are just as prevalent when optometrists dispense eyewear." *Ibid.* The District Court concluded that:

> [T]he record is essentially silent as to how the practices identified by the [Respondents] actually harm the public's health. * * * [T]here is no evidence which links the complained of practices to actual harm to the public's health.

A. 114.

Indeed, if California truly were concerned with protecting the public's health, the challenged regulations would be singularly ill-suited for that purpose. If providing eye examinations and selling eyewear at the same location did threaten the public's health, that might justify a prohibition on *all* co-location between examinations and sales. But it cannot justify a regime under which favored, in-state businesses are permitted to combine examinations and sales, while their interstate competitors are prohibited.

The incoherence of California's discriminatory regulatory regime can be illustrated by looking at the beneficiaries and casualties of the scheme:

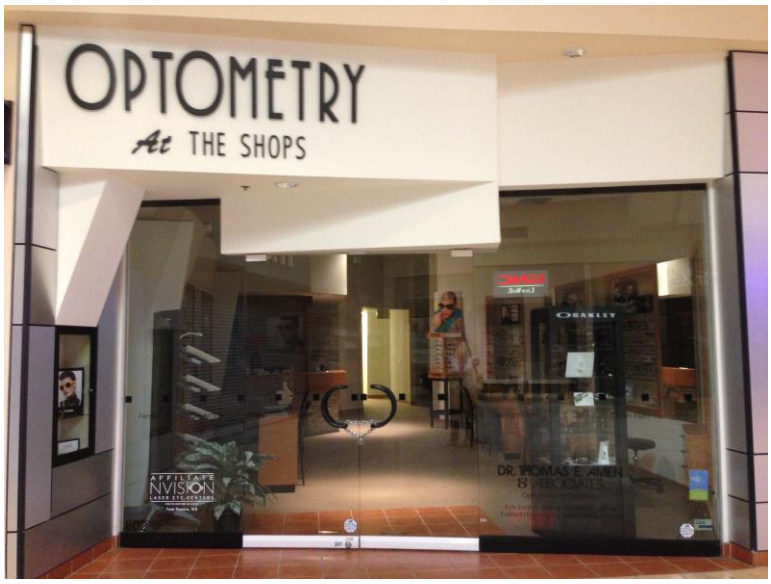

Photo 1: A California dispensing optometrist.

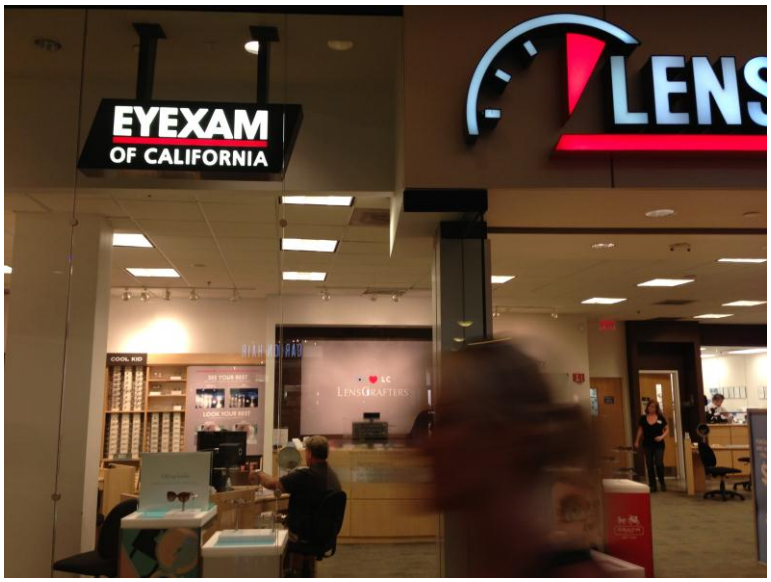

Photo 2: An interstate optical retailer.

