

The Mysterious MIB - Not Any More...

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AGENT: "Mr. Prospect, please sign here. This authorizes the insurance company to have access to your medical records as well as to check with the MIB for any information they may have on you."

PROSPECT: "Who is the MIB? Are they part of the FBI?"

AGENT: "No, they're a centralized clearing house that provides medical and avocation information on people who apply for insurance to insurance companies that belong to MIB and contribute information to them. I'm really not too sure exactly what they do or how they operate, but everything they have is confidential so don't worry."

This probably pretty closely represents the degree of knowledge the average agent possesses concerning one of the most important organizations in the insurance industry. Over the 90+ years they've been in existence, MIB has saved the insurance-buying public. . . millions. . . probably billions. . . over what they would have had to pay if there had been no MIB, and if those who have attempted to commit fraud on insurance companies (whether intentionally *or* unintentionally) had been allowed to do so.

The science of risk management and insurance is all based upon the concept of risk-pooling and risk sharing. The idea is that everyone puts some money into a pool knowing that some in the group will definitely suffer losses. The only question is who and how much, and by **each** contributing a fair share, **all** will be protected from the chance it might be them.

Social Security, Medicare, and many government programs are based upon a more *socialistic* approach, which disregards most of the risk characteristics of individual risk selection and instead treats everyone pretty much the same. Even here, contributions to Social Security, for example, are based upon earnings and years covered, so the person who earns more will be eligible for a higher retirement benefit, or his or her spouse and dependents will receive more in the event of a death or permanent disability of the breadwinner. But the criteria for selection are very generic, and the uninsurable individual who goes to work under Social Security will be treated and charged the same amount as the vegetarian marathon runner whose great-grandparents are both still alive.

But, as a nation of independent individuals, the American system is mostly based upon individual freedoms. And, although it's long been established that we believe in providing *safety nets* for those who need them (welfare, Medicaid, etc.), we believe that individuals have responsibilities, and that those persons who pose greater risks from an insurability standpoint, should pay higher premiums for various forms of insurance – life, health, disability, long term care, property, and casualty – than those who are lower risks. That applies all the way from the person who voluntarily chooses to build a house on an island, which routinely gets hit by a hurricane, to an individual who smokes 3 packs of cigarettes a day, is 50 pounds overweight, and who applies for health, life, long term care, or disability insurance coverage.

Do you get mad when you're in a long line and some jerk butts in, basically ignoring the rights of others in the line? Somehow this person doesn't see what he or she is doing as infringing on the rights of the others in line. Their right to *butt in* is somehow more important than the rights of others who are conscientiously waiting their turn.

In much the same way, there are those individuals who don't understand or want to pretend they don't understand "risk-sharing" and/or "risk-pooling" and somehow can rationalize to themselves that paying their fair share should apply to everyone else, but not to them. So the fact that they would misrepresent information or omit entirely accurate answers on an insurance application about their health, family history, or hazardous occupations they may have or hazardous avocations that they may be engaged in, is just part of their belief that the law and rules should apply to others, but not to them.

The concept of accurate and fair pricing of insurance is based upon accurate "individual" risk selection. When individuals *fudge*, they're doing the same thing that individual butting in line is doing. But in this case, some people don't see it as hurting the others in the line. They see that they are somehow getting a free ride at the expense of some huge, impersonal insurance company.

Someone needs to monitor the line and to prevent those individuals who would attempt to butt in from doing so, hurting all those who are patiently waiting their turn.

This is what MIB does.

Here are some of the most important pieces of *Fact and Fiction* about MIB and information that agents, as well as Home Officer personnel, should know. This will enable agents and planners to better explain to their prospects and clients the role of MIB and its value to them as members of the insurance buying public. These points should also help agents explain to prospects and clients why they should willingly want to contribute their information to MIB knowing that fairness and accuracy of the information is absolutely paramount to them. And, if legitimate mistaken information resides in their records, MIB will bend over backwards to correct it immediately or advise them why they can't change it, and they have the procedures to do so.

FICTION #1 – *MIB reports what action other Insurance companies have taken so if Companies A and B have declined the prospect, it makes it easier for Company C to do so without having to dig any deeper.*

FACT - MIB is a not-for-profit incorporated trade association operating since 1902. There are over 600 member companies who agree to share information in the form of medical and avocation "codes". There are approximately 230 codes, which MIB uses to signify different medical conditions. A very few of these indicate risks involving hazardous avocations or adverse driving records, etc. These codes DO NOT indicate what action another company took. . .only that further investigation may be warranted.

