

11:16-2.4 Insurer reporting requirements

(a) Insurers shall report to the NICB all motor vehicles involved in losses as follows:

1. All thefts of a motor vehicle, or any of its major component parts, shall be reported within two working days from the receipt of sufficient information from the insured. The NICB shall acknowledge the receipt of each theft report received from an insurer within 10 working days. If the insurer has not received any acknowledgment or communication from the NICB within 10 working days following its submission to the NICB of the report, the insurer shall immediately communicate with the NICB to determine the status of its report.
2. All losses involving motor vehicle salvage, however sustained, including salvage retained by either an insured or a third party claimant, shall be reported to the NICB within five working days after the sale of salvage; or, if the insured is permitted to retain salvage, within five working days after the date of loss payment.
3. All insurers required to submit reports to the NICB in compliance with this subchapter shall be bound by all of the reporting requirements of the NICB.

Amended by R.1993 d.48, effective January 19, 1993.
 See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
 National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16-2.5 Insurer cooperation with NICB

Insurers shall cooperate with the NICB and shall release information in their possession to the NICB upon its reasonable request.

Amended by R.1993 d.48, effective January 19, 1993.
 See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
 National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16-2.6 NICB cooperation with insurers

The NICB shall cooperate with insurers in the resolution of errors and the investigation of claims suspected to be fraudulent.

Amended by R.1993 d.48, effective January 19, 1993.
 See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
 National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16-2.7 Deferred claim processing and payment

(a) Notwithstanding any provision of Title 11 of the New Jersey Administrative Code to the contrary, an insurer shall defer the processing and payment of a claim filed under comprehensive or other coverage in accordance with the following:

1. No insurer shall pay a claim filed by an insured under comprehensive or other coverage for the theft of a motor vehicle or its major component parts unless said

claim has first been reported to and acknowledged by the NICB.

2. An insurer shall defer the payment of a claim for five calendar days following receipt of the acknowledgment from the NICB of the insurer's report. If no further communication is received from the NICB during this five-day period indicating unresolved questionable circumstances, the insurer shall continue with the processing of the claim in accordance with the provisions of this section and other provisions of Title 11 of the New Jersey Administrative Code.

3. If the NICB indicates in its response to the insurer that coverage is in effect by more than one insurer for the same motor vehicle or that the motor vehicle has been previously reported as stolen and unrecovered, or that previous claims on the vehicle have been reported, the insurer shall promptly investigate and resolve such discrepancy.

4. If the NICB discovers an erroneous vehicle identification number (VIN) and the NICB is unable to clear up such discrepancy internally, the NICB shall send a questionnaire to the insurer. This questionnaire shall be returned within five working days of receipt by the insurer. If the NICB and insurer are unsuccessful, after due diligence, in resolving the VIN error after a 30-day period from the date of the receipt by the insurer of sufficient information from the insured, the insurer shall proceed with the processing of the loss claim.

5. If the NICB indicates in its response to the insurer or the insurer finds that it has reasonable cause to believe that the loss may have been caused by the criminal or fraudulent act of any person, the insurer shall suspend the processing of the claim and promptly begin an investigation. The insurer shall promptly provide such information to the NICB and shall cooperate fully with the NICB in its investigation of criminal or fraudulent acts.

Amended by R.1993 d.48, effective January 19, 1993.
 See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
 National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16-2.8 NICB record retention

Such reports as may be required to be filed with the NICB by an insurer pursuant to P.L. 1989, c.65, this subchapter and the operating procedures of the NICB, shall be maintained by the NICB for at least a period of five years from the date of entry into the NICB system, except that in the case of motor vehicle salvage, such reports shall be maintained for a period of at least two years from such entry.

Amended by R.1993 d.48, effective January 19, 1993.
 See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
 National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16-2.9 Penalties

Failure of an insurer to abide by the requirements of this subchapter may lead to the imposition of sanctions or penalties as provided by law.

SUBCHAPTER 3. (RESERVED)

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

**SUBCHAPTER 6. FRAUD PREVENTION AND
DETECTION PLANS**
11:16-6.1 Purpose and scope

(a) This subchapter sets forth the standards for a plan for the prevention and detection of fraudulent insurance applications and claims filed for approval pursuant to N.J.S.A. 17:33A-15 by insurers which transact the business of private passenger automobile insurance or health insurance in this State. These provisions apply to all insurers that transact the business of private passenger automobile insurance in New Jersey, including both personal and commercial coverage; and to all insurers transacting the business of health insurance as set forth in N.J.S.A. 17:33A-3 and N.J.A.C. 11:16-6.2.