These photographs dramatically show that the types of establishments between which California discriminates are virtually indistinguishable to the public: Each offers eye exams along with retail glasses and other eyewear. As the District Court found, "in-state optometrists and ophthamologists who sell eyewear compete with interstate optical chains to sell the same product—prescription eyewear—to the same customers in the same retail eyewear market." A. 91; see also A. 99. Moreover, there was "no evidence that the quality of eye care varies by practice setting." A. 115. Under California's protectionist regime, however, the in-state establishment in Photo 1 could offer one-stop shopping, while its interstate competitor in Photo 2 could not. California cannot articulate what legitimate public purpose is served by such an arbitrary distinction.

When a state "employ[s] a highly ineffective means to pursue its ostensible purpose" which "does virtually nothing to further [its] purported goal," that in itself can support a finding of discriminatory purpose. *SDDS, Inc.* v. *South Dakota*, 47 F.3d 267, 269–270 (4th Cir. 2003); see also *South Dakota Farm Bureau*, 340 F.3d at 595 ("[a] low probability of effectiveness can be indirect evidence of discriminatory purpose"); *Pete's Brewing Co.* v. *Whitehead*, 19 F. Supp. 2d 1004, 1016 (W.D. Mo. 1998) (evidence "that the means used to achieve the state's 'ostensible purpose' were relatively ineffective * * * strengthens the Court's conclusion that Missouri's labeling statute has a discriminatory purpose"). The incoherence of the challenged regulatory scheme supports such a finding here.

II. California's Protectionist Regime Increases Costs And Decreases Access To Eye Care For Members Of Poor And Minority Communities.

Far from furthering any legitimate public health goal, California's protectionist regime actually puts affordable, accessible eye care further out of reach for vulnerable populations. Visual impairment is a particularly pervasive problem in poor and minority communities, where many residents cannot afford the cost of effective eye care. Allowing eye care professionals to affiliate with interstate eyewear retailers promotes competition, which increases access to and reduces the cost of vision care for underserved consumers.

A. Minority communities are disproportionately impacted by visual impairments and lack of access to adequate eye care.

1. Visual impairment is one of the most frequent causes of disability in the United States. According to the National Center for Health Statistics' 2010 National Health Interview Survey, 21.5 million American adults reported experiencing vision loss, which is defined as blindness or trouble seeing even when wearing glasses or contact lenses. J.S. Schiller, *et al.*, *Provisional Report: Summary health statistics for U.S. adults: National Health Interview Survey, 2010*, 10 Vital Health Stat. 252 (2012). In 2006, researchers estimated the annual economic burden of vision disorders in the United States just among adults older than 40 years to be $35.4 billion—$16.2 billion in direct medical costs, $11.1 billion in other direct costs, and $8 billion in productivity losses. D.B. Rein, *et al.*, *The economic burden of major adult visual disorders in the United States*, 124 Arch. Ophthalmology 1754 (2006).

While visual impairment is widespread, many Americans do not regularly use or have access to optometric services. The American Optometric Association ("AOA") recommends that adults under age 60 be examined every two years, and that adults over 60 be examined every year. American Optometric Association, Optometric Clinical Practice Guideline 11, available at http://www.aoa.org/documents/CPG-1.pdf. In 2006, however, only 55 percent of American adults reported having had an eye examination within the past two years. U.S. Department of Health & Human Services, Healthy People 2020 Summary of Objectives: Vision V-4, available at http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf. The AOA recommends that children should have their first eye exam at six months of age, another exam at age three, and another at the start of school. American Optometric Association, Need for Comprehensive Vision Examination of Preschool and School-age Children, available at http://www.aoa.org/x5419.xml. But only about a third of American children have had an eye exam before entering school. *Ibid.*

2. These problems are especially severe in minority communities. "There is little argument that segments of the population in the United States, especially racial minorities, have not had equal access to health care services. Lack of access to health care was a predictable outcome of a largely segregated society." Vera B. Thurmond & Darrell G. Kirch, *Impact of Minority Physicians on Health Care*, 91 S. Med. J. 1009, 1012 (1998).

For example, three times as many African Americans have glaucoma than whites, and four times as many are blind. Between the ages of 45 and 64, glaucoma is fifteen times more likely to cause blindness in African Americans than in whites. *Blindness and Visual Impairment—A Public Health Issue for the Future as Well as*

Today, 122 Arch. Ophthamology 451 (2004). Moreover, a study by the National Institutes of Health found that Latinos "have higher rates of developing visual impairment, blindness, diabetic eye disease, and cataracts than non-Hispanic whites." National Eye Institute, U.S. Latinos Have High Rates of Developing Vision Loss and Certain Eye Conditions (May 1, 2010), available at http://www.nei.nih.gov/news/pressreleases/050110.asp. The study also found that over 60 percent of eye disease in Latinos is undiagnosed and undetected. See also, *e.g.*, M.R. Wilson & D.R. Eezzuduemhoi, *Ophthalmologic disorders in minority populations*, 89 Med. Clin. N. Am. 795 (2005) (noting that African Americans and Hispanics suffer higher rates of blindness and visual impairment than white Americans).

These disparities exist in every age group. Research reports that older African Americans are under-treated for cataracts, diabetic retinopathy, and glaucoma. Bahram Rahmani, *et al.*, *The Cause-specific Prevalence of Visual Impairment in an Urban Population: The Baltimore Eye Survey*, 103 Ophthamology 1721 (1996). A 1998 study of Alabama public schools found that an estimated 28.3 percent of African American children were not receiving needed eye care. Janene Sims, *et al.*, *Need for eyecare in an African-American community*, 40 Invest. Ophthalmology & Visual Science (Supp.) S284 (1999). The authors attributed this shortfall to lack of access, high costs, and a poor understanding of the importance of eye care for school-aged children. *Ibid.*

3. Cost is a major barrier to proper eye care in many minority communities. Because the "prevalence of eye diseases * * * is directly associated with the accessibility, utilization, and quality of eye care services in the community," poor people who are priced out of optometric care suffer the health consequences. Edwin C. Marshall, *A*

Public Health Perspective to Clinical Health Care in Indiana, 2 Ind. J. Optometry 22 (1999).

Of the 21.5 million Americans who report vision loss, almost 4 million are uninsured. Schiller, *et al.*, *supra*. And even patients with health insurance often must cover much of the cost of optometric care out of their own pockets. See U.S. Department of Health & Human Services, Visits to Selected Health Care Practitioners: United States 1980 (1986), available at http://www.cdc.gov/nchs/data/natmedcare/nmc_b_08acc.pdf (finding that the patient or patient's family paid for 76 percent of the total cost of optometric services). As a series of focus groups conducted by the National Eye Institute revealed, "cost was reported to be a factor that got in the way of participants receiving eye care services, as well as required followup services, such as prescriptions." National Eye Institute, Identification of Variables That Influence the Receipt of Eye Care: Focus Group Report 70 (Aug. 2005), available at http://www.nei.nih.gov/nehep/research/REC_FocusGroupReport_10-25-05_wExec.pdf.

B. The competition provided by retail eyewear chains increases access to eye care services by increasing convenience and reducing costs.

Just as high costs deter many from obtaining routine eye care, reduced costs improve access to vision services and increase the frequency of optometric visits. A 2003 study, for example, found that patients with diabetes were more likely to get annual dilated eye exams if the cost were covered by health insurance or reduced to a copay than if they were required to cover the full costs out-of-pocket. Andrew Karter, *et al.*, *Out-of-Pocket Costs and Diabetes Preventative Services*, 26 Diabetes Care 2294 (2003). When costs are high, low-income minority indi-

viduals are more likely to delay routine eye examinations. See *id.* at 2298 ("patients are more price sensitive when they perceive a health service as optional"). This delay may aggravate existing problems or even render them untreatable.[3] The lesson is clear: Reducing the cost of optometric care is essential to improving the visual health of low-income minority communities.