Also, MIB does not report actual details about the person's medical condition or problem. The codes are simply act as *red flags*, and alert companies to the fact that there was information obtained and reported by a member company on this particular impairment or avocation risk. For example, if an underwriter, while reviewing medical records discovered that this person had had a heart attack, there would be a specific code to indicate that, and the underwriter would check MIB for such a code and if there was none there, he or she would add this code to the file.

Here's an analogy agents can use to explain MIB to clients. When an inquiry is made by a member company, MIB only tells them that the time on their watch is DIFFERENT from what another member has reported it to be. It will still be up to the individual company to determine for themselves which time is more accurate.

FICTION #2 – *Once someone has had a condition noted in their MIB record, it is almost impossible to get it removed.*

FACT - In a year's time, about 138,000 requests are received for disclosure. In fact, MIB has a separate department staffed by 15 employees whose sole function is to send out, check, and occasionally correct information on file. Only about 550 of the persons requesting their MIB record actually then request that it be corrected. Actual errors, meaning those where the corrections are made, amount to less than 1%. As you can also appreciate, one's MIB record will also be a *motion picture* rather than a *static photograph*. When one next applies for insurance and, for example, has lost 50 pounds and should no longer be classified as obese or previously had an abnormal ECG which is now normal, an updated MIB report is required.

Also there is an established procedure for inquiring about one's MIB record. The written request is made on a form called "Request for Disclosure of MIB Record Information". [Request your Record now](#)

FICTION # 3 - *Since the information is coded and doesn't contain my actual medical records, isn't there a chance that with the growth of the Internet and E-Commerce, someday companies will be allowed access to any of my personal information?*

FACT – Privacy concerns at MIB and member companies are taken more seriously than you can possibly imagine. In addition to a whole series of safeguards put into place both at MIB as well as at member companies, persons with actual access to the code book are limited to the Medical Director, authorized underwriting and claims personnel at the member company, and a few persons on the MIB staff. Physical access to the computer is limited exclusively to authorized personnel and, probably most importantly, MIB not only requires that companies do an annual "self-audit" and report the results, but every third year an outside audit team comes in and does a very high-level and thorough audit. These audits are taken VERY seriously and penalties can range from terminating a member company to suspending access to the system until a redo of the audit shows the problem has been corrected. Penalties may also include monetary fines as well.

In addition, all MIB codes are purged at the end of 7 years from the report date.

FICTION #4 – *MIB only acts as a repository for Medical and Avocation information.*

FACT - One of the key problems that insurance companies faced a few years ago, and still do today to a somewhat lesser extent, is persons who were purchasing Annually Renewable Term policies and keeping them only for 1 or 2 years and replacing them for same face to obtain the lowest possible premiums. With the costs of underwriting and issuing policies being what they are, this became not only a big problem for insurance companies, but for their reinsurers as well.

Back in 1987, MIB introduced the Insurance Activity Index (IAI), which would report any time a member company requested MIB information within the last 2 years.

The other main reason why this IAI is important is to alert a company to a situation where someone might be trying to load up on insurance by applying for a series of smaller policies that might fall below the radar screen for other underwriting requirements.

There was a fascinating story which appeared in *Forbes* last year (September 20, 1999) entitled "Zombie Insurance". Between Bonnie McCaslin and her 32 year old son, they purchased 78 life insurance policies on Bonnie's ex-husband. . . \$11 million face amount in total. . . from dozens of companies, including a number of MIB member companies. Those Members who used the IAI as part of their underwriting process were of course alerted to the extraordinary activity of applications submissions that took place in a relatively short period of time. Many companies, upon further investigation, declined to issue or postponed consideration. Others that didn't take advantage of the service may not have been aware that this activity had taken place, and as a result, may have found themselves among the 78 companies who issued.

Timothy, the ex-husband who was reported killed in the Mexican earthquake in 1995, turned up alive and well in California working as none other than as an insurance agent. Interviewed while incarcerated, Bonnie's non-repentant "the world owes me" attitude is suggestive of the jerk butting in line: *"He's such a jerk (referring to her ex). If it weren't for him, I wouldn't be in here."*

Hopefully, agents and planners will now have a better appreciation for how MIB has served as a defender and guardian for both the insurance buying public, as well as for the insurance industry. Indirectly, MIB represents the consumer at the actuarial pricing table. . . as their advocate for equitable risk-sharing. . . and opposing and exposing those who might favor a more socialistic approach to insurance – ignoring any or all risk factors, and causing healthy, health-conscious, and lower risk individuals. . . to subsidize those who pose greater risks.