(b) The subchapter also sets forth the reporting standards and forms necessary to refer insurance fraud matters to the Office of Insurance Fraud Prosecutor ("OIFP"). These provisions apply to all insurers as defined by N.J.S.A. 17:33A-3 and N.J.A.C. 11:16-6.2 including those with PAIP and CAIP assignments.

11:16-6.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Application" means any document that contains the minimum information necessary as set forth at N.J.A.C. 11:3-44.3(a) to determine whether an applicant is an eligible person or is used in any way by the insurer to rate or underwrite a policy, including the coverage selection form and renewal questionnaire as provided at N.J.A.C. 11:3-15.7 and 11:3-8 and, if requested, a copy of the applicant's driver's license, a copy of the motor vehicle registration of the principal vehicle to be insured and any additional proof of New Jersey residency.

The term "application" shall also mean those signed forms, data, reports, analysis and other documents supplied in support of an application when requested by an insurer or by any other person, and/or supplied by the insured/applicant, or other person(s), seeking coverage under a policy or plan of health insurance that is provided to or used by an insurer in assessing the risk, or premium, or which is relied upon by the insurer in agreeing to provide coverage under the policy or plan, including but not limited to that information submitted in accordance with N.J.A.C. 11:4-16.7, 11:20-4.1 and 11:21-6.1.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Eligible person" means an individual who meets the qualifications set forth in N.J.A.C. 11:3-34.

"Fraud and misrepresentation" means the knowing misrepresentation of any material fact in a claim or application or the knowing failure to disclose any material fact in a claim or application which, if properly revealed or disclosed, could change the premium, or affect the placement or underwriting of the risk, or the assignment in the insurer's rating plan, or could affect the payment of a claim.

"Fraud prevention and detection plan" or "plan" means an insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include any administrative services only (ASO) contracts, workers' compensation coverage, or stop-loss coverage.

"Insured lives" means the actual number of New Jersey residents entitled to receive benefits under a contract delivered or issued for delivery in this State.

"Insurer" means any person or entity authorized to transact the business of private passenger automobile insurance in New Jersey, whether in accordance with a personal lines or commercial lines rating system, and includes a group of affiliated companies, and the Property Liability Insurance Guaranty Association established pursuant to N.J.S.A. 17:30A-1 et seq. when performing its statutory function.

"Insurer" pursuant to N.J.S.A. 17:33A-3 (health insurance) also means:

1. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or 17B:17-1 et seq.)

2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.

3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;

5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

6. Any dental plan organization operating pursuant to N.J.S.A. 17:48D-1 et seq.

"MCEAFC" means the Market Conduct Examinations and Anti-Fraud Compliance Unit in the Department of Banking and Insurance, Office of Consumer Protection Services.

"OIFP" means the Office of the Insurance Fraud Prosecutor in the Division of Criminal Justice in the Department of Law and Public Safety.

"Special Investigations Unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in N.J.A.C. 11:16-6.4.

"Stop-loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified person retention limits and/or aggregate retention limits, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

Amended by R.2005 d.159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
Deleted "DAFC"; added "MCEAFC".

11:16-6.3 General requirements and filing format

(a) All insurers shall file for approval a fraud prevention and detection plan ("plan") in accordance with N.J.S.A. 17:33A-15 and this subchapter. No insurer shall use or implement any plan that is not filed and approved.

(b) Insurers shall submit their plan on 8½ by 11-inch paper. The first page shall show the filer's company name, the filer's identifying number for this filing, National Association of Insurance Commissioners ("NAIC") company number(s), and NAIC group number.

(c) Insurers shall file their plan with the Department at the following address:

Fraud Prevention and Detection Plans
New Jersey Department of Banking and Insurance
Market Conduct Examinations and Anti Fraud
Compliance Unit
PO Box 329
Trenton, NJ 08625-0329

Amended by R.2005 d.159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
In (c), amended the address.