The availability of optometric care at retail optical chains provides an important point of health care access in such communities. Optical chains are often located in shopping malls, close to other retail outlets. These establishments provide a convenient way for underserved individuals, who often do not have a usual source of health care, to obtain vision services. See 1 U.S. Department of Health & Human Services, Healthy People 2010 1-8 (2d ed. 2000).

Even more significantly, the increased competition made possible by allowing optometrists to affiliate with optical retailers reduces the cost of services across the industry, making eye care more accessible to low-income and minority communities.

As the FTC found during its review of state optometric regulations, prices for eye exams and eyeglasses were 18 percent higher in markets without chain optical retailers. 54 Fed. Reg. 10288. The FTC concluded:

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[3] For example, early diagnosis and treatment of diabetic retinopathy, a leading cause of blindness among people with diabetes, has been shown to prevent vision loss in more than 90 percent of patients. 2 U.S. Department of Health & Human Services, Healthy People 2010 28-4 (2d ed. 2000). Because people with diabetes often do not visit optometrists for the recommended annual dilated eye exam, an estimated half of all patients are diagnosed too late for treatment to be effective. See *ibid.*

> (1) That average prices for eye exams and eyeglasses are lower in markets with chain firms than in markets without chain firms; (2) that chain firms and other large-volume providers charge significantly lower prices than noncommercial providers; and (3) that each of the restrictions imposes unnecessary costs on commercial practice that impede its development and raise prices to consumers.

Ibid.[4] Other studies have also concluded that commercial practice restrictions like California's increase prices without significantly raising the quality of eye examinations. See Deborah Haas-Wilson, *The Effect of Commercial Practice Restrictions: The Case of Optometry*, 29 J.L. & Econ. 165 (1986). Such restrictions also deter optical retail chains from entering the market, reducing the availability of low-cost ophthalmic services. See Deborah Haas-Wilson, *Strategic Regulatory Entry Deterrence: An Empirical Test in the Ophthalmic Market*, 8 J. Health Econ. 339, 351 (1989).

In California, where over 20 percent of African Americans and Hispanics live below the poverty line, permit-

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[4] Commenting on proposed Tennessee regulations similar to those at issue here, then-FTC Chairman Timothy Muris reconfirmed the Commission's earlier findings, observing that the Tennessee law would likely reduce competition and negatively impact the price, variety, and quality of eye care services. Chairman Muris reaffirmed the FTC's earlier findings that co-location restrictions tend to drive up prices and thus deter consumers from seeking eye care: "[W]e have identified no change in the marketplace that economic analysis suggests would likely reverse or eliminate the price effect if a new study were conducted with more recent data." Letter from Timothy Muris to Ward Crutchfield (April 29, 2003), available at http://www.ftc.gov/be/v030009.shtm.

ting optical chains to continue to provide optometric services will not immediately remedy the state's serious health care disparities. See Sarah Bohn, Poverty in California (2011), available at http://www.ppic.org/content/pubs/jtf/JTF_PovertyJTF.pdf. But the competition spurred by retail optical chains and the resulting reduction in the cost of services will certainly benefit underserved minority communities.

C. Retail chain affiliations provide a gateway into the profession for minority optometrists.

In addition to improving access to eye care in minority communities by decreasing cost, affiliation with retail optical chains provides an important gateway into the profession for newly-licensed minority optometrists who may not have the capital necessary to open their own practices. California's challenged regulations slam shut this gateway—thus perpetuating the underrepresentation of minorities in the optometric profession.

Minorities are severely underrepresented in the field of optometry. As of 2007, only 3.5% of enrolled optometry students in the United States were African American, and only 5.7% were Hispanic. Gulroop S. Hansra, *Why Can't I Find an O.D. Who Looks Like Me?*, Optometric Mgmt. (Sept. 2007), available at http://www.optometricmanagment.com/articleviewer.aspx?articleid=100895.

