

Clara Mezza

From: Lisa Anne Hurt-Forsythe <laHurt-Forsythe@aapan.org>
Sent: Friday, April 17, 2026 4:57 PM
To: Insurance.Legal
Cc: Ian Trepanier; Julian Roberts
Subject: Comments of NAVCP and ACLI on Proposed Rule, 23 CAR Part 142 (Vision Care Plan Coverage)
Attachments: AR Comment Letter of NAVCP and ACLI re Proposed Regs Related to Managed Vision Care April 17 2026.pdf
Importance: High

CAUTION: External Email

Dear Sirs-

On behalf of NAVCP and ACLI, please find attached our public comment letter on the aforementioned sections.

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NATIONAL
ASSOCIATION
OF VISION
CARE PLANS



April 17, 2026

Office of the Commissioner of Insurance
Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

Submitted by Electronic Mail to: insurance.legal@arkansas.gov

Re: Comments on Proposed Rule, 23 CAR Part 142 (Vision Care Plan Coverage)

Dear Sirs:

The National Association of Vision Care Plans (NAVCP)¹ and the American Council of Life Insurers (ACLI)² appreciate the opportunity to comment on the proposed amendments to 23 CAR Part 142, implementing Act 142 of 2025 (“Act 142”) related to the provision of managed vision care. We recognize and respect the Department’s role in translating legislation into workable regulatory requirements, however, as currently drafted, provisions of the proposed rule depart from the structure of the authorizing statute and impose obligations that are inconsistent with the law. Several provisions introduce regulatory standards that risk increasing costs for Arkansas consumers without increasing access or value.

Our comments focus on the need for the final rule promulgation to give faithful effect to the statutory text and avoid introducing unworkable or legally vulnerable requirements that arise from regulatory interpretation.

I. The Rule Extends Medicare Benchmarking Beyond Clear Statutory Direction

Act 142 establishes two express reimbursement standards for covered services and covered materials: 1) reimbursement must not be nominal or *de minimis*, and 2) reimbursement must not be less than the applicable Medicare rate. The statute is

¹ The National Association of Vision Care Plans (NAVCP) is the unified voice for the managed vision care industry. Nationally, our members provide valuable vision care benefits for over 220 million Americans and partner with eye care providers in all 50 states and Puerto Rico to deliver affordable, quality managed vision care. Our NAVCP members work with Arkansas employers throughout the state to provide vision care benefits to over 1.3 million covered lives in the state.

² The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI’s member companies are dedicated to protecting consumers’ financial wellbeing through life insurance, annuities, retirement plans, long-term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI’s 275 member companies represent 94 percent of industry assets in the United States.

specific in its scope and does not authorize the Department to extend Medicare-based benchmarks beyond those express boundaries.

The proposed amendments to Rule 23 CAR Part 142 go further by applying Medicare-based benchmarks to “applicable or similar” services and by creating a safe harbor for payments meeting or exceeding the Medicare Physician Fee Schedule, even for services not eligible for Medicare coverage at all. In Act 142, the legislature established a specific, limited reimbursement standard, however the Department substituted a broader rate-setting framework that is inconsistent with the underlying law.

Act 142’s silence on how Medicare benchmarking should operate for non-covered services creates a boundary, not a grant of authority. The Department’s construct of Medicare proxies converts a targeted reimbursement floor into a comprehensive rate-setting regime. We respectfully request that the Department revise the proposed rule to limit Medicare benchmarking strictly to services and materials for which an established Medicare rate exists, consistent with statutory text.

The proposed addition of Medicare benchmarking for “applicable or similar services,” including those not covered by Medicare, raises both legal and operational concerns. While framed as a gap-filling measure, this construct creates a proxy rate-setting regime that extends beyond the statute’s limits and introduces a subjective standard with no clear benchmark. In practice, this ambiguity makes compliance impossible to assess — particularly for services such as exam fees that lack direct Medicare analogs— and prevents reliable notice of alleged deficiencies. As a result, the provision not only exceeds the Department’s delegated authority, it creates an unworkable framework that exposes plans to unpredictable enforcement.

To resolve this issue, we recommend that the proposed rule language be amended as follows:

(2) For a covered service or covered materials, reimbursement that is greater than or equal to the Medicare Physician Fee Schedule reimbursement rate for the applicable or similar service, regardless of whether the service is eligible for Medicare coverage, shall not be considered a violation.

II. The Proposed Rule Misinterprets Arkansas Code § 23-99-1003(d) by Conflating Provider Reimbursement Standards with Benefit Design

Arkansas Code § 23-99-1003(d) addresses the level of reimbursement paid to providers for covered services and covered materials. It does not mandate benefit design, nor does it prohibit reasonable enrollee cost-sharing such as deductibles, copayments, or coinsurance.

Act 142 explicitly defines covered services and covered materials as those subject to contractual limitations, including cost-sharing. Interpreting subsection (d) to require that plan payment alone — without regard to enrollee contribution— is required to satisfy the Medicare benchmark directly conflicts with the statute’s own definition of covered

services and materials. The proposed interpretation would impose first-dollar coverage requirements that are not prescribed by the legislation, making the proposed rule inconsistent with statute.