11:16-6.4 Special Investigations Unit (SIU)—duties, qualifications, and composition

(a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile policies, and health insurers that insure fewer than 10,000 lives, the plan filed in accordance with N.J.A.C. 11:16-6.3 shall establish a full-time Special Investigations Unit ("SIU").

(b) The SIU shall be responsible for the following:

1. Conducting investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;

2. Providing liaison with OIFP, other law enforcement personnel and the MCEAFC;

3. Providing in-service training to claims personnel, underwriting personnel, and adjusters in accordance with the provisions of N.J.A.C. 11:16-6.5;

4. Maintaining a database of fraudulent claims and application fraud which shall contain, at a minimum, the names, addresses and other identifying information regarding all parties to the investigation referred to in (b)1 above;

5. Informing insurance underwriters of ineligible risks by reason of prior fraudulent activities from the database in (b)4 above;

6. Identifying persons and organizations that are involved in suspicious claim activity and application fraud, as described in (b)1 above;

7. Referring matters to OIFP in accordance with N.J.A.C. 11:16-6.6(b) and 6.7 and providing notice of suspicious claims in accordance with N.J.A.C. 11:16-6.6(c); and

8. Ensuring that all evidence on matters referred to the SIU including, but not limited to, checks issued in payment of claims, taped statements, original receipts, and original documents submitted by a person or entity in support of or in opposition to a claim applicant, are identified, collected and preserved in order to be turned

over to OIFP at the request of OIFP in connection with the referral of cases to OIFP.

(c) The SIU shall have the following composition:

1. SIU investigators and SIU specialists shall be a separate unit from the claims or underwriting unit. For purposes of this paragraph, it shall not violate this provision if the SIU issues a check paying a claim or denies payment of a claim so long as:

i. The SIU personnel are a separate and distinct unit; and

ii. When closing the file at the completion of the investigation, the SIU records its findings in writing together with its recommendation to pay or deny the claim with the reasons.

2. Automobile insurers shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for each 30,000 New Jersey automobile policies serviced.

3. Health insurers offering comprehensive benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 60,000 insured lives.

4. Health insurers offering limited benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long-term care; Medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any other supplemental hospital indemnity benefits.

(d) Qualifications of SIU investigators and specialists shall be as follows:

1. SIU investigators shall have at least one of the following:

i. A Bachelor's degree;

ii. An Associate's degree plus a minimum of two years experience with insurance related employment;

iii. A minimum of four years of experience with insurance related employment; or

iv. A minimum of five years of law enforcement experience.

2. When approved by the Department in the plan, an insurer shall be permitted to employ a limited number of SIU specialists who shall possess unique qualifications by way of training, technical skill, and/or experience to investigate and identify cases of fraud, but lack the specific educational requirements set forth in (d)1 above, to be SIU investigators.

(e) The plan may provide that the functions of the SIU may be assigned to an outside vendor or third party administrator. In such case, the plan shall provide that the outside vendor or third party administrator shall also be responsible, together with the insurer, for compliance with N.J.A.C. 11:16-6.

Amended by R.2005 d.159, effective May 16, 2005.

See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).

In (b), substituted "MCEAFC" for "DAFC" in 2.

11:16-6.5 Training program and manual for the prevention and detection of fraud

(a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile policies and health insurers that insure fewer than 10,000 lives, the plan shall provide anti-fraud education for SIU investigators, SIU specialists, claims adjusters and underwriters that shall include a detailed and comprehensive program of insurance fraud awareness and education to prepare claims adjusting and underwriting personnel for insurance fraud prevention and detection.

1. The training program, which shall include Basic Entry Level Training and Continuing Education Training for all adjusters, claims processors, underwriters, SIU investigators and SIU specialists, shall be submitted to and approved by the Department by August 5, 2000. The instructions format may be classroom instruction, self-guided instruction, videotape, seminar, computer based or by any other means.

