The Medical Information Bureau

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A medical information sharing or exchange system was first established by life-insurance companies in the United States and Canada to prevent fraud through the omission and misrepresentation of relevant medical facts. In 1902 the Medical Information Bureau Inc. (MIB), later The Medical Information Bureau Group Inc., was organized as a nonstock, nonprofit membership association of health-care and life-insurance companies. It was subsequently incorporated in Delaware, US. Today its main headquarters is in Braintree, Massachusetts. It is the only one of its kind in North America.

Currently it is composed of about 600 companies. Its primary objective is the maintenance of accurate medical information on persons applying for insurance, which, in turn, is needed for accurate insurance underwriting. The MIB states that its mission is “detecting and deterring fraud that may occur in the course of obtaining life, health, disability income, critical illness and long-term care insurance.” Indeed, it has become an essential tool in life- insurance underwriting process.

In practice, the member-companies send relevant medical information to the MIB. These medical and health information may then be shared or exchanged among the member insurance companies. Non-member companies and employers of applicants cannot access MIB records. It is important to emphasize that the information is not sourced from medical practitioners.

The medical information are set in codes corresponding to specific medical conditions, which are also called “impairments.” For example, there are codes for high blood pressure, diabetes, or heart ailments. There are a total of 230 codes. The codes are classified into 10 categories of bodily systems: General (medical), Brain and Nervous, Circulatory, Respiratory, Digestive, Kidneys and Genito-Urinary, Family History (medical), Miscellaneous (medical), Glands of Internal Secretion and Metabolism, and Supplementary. Anything that affects mortality or morbidity is required to be reported to the MIB.

Whenever there is an applicant for insurance, the insurer may validate information given by the applicant with the MIB. Under the MIB system, records are kept for seven years after which they are deleted. Medical information is kept in a computer database and, as of 1999 figures, 65,000 searches are done

every day. Automation of database started in the early 1970s. Prior to this, data were kept in 3×5 cards and a search was done manually.

MIB records are kept transparent to the consumer, and the consumer may correct any inaccurate or incomplete information. The medical information is, in fact, obtained with the consent of the applicant. In most cases, it is disclosed by the applicant himself.

In New Zealand, insurers can only collect health information that is “necessary” to make insurance decisions. Beyond that, there is a risk of violating the 1994 Health Information Privacy Code. In the United Kingdom, accessing a patient’s entire medical record beyond what is relevant in underwriting a policy is deemed abusive. The reports are made available to other insurers with the written authorization of the applicant. If a medical record discloses derogatory information, the insurance application may either be denied, in which case it is called an “adverse action,” or the premiums may be increased. It should be emphasized that information reflected in the MIB reports are not conclusive, as they should be subjected to verification or validation from other sources in case of inconsistent information.

A typical MIB report would include information about health condition, surgeries, critical illnesses and other disabilities. A few non-medical information are also kept, such as your avocation interests like participation in hazardous sports. The MIB has been hailed as “the fastest, most cost-effective way for insurance companies to determine if medical statements on application are accurate and complete.”

In the US, the MIB is regulated by the Fair Credit Reporting Act, which guarantees the applicant access to his or her records once a year for free. It is classified as a “consumer-reporting agency,” very much akin to a credit-reporting agency. It is also covered by the Health Insurance Portability and Accountability Act of 1996, which guarantees privacy protection for health and medical information. In addition, customer information is subject to privacy protection under the Gramm-Leach-Bliley Act. The latest legislative development in the US is the Medical Information Privacy and Security Act.

The MIB was established in 1902 by a group of physicians (medical directors) representing 15 life-insurance companies after a string of fraudulent claims to the detriment of legitimate policyholders. Omissions and fraud went undetected during the underwriting process. Previous to the MIB, a similar unit called The Rejection Bureau, or Rejection Exchange, was organized in 1897.

Until 1945 the MIB was governed by a subcommittee of the Association of Life Insurance Medical Directors of America. Eventually, in 1946, it became an unincorporated association under New York law. In 1978 it became a Delaware membership corporation. In the 1970s the MIB became controversial largely due to the nondisclosure to the applicants that their medical files were being

accessed by other insurance companies. Most insurance applicants were not even aware that such medical files existed.

In the Philippines, a Medical Information Bureau is constituted as a committee within the Philippine Life Insurance Association. Every life- insurance applicant signs a consent form allowing an insurance company to share with the MIB any relevant medical information disclosed by the applicant. Data collected by the Philippine MIB is covered by Republic Act 10173, otherwise known as the Data Privacy Act of 2012.

A corollary subject is the field of insurance medicine. It was in 1960 when life-insurance medical directors formed an association that would eventually become the Philippine Society of Insurance Medicine. These medical directors are called upon to address medical issues in underwriting.

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