The low number of minority optometrists impacts both the optometric profession and minority eye care. Minority physicians are more likely to provide care for underserved populations. Thurmond & Kirch, *supra*, at 1009–1010. Minority optometrists thus help improve awareness of the need for vision services in minority communities.

Minority underrepresentation in the optometry profession is a result of many factors. Some are systemic—admission to optometry school requires a bachelor's degree, an educational level obtained by comparatively fewer people of color. In some ways, the low number of minority optometrists is a self-reinforcing cycle: Minority students often face "a lack of mentors, encouragement in their academic pursuits or family financial assistance before entering the program." Marlee M. Spafford, *et al.*, *Diversity within the Profession, Part I: Trends and Challenges*, 27 Optometric Educ. 114, 117 (2003).

Cost is also a deterrent. Tuition and fees for a single year of optometry school can range from over $13,000 for a resident student at a public college to almost $40,000. Association of Schools and Colleges of Optometry, Schools and Colleges of Optometry: Admission Requirements 2009–2010, available at http://www.opted.org/files/public/Admission_Requirements_09-10.pdf. Facing heavy student debt loads, many minority optometrists must generate some type of income soon after graduation. Opening an individual practice is often not a realistic option due to lack of experience, start-up funds, and contacts. See Spafford, *supra*, at 118 (minority optometry graduates often have trouble realizing the "factors that determine successful self-employment (obtaining supportive capital, developing a stable client base, community support and sufficient management training)").

In situations like these, affiliation with a retail optical chain—which provides an existing client base, office space, and capital equipment—provides an indispensable opportunity for many new entrants to the profession. Many minority students enter into such affiliations as their first step into the profession. If California's protectionist regulations are permitted to stand, newly-graduated minority optometrists facing heavy student

loan debt and limited financial resources and contacts will have few viable options for practice in California.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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APPENDIX

Antonio Moran, O.D. is a graduate of the University of California at Berkeley School of Optometry and has been in practice for 11 years. He is the managing optometrist at the EYEXAM of California office in Santa Rosa. Fluent in English and Spanish, Dr. Moran takes pride in providing eye care and eye health education to a diverse community of residents through his participation in EYEXAM's OneSight program and other volunteer work in the community.

Mehri Moshtaghi, O.D. attended the University of California, San Diego, majoring in bioengineering and psychology; she received her doctorate from the Southern California College of Optometry. She currently manages the La Jolla location of EYEXAM of California. Throughout her career, Dr. Moshtaghi has worked to ensure that everyone, regardless of their economic circumstances, has access to quality eye care. To that end, she has volunteered at Remote Medical Area in Los Angeles, gone on a mission trip to El Salvador, and provided free eye exams at her office to elementary school children. Dr. Moshtaghi is fluent in Spanish and Farsi, and uses these skills to provide care to underserved communities.

Jessica Rachel Totten, O.D. is a graduate of the University of California, San Diego and the University of Houston College of Optometry. Dr. Totten has been working at EYEXAM of California for over a year and managing the Riverside office for six months. She participates in EYEXAM's OneSight program, through which she provides two free eye exams each week for those in need.

Kevin H. Tran, O.D. received his bachelors degree from the University of California, San Diego and his doctorate from the Southern California College of Optometry. He completed his residency training in ocular diseas-

es at West Los Angeles Veterans Hospital. Dr. Tran participates in the OneSight program by providing weekly exams to underprivileged children, as well as to adults in conjunction with the AIDS Project and local homeless shelters.

Bei Zhang, O.D. received her masters degree in vision science from the University of Houston College of Optometry, and her doctorate from the School of Optometry at the University of California, Berkeley. Dr. Zhang has worked at EYEXAM of California for seven years and managed the Pleasanton office for four years. She regularly provides free exams for homeless and low income patients in the Greater Bay Area, providing services three days a week for low-income patients, volunteering with the OneSight vision van in Oakland, and serving over 80 Lions Club patients in 2011. Dr. Zhang is bilingual in English and Chinese, and is able to help Chinese-speaking patients and customers at her office.