2. The training programs referred to in (a)1 above shall be provided as follows:

i. In the case of automobile insurers, training shall include, but not be limited to, the following areas as appropriate: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, bodily injury liability claim investigation, statutory requirements for fraud referrals, techniques for the identification of fraudulent applications for coverage, insurance rate making practices, tier rating plans used by the insurer, PIP medical expense benefits and medical treatment protocols and precertification plans, and current indicators of fraud.

ii. In the case of health insurers, training shall include, but not be limited to, the following areas as appropriate: overcharging and overpayment detection, claims processing guidelines, medical coding, duplicate bills, excessive charges, unnecessary services or supplies, over-utilization, services never rendered, miscoded or misleading claim information, hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement, abusive or fraudulent referrals, statutory requirements dealing with fraud referrals, techniques for the identification of fraudulent applications for coverage, the type, methods of service and operating procedures of various health insurers, and current indicators of fraud.

iii. The Basic Entry Level Training shall be no less than nine hours of classroom instruction. The Continuing Education Training shall be no less than nine hours of training per year for SIU personnel and four hours per year for claims and underwriting personnel. Basic Entry Level training shall be given to all employees within 180 days from the commencement of their employment at each of these positions: underwriters, adjusters, claims processors, SIU investigators, or SIU specialists. The four hour continuous education training provided to non-SIU personnel shall emphasize the responsibility of all employees to identify and report indications of internal and external fraud to the proper authority. Persons currently employed in these positions as of February 7, 2000 shall be exempt from entry level training requirements.

(b) Except for insurers which insure fewer than 2,500 New Jersey automobile policies, or health insurers fewer than 10,000 lives, the plan shall provide a Fraud Prevention and Detection Procedures Manual and disseminate it to, or make it available to, as appropriate, all SIU, claims adjusters, and underwriting personnel. The Fraud Prevention and Detection Procedures Manual shall include, at a minimum, the following:

1. Information for claim adjusters, underwriting personnel, SIU investigators and SIU specialists regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Insurance Fraud Prevention Act;
2. The process to be employed for reporting to OIFP when specific facts and circumstances are identified, in connection with a claim or application, which upon further SIU investigation leads to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;
3. For automobile insurers, the "fraud indicators" used for automobile theft, automobile physical damage fraud, personal injury claims fraud, bodily injury claims fraud, and application fraud;
4. For health insurers, "fraud factors" or "indicators" for health fraud, application fraud, and claims fraud;
5. The duties and functions of the SIU;
6. The procedure for referral of a claim or application to the SIU;
7. The post-referral procedure for communication between the claims unit and/or the underwriting unit and the SIU; and
8. An update page indicating that the manual has been updated and kept current.

11:16-6.6 Fraud prevention and detection plan

(a) The plan shall provide for underwriting inquiry to verify that the insured is an eligible person and the policy is

properly rated within 60 days of receipt of the application. These underwriting inquiries shall verify the insured's residency provided by the insured on his or her application for insurance. The plan may provide that these inquiries are generally done "in-house" by telephone and by using information from the New Jersey Division of Motor Vehicle Services (or similar agencies in other states) and prior insurers.

(b) The following concern referral of applications and claims.

1. The plan shall provide that an application or claim shall be referred as a case to OIFP, for further OIFP investigation or other appropriate action, on the prescribed Referral Form (OIFP-1 for Claim Fraud Referral or Notification, OIFP-2 for Application Fraud Referral or Notification, OIFP-3 for Health Claim Fraud Referral or Notification, and OIFP-4 for Health Application Fraud Referral or Notification incorporated herein by reference in the subchapter Appendix), with all other information required by the form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16-6.7.

2. The plan shall provide that all applications and claims, which meet the standard for referral set forth in N.J.A.C. 11:16-6.7, shall be referred to OIFP by the SIU as soon as practicable, but in no case later than 30 days from when the investigation is complete.

3. The plan shall provide criteria and levels of economic impact for the referral of insurance claims and application fraud in accordance with the requirements of N.J.A.C. 11:16-6.7.

(c) The plan shall provide that after completion of an SIU investigation, or after identification by an SIU of a pattern of applications or claims, the insurer shall provide notice to OIFP on OIFP Form 1, OIFP Form 2, OIFP Form 3 or OIFP Form 4, indicating "NOTIFICATION," incorporated herein by reference in the subchapter Appendix, unless this form is superseded by an electronic reporting form, of instances in which a violation of N.J.S.A. 17:33A-4 is suspected on the basis of fraud factors or indicators, but where sufficient evidence to support a case referral pursuant to N.J.A.C. 11:16-6.7 has not been developed.