A faithful reading of the statute is that it establishes a floor on total provider reimbursement while preserving plan flexibility in how that reimbursement is allocated between plan payment and enrollee cost-sharing. There is no statutory authority for the rule's creation of benefit design mandates which would result in increased premiums.

III. The Rule's Treatment of "Nominal or *De Minimis*" Risks Converting a Consumer Protection into Rate Regulation

Act 142 prohibits nominal or *de minimis* reimbursement to prevent arrangements where purported coverage provides little or no value to enrollees. The statute does not define these terms, nor does it direct the Department to establish minimum reimbursement levels divorced from consumer impact.

The proposed rule, however, focuses primarily on provider payment thresholds rather than on whether coverage meaningfully reduces enrollee costs. This emphasis risks transforming a targeted anti-evasion provision into a *de facto* rate regulatory mechanism. Absent a clear, consumer-focused standard tied to enrollee value, enforcement will necessarily be subjective and unpredictable.

IV. The Materials Reimbursement Provision Lacks an Administrable Standard

The rule's prohibition on nominal or *de minimis* reimbursement for covered materials illustrates our concern that the materials reimbursement provision lacks an administrable standard. While Act 142 applies the standard to both services and materials, the rule provides no objective metric or benchmark by which materials reimbursement compliance may be assessed.

A provision that is too vague to be applied consistently raises serious questions of arbitrary enforcement. Without a clear and administrable standard, plans and providers lack meaningful guidance and fair notice of what is required. If the Department intends to retain this provision, the final rule must provide an administrable, consumer-impact-focused standard. Absent such a standard, we recommend the provision be withdrawn.

V. The Rule's Applicability Provision Exceeds the Statute's Express Triggers

Act 142 includes explicit applicability triggers tied to renewals, new contracts, and a defined effective date. The proposed rule discards those guardrails and applies its requirements broadly. Most significantly, the rule creates new obligations upon recredentialing even in the absence of contract renewal or amendment inconsistent with what is required in Act 142.

The Department is expanding the statute's scope through rulemaking. In Act 142, the legislature respected contractual certainty and pricing stability through the effective date

choices in the law. The proposed rule alters contractual arrangements negotiated under prior law and undermines the certainty on which pricing and benefit design depend.

VI. The Anti-Recoupment Provision Requires a Fraud Exception

NAVCP and ACLI support robust protections for providers who rely in good faith on eligibility verification. Act 142's anti-recoupment provision reflects a legitimate and important policy goal. However, the proposed rule fails to include language addressing recoupment in cases of fraud, identity theft, or intentional misrepresentation, and imposes no temporal limitation on a plan's reimbursement exposure.

Nothing in Act 142's text or evident purpose supports a position that the General Assembly intended to insulate fraudulent conduct from recovery. We respectfully request that the final rule include an exception permitting recoupment where payments result from fraud, identity theft, or material misrepresentation consistent with the legislature's reasonable expectations.

VII. Obligations Applicable to Vision Benefit Managers and Subcontractors Must Track the Statute's Express Definitions and Assignments of Responsibility

Act 142 introduces and defines the term "vision benefit manager" and assigns specific obligations to entities meeting that definition. The Department's implementing rule must remain closely tethered to that statutory definition and to the obligations expressly assigned by the legislature.

The proposed rule applies reimbursement and anti-recoupment requirements to subcontractors captured within the vision benefit manager definition, even where those subcontractors do not have a direct contractual relationship with providers. Act 142 does not expressly address the allocation of liability or enforcement responsibility in such circumstances. Extending provider-facing obligations to entities without contractual privity creates duplicative and unpredictable compliance exposure. The final rule should limit provider-facing obligations to entities that Act 142 expressly subjects to those requirements.

Conclusion

In each of the areas identified above, the proposed rule reflects interpretations of Act 142 that are inconsistent with the statute's text and impose obligations and requirements that are not included in the legislation enacted by the General Assembly. If adopted as drafted, the rule not only has negative consequences for Arkansas consumers with likely cost increases and reduction in plan flexibility, but exposes the Department to meaningful legal and operational risk.

To ensure the rule is grounded in statute, NAVCP and ACLI respectfully urge the Department revise the proposed rule to: (1) limit Medicare benchmarking to services and materials for which a rate exists; (2) clarify that Arkansas Code § 23-99-1003(d) does not prohibit reasonable cost-sharing; (3) adopt a consumer-focused, enrollee-impact standard for the “nominal or de minimis” prohibition; (4) provide an administrable standard for materials reimbursement or remove that provision; (5) align the rule’s applicability provisions with Act 142’s express statutory triggers; (6) include a fraud and material misrepresentation exception in the anti-recoupment provision; and (7) limit provider-facing obligations to entities expressly covered by the statute.

NAVCP and ACLI stand ready to discuss these issues and to work collaboratively with the Department on a final rule that gives full and faithful effect to Act 142, protects Arkansas consumer affordability and provides a stable and workable framework for the vision care market in Arkansas.

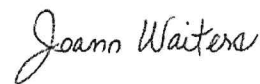
Thank you for your consideration.

Sincerely,



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