(d) The plan shall provide that all referrals of application and claims fraud and notifications of suspected application or claims fraud by the insurer to OIFP shall be made by personnel in the insurer's SIU or other personnel designated in the plan so long as records are kept of all referrals and notifications and the appropriate form is used.

(e) Where an insurer contracts any of its SIU functions to an outside vendor or third party administrator in accordance with N.J.A.C. 11:16-6.4(e), the plan shall provide the name and address of the outside vendor or third party administrator used by the insurer to conduct investigations or perform SIU

functions together with a copy of the contract between the insurer and the outside vendor or third party administrator.

(f) The plan may include such other items as the insurer may wish to provide.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Rewrote (b)1 and (c).

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote (b)1 and (c).

11:16-6.7 Referrals to OIFP

(a) The plan shall provide that upon completion of its investigation, as described in (d) below, an SIU shall refer cases, on form OIFP 1, OIFP 2, OIFP 3, OIFP 4, indicating "REFERRAL," which meet the following standard to OIFP.

1. Any application or claim where the facts and circumstances create a reasonable suspicion that a person or entity has violated N.J.S.A. 17:33A-4; and

2. There is sufficient independent evidence corroborating the reasonable suspicion described in (a)1 above, from which a person could reasonably conclude that the person or entity has violated N.J.S.A. 17:33A-4.

(b) The facts and circumstances referred to in (a)1 above can include, but are not limited to, "fraud indicators" contained in an insurer's approved plan, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of N.J.S.A. 17:33A-4 has occurred.

(c) As referred to in (a)2 above, independent evidence corroborating the reasonable suspicion that a person has violated N.J.S.A. 17:33A-4 includes, but is not limited to:

1. A statement from a witness;

2. Documentary evidence that directly negates a material element of the claim or directly establishes the falsity of a material element of an insurance application;

3. A report of an expert; or

4. Additional apparent misrepresentations tending to negate a possibility that the misrepresentation was merely an error.

(d) An investigation shall be complete for purposes of referral to OIFP when reasonable and appropriate investigative leads and opportunities have been exhausted. When an investigation has identified a pattern of possible violations of N.J.S.A. 17:33A-4, the investigation will be deemed complete for purposes of referral as a case to OIFP when one or more violations included in the identified pattern have been sufficiently investigated and corroborated, in accordance with (a) above for referral to OIFP.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

In (a), inserted "OIFP-3A or OIFP-3B" preceding "which meet".

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote introductory paragraph of (a).

11:16-6.8 Record retention

(a) Insurers shall maintain up-to-date and accurate records on their fraud prevention and detection plan, which shall at minimum include those necessary to prepare the report required in (b) below.

(b) Insurers shall submit to the Commissioner on or before March 31 of each year an annual report for the prior calendar year on MCEAFC Form #1A and/or #2A, pursuant to instructions and definitions provided in MCEAFC Form #1B (for the completion of #1A) and Form #2B (for the completion of #2A), incorporated herein by reference in the subchapter Appendix. Individual insurers that comprise a group shall submit separate reports. Reports shall be submitted in hard copy or by email to:

New Jersey Department of Banking and Insurance
Market Conduct Examinations and Anti-Fraud
Compliance Unit
20 West State Street
PO Box 329
Trenton, NJ 08625-0329
Email: mceafc@dobi.state.nj.us

1. The information shall be submitted in a spreadsheet format established by the Department. Insurers may acquire the required spreadsheet format from the Department:

i. By directing an email request for the "Annual Filing Template" to mceafc@dobi.state.nj.us; or

ii. By directing a written request, along with a blank 3.5 inch, 1.44 MB MS-DOS formatted disk, to the above address. The Department shall return the disk and a blank spreadsheet for completion by the insurer.

Amended by R.2005 d.159, effective May 16, 2005.

See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).

Rewrote (b).

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote introductory paragraph of (b).

11:16-6.9 Approval and filing of fraud prevention and detection plans

(a) An insurer's fraud prevention and detection plan shall be deemed approved by the Commissioner if not affirmatively approved or disapproved by the Commissioner within 90 days of the date of filing.

(b) The Commissioner may request such amendments to the plan as he or she deems necessary.

(c) An insurer must submit amendments to its plan when necessary to achieve compliance with these rules. Any amendments to a plan filed with the Commissioner shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing.