ISSUE ANALYSIS

Patients' Compensation System

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Executive Summary

The current medical liability tort system is exceptionally expensive, complicated and only awards 20 percent of all legitimate malpractice claims – leaving many patients without the compensation they may need and deserve – in particular, the poor and minorities. Despite the political and economic turmoil throughout the nation, there is an opening – and a need – to finally address the physician liability and patient safety issues that plague the U.S. health care system.

This paper introduces the concept of the Patients' Compensation System, an alternative to the existing medical tort system modeled after the workers' compensation system, designed to:

- ***Lower health care costs*** by reducing the incidence of unnecessary tests and procedures ordered by health care providers to protect themselves from potential lawsuits while adding no additional cost to taxpayers. This form of "defensive" medicine is estimated to cost the U.S. health care system as much as $650 billion a year.
- ***Eliminate the incentive for physicians to order unnecessary tests and procedures to prevent malpractice lawsuits*** by eliminating both the personal financial liability of physicians and the litigation process.
- ***Improve the quality of patient medical care*** by establishing a new system that puts patients at the forefront of the process. The Patients' Compensation System realigns incentives towards patient safety and reduces medical errors, while assuring all patient complaints are heard, quickly resolved, and more patients are fairly compensated.

Drawing upon core components of the U.S. workers' compensation system, international examples and other innovative medical malpractice solutions, the Patients' Compensation System is a:

- ***State-driven*** approach that seeks maximum participation from patients and providers.
- ***Administrative process for resolution of claims*** that includes input from medical and compensation experts, administrative law judges and oversight from a non-political board providing balanced representation of key stakeholders.
- ***Prompt compensation*** process for patients based on the recommendations of experts without the hassle and expense of litigation.
- ***Systemwide focus on quality and safety of patient care*** by discouraging unnecessary medical procedures, encouraging the reporting of medical errors and allowing for constructive use of that data to prevent future adverse outcomes and drive best practices and higher quality care.

In a unique survey of physicians conducted in 2010, Gallup Inc. found that 73 percent of U.S. physicians acknowledge practicing defensive medicine. This same physician group indicated that they believe the cost of defensive medicine is at least 26 percent of health care costs each year, or roughly $650 billion of the $2.5 trillion that the Centers for Medicare and Medicaid Services recently estimated that the United States spends on health care annually. A separate 2010 survey conducted by Jackson Healthcare found that fear of personal financial liability and disdain for the litigation process are the primary drivers in physicians' practice of defensive medicine. By addressing these problems, the Patients' Compensation System seeks to address the fundamental causes of defensive medicine, thereby reducing health care costs and improving the quality and safety of patient care.

Introduction

Factions on both sides of the debate over the federal Patient Protection and Affordable Care Act can probably agree that the bill did little, if anything, to address the crisis of physician liability and medical malpractice in the U.S. health care system. Indeed, amid its thousands of pages, the law's primary mention of medical malpractice comes in the form of a "sense of the Senate" – a nonbinding statement used to express the position of the Senate on a particular issue. Through this language, the law suggested states should be encouraged to "develop and test" alternatives to the existing civil litigation system and that Congress should "consider establishing a State demonstration" to evaluate such solutions.[1] The law, however, included no funding or binding provisions for these purposes.

This omission is not unnoticed by Republican members of Congress or President Obama. Not only does medical malpractice reform remain a central tenet of the Republican health care agenda, but President Obama surprised many by highlighting medical malpractice reform as one area of the law that he was interested in working with Congress to improve.[2] Further, the administration included $250 million in its fiscal year 2012 budget for support of existing medical malpractice pilots, building on the $25 million Medical Liability and Patient Safety Initiative it implemented in 2009.[3]

Unfortunately, many of the proposals under consideration in Washington and in state capitals are piecemeal and offer inadequate solutions to the current litigation-based medical malpractice system in the United States. Moreover, years of political and legislative fighting over how to fix the malpractice system have resulted in firmly drawn lines between camps and strong lobbies for or against specific proposals. Sadly, most of this time, energy and money have been spent fighting over solutions that will not actually change the systemic incentives that encourage unnecessary tests, procedures and other forms of defensive medicine, discourage quick and fair patient compensation, and discourage the openness and reporting necessary to promote quality care and patient safety.

In short, despite the political and economic turmoil across the nation, there is an opening to finally address the physician liability issues that are driving increased costs and lowering quality and safety in the U.S. health care system. But the answers do not lie in making small modifications to the current system. Rather, **we must recognize that the *system itself* creates the disincentives** that drive up costs and put the safety and financial needs of patients secondary.

A viable solution must create a new system where the needs of all parties are met:

- Patients must trust that medical errors will be addressed through ***timely and fair compensation***.
- Physicians must have ***peace of mind*** that they are protected from personal financial liability and the threat of litigation.
- Our medical system must **embrace an environment that creates incentives**, rather than disincentives, to report and learn from medical errors.

This paper will bring to the fore the concept of the Patients' Compensation System. Drawing from today's workers' compensation system, international examples and other innovative medical malpractice reform ideas, the Patients' Compensation System establishes an alternative to the traditional medical tort system designed to lower costs, improve quality and better serve patients by decreasing the incidence of defensive medicine.

The Problems: Defensive Medicine, Ineffective Patient Compensation and Barriers to Quality Patient Care.

Today's tort-based system is established on an adversarial construct: The medical professional and patient are opposed to the interests of the other, which runs directly counter to the doctor-patient trust relationship underlying medical practice. Decisions to compensate patients are based on a *negligence standard*, under which the patient must prove that:

(a) the doctor owed the patient a duty of care;

(b) that duty was to adhere to or exceed the standard of care;
(c) the breach of which caused;
(d) damages.

In this legal setting, "standard of care" is interpreted as what a reasonably prudent practitioner (in the same or a similar specialty) would have done under the same or similar circumstances.

Today's medical tort system falls short on several fronts.

Defensive Medicine:

The current system leaves physicians fearful of litigation and personal financial liability, thereby encouraging the practice of "defensive" medicine. Defensive medicine is defined as the "practice of ordering medical tests, procedures, or consultations of doubtful clinical value in order to protect the prescribing physician from malpractice suits."[4] Interestingly, physicians themselves admit that defensive medicine is a reality in the U.S. health care system. A recent survey by the American Medical Association found that 91 percent of physicians reported "believing that physicians order more tests and procedures than needed to protect themselves from malpractice suits."[5] Other surveys of U.S. physicians consistently report similar findings.

Indeed, a recent survey[6] of close to 1,500 U.S. physicians found:

- ***97 percent*** agreed that one explanation for practicing defensive medicine is that, "physicians abhor ***defending themselves in lawsuits***."
- ***96 percent*** agreed that physicians practice defensive medicine to "***avoid being held personally financially liable***."
- The treatment areas where the ***cost of defensive medicine*** is highest:
  - 35 percent diagnostic tests
  - 29 percent lab tests
  - 19 percent hospitalizations
  - 14 percent prescriptions
  - 8 percent surgeries

Quantifying the cost and incidence of defensive medicine has been difficult for academia because physicians often may have more than one reason for ordering a test or procedure.[7] However, identifying these costs is not challenging for physicians. Studies find regularly that physicians order unnecessary or inappropriate tests and procedures and that this behavior increases in "malpractice crises." Indeed, a 2010 survey by Gallup found that physicians attribute 26 percent of health care costs to the practice of defensive medicine.[8] Recently, the Centers for Medicare and Medicaid Services estimated that the annual spend on health care in the United States is $2.5 trillion.

If the physicians' estimates of defensive medicine within the system are accurate, then as much as $650 billion a year could be attributed to defensive medicine. Even if physicians are over-estimating the systemic incidence of defensive medicine, based on their own practices, even a small incidence of defensive medicine has enormous cost implications in the U.S. system. For example, another study frequently cited pegs the yearly cost of defensive medicine at around $60 billion per year.[9]

Ineffective Patient Compensation:

Today's malpractice system often fails patients by tying them up in years of expensive litigation, frequently with little return. The tort system in the United States often discourages those individuals who have been injured in the health care system from seeking compensation (particularly those with small claims).

- One study showed about only ***2 percent of injuries*** as a result of medical negligence become malpractice claims.
- The widely cited Harvard Medical Practice Study found that only ***one in 15*** actual cases of medical negligence resulting in serious injury or death is eventually litigated.
- Meanwhile, those that receive compensation typically spend ***more than 50 percent*** of their award on legal and administrative costs.[10]

Barriers to Quality Patient Care:

Today's malpractice tort system creates an environment that stifles reporting of medical errors and the education and data collection needed for a strong quality and patient safety focus.

Moreover, today's system holds physicians personally liable for medical errors and in doing so inhibits efforts to improve the quality and safety of patient care. Recent studies show that medical errors cost the U.S. health care system as much as $17 billion annually. Physicians currently have no incentive – in fact, many have a disincentive – to report errors. Yet timely and accurate reporting of medical errors can help improve the quality of patient care by allowing physicians and their colleagues to learn from mistakes and address deficiencies in systems of care and workplace environments that often lead to preventable errors. Furthermore, more information about the causes of medical errors can help inform best practices, making the system safer for patients and providers alike.

Many proposals to date fail to truly solve the problems identified above. While caps on damages have helped control medical malpractice insurance premiums, they do not address physicians' aversion to litigation nor have they proved very successful in controlling overall health care costs.[11] In fact, according to one survey, more than half of physicians do not believe that traditional tort reform addresses adequately the reasons doctors practice defensive medicine.[12] State experiments to create no-fault systems, physician safe harbors or health courts have yet to garner the political and administrative steam to multiply.[13] Yet, within a combination of these and other ideas lies a solution to our crisis. Limits on physician liability, alternatives to traditional litigation and best practices all have a role to play, as does our workers' compensation system.

At a Glance: U.S. Workers' Compensation System

The U.S. workers' compensation system arose in the early 1900s because common-law remedies were inadequate to resolve disputes relating to injuries suffered by workers on the job. Prior to the implementation of the workers' compensation system, workers were generally required to file suits for negligence. Much like with today's malpractice system, these suits were often quite complex and resulted in long delays for the receipt of compensation. As a result, the workers' compensation system discards negligence as the basis of recovery and replaces it with a statutory scheme that offers workers prompt compensation for lost wages as well as medical and rehabilitation costs. Eligibility for compensation is a result of the incident's connection to the workplace, rather than fault. As a general matter, the workers' compensation system is an administrative remedy designed to speed an employee's compensation while protecting both employers and employees from the costs and delays of the judicial system.

Workers' compensation programs are state-based, with significant differences across the country. Yet, several key characteristics common to most, if not all, systems can inform the medical malpractice discussion.

Some core components the medical malpractice system could borrow might include:

- ***Participation*****.** Workers' compensation systems are state-driven. Participation is mandatory in all but two states. By virtue of their employment, employees are "covered" by workers' compensation.
- ***Scope of coverage*****.** As mentioned above, workers may receive compensation for most incidences during a normal employer-employee relationship, as defined by the state's statute.
- ***Relationship to traditional tort system*****.** Workers' compensation acts generally preclude the right of a worker to engage in traditional litigation except in extreme circumstances.

- ***Governance*.** Workers' compensation systems are largely governed by a board or a commission created by government, but not under its complete control.
- ***Level of compensation*.** Compensation is generally based on lost income and expected medical and rehabilitation costs and is awarded pursuant to predetermined schedules.
- ***Financing*.** Workers' compensation systems are primarily supported by contributions and assessments of employers (the potentially liable party). Depending on the state, employers either purchase private insurance or contribute toward a state fund.

A New Alternative: the Patients' Compensation System

The proposed Patients' Compensation System builds on many of the key elements contained within the workers' compensation system, international examples of alternative medical malpractice systems and innovative ideas from thought leaders across the United States. The Patients' Compensation System's approach to some of the core components of any medical malpractice system is explained below. While such a large-scale reform of the medical malpractice system would likely require a phased-in approach, this paper describes a fully implemented system.

At a Glance: Patients' Compensation System

- ***Participation.*** A state-driven approach that seeks maximum participation from patients and providers.
- ***Claims standards.*** Similar to today's medical malpractice standards with option for states to examine alternative approaches.
- ***Governance.*** A politically isolated governing board informed by medical and compensation experts and supported by administrative law judges and administrative staff.
- ***Administration process.*** Claim resolution through an administrative process that yields better results more efficiently and lowers costs.
- ***Compensation.*** Fair compensation to all patients based on a schedule.
- ***Source of Financing.*** Financed through all providers purchasing of insurance; no additional cost to taxpayer.
- ***Quality care.*** A focus on eliminating unnecessary tests and procedures and preventing medical errors drives best practices and higher quality care.

Participation

Much like the workers' compensation system, the Patients' Compensation System would take a federalist approach, allowing states the flexibility to decide if and how to alter their current medical malpractice policies. Federal lawmakers could, however, play a role in encouraging the adoption of such systems by providing seed grants to states or conditioning other federal monies on adoption of "meaningful" medical malpractice reform (wherein "meaningful reform" is defined as containing certain key elements described below). This approach allows the Patients' Compensation System to be designed in accordance with individual state laws and regulations and implemented only in states with the political and structural commitment to make it successful.

In states where the Patients' Compensation System is adopted, all providers who currently buy medical malpractice insurance, including physicians, nurses, hospitals and other medical facilities, will be required to "buy in" to the system. Likewise, all patients will automatically be placed into an administrative system, rather than into the traditional negligence context in civil court, except in circumstances of intentional harm. Therefore, except in the unusual case in which the patient claims the provider intended to cause harm to the patient, patients living in states participating in the Patients' Compensation System will forgo traditional lawsuits as a means to address malpractice claims.

Interestingly, research shows that when patients are given the option to pursue litigation in addition to alternative resolution methods (such as disclosure and offer programs) they are less likely to pursue further legal action.[14] One study by the University of Michigan found that patients (and their attorneys) are

less likely to seek compensation when they believe they are getting the "real story." This makes the case that patients generally prefer swift, fair resolution over traditional legal action. Nevertheless, widespread adoption is necessary to truly drive efficiencies and savings within the system. Patchwork reforms have worked to a degree – and one could imagine states choosing to phase in reforms over time – but these approaches fall short of what is necessary to help most patients and providers.[15]

Claim Standards

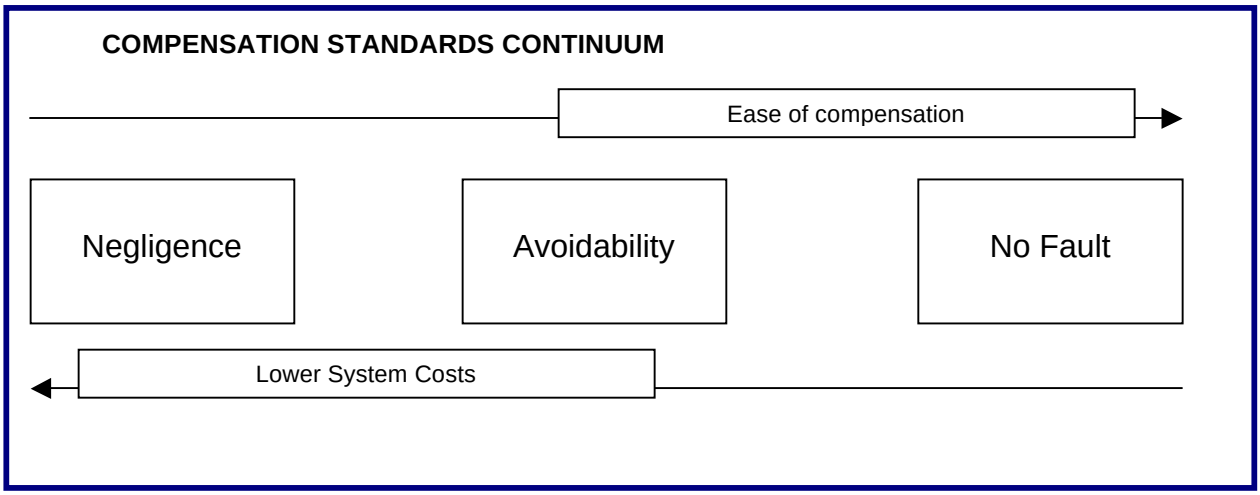
Today's medical malpractice system generally requires an aggrieved patient to seek redress in civil court, often culminating in a necessity to prove negligence on the part of a physician. Litigating malpractice claims is costly and inefficient for both patients and providers and does not result in high rates of realization for those who are legitimate victims of medical negligence or medical errors.[16] The Patients' Compensation System would move most medical malpractice claims from the courtroom to an administrative process. Patients alleging malpractice would be entitled to a hearing through the Patients' Compensation System. Should malpractice be found, they would be eligible for compensation.

Under the Patients' Compensation System, the standards for malpractice would be defined by a state legislature or by the Patients' Compensation Board, and implemented by the Medical Review Council in a particular state (described further below). These standards would likely be similar to those established today for negligence and would take into account established best practice standards. Maintaining some continuity in malpractice standards under the Patients' Compensation System would allow for an easier transition period for states. Yet, the process for accessing compensation would be less time consuming and costly for patients under the Patients' Compensation System.

Some have suggested that establishing a standard for compensation other than negligence might help ease administrative burdens and benefit patients by granting compensation for a larger percentage of adverse events. Two specific examples include:

- **No-fault.** Both the U.S. workers' compensation system and New Zealand's Accident Compensation Corporation operate on a largely no-fault basis. Under New Zealand's system, patients are compensated for almost all "personal injuries caused by treatment." Injuries resulting from normal course of treatment (i.e. hair loss during chemotherapy) and injuries not resulting from treatment are not eligible for compensation. A true "no-fault" system could simplify the compensation process for both patients and providers. Unfortunately, the costs associated with such a system could make it an unaffordable option in the United States.[17]

- **Avoidability.** Under the "avoidability" standard, patients are compensated for injuries that would have been "avoided" by the best provider or system.[18] Both Sweden and Denmark currently employ such standards. Injuries that could not have been avoided – even by the most excellent care – and injuries resulting from normal course of treatment, would not be compensated. As opposed to today's negligence standard that grants compensation only when *acceptable* care is not provided, the "avoidability" standard permits compensation in instances where the *highest level* of care is not provided. Thus, the "avoidability" standard lies somewhere between true no-fault and negligence, providing an easier path to compensation without the high cost of a no-fault system.



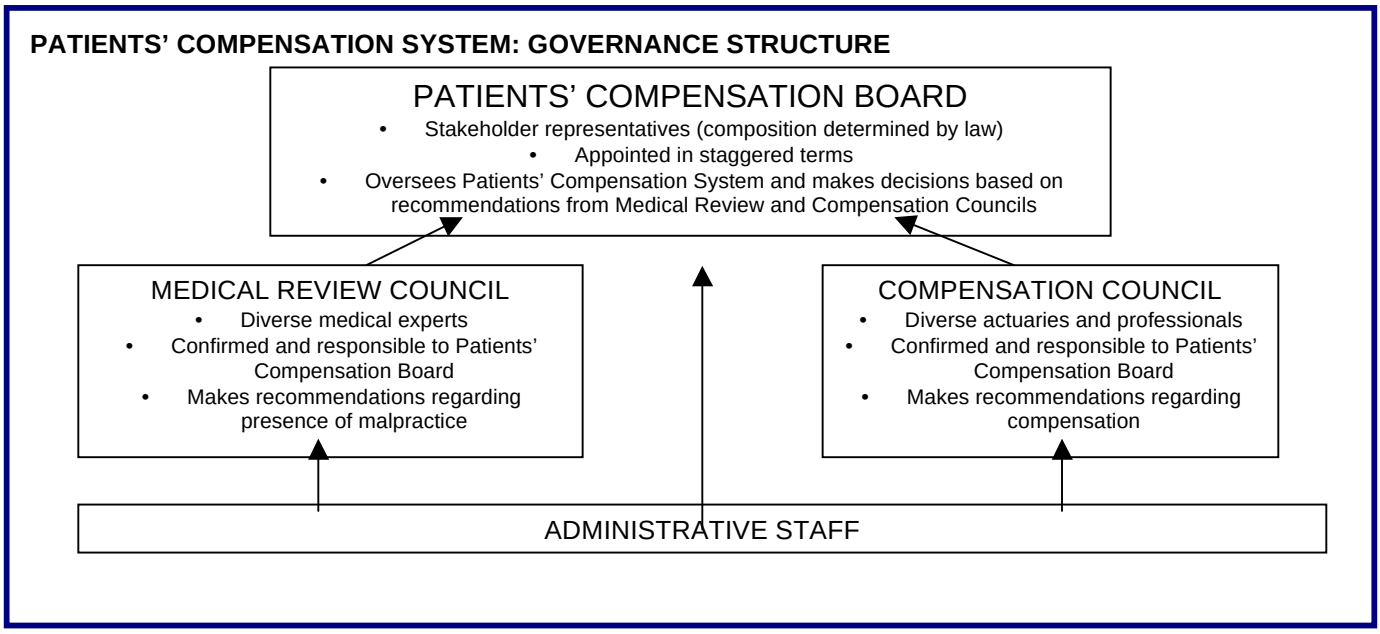
Structure

Ultimately, the decision of how to structure the Patients' Compensation System would be left to individual states. The preferable approach, however, would be to establish a quasi-governmental body as the governance entity. This could be a board or commission comprised of key stakeholders that, while created by the government, is not under direct control of an elected official.

To minimize political influence, officials could be nominated in staggered terms by elected or non-elected officials and required to represent specific sectors of society from varying geographic areas. For example, members of the Board of Governors of the Federal Reserve are nominated for staggered terms by the President. By law, these appointments must produce a "fair representation of the financial, agricultural, industrial, and commercial interests and geographical divisions of the country."[19] A state's Patients' Compensation Board could be required by law to include representation from the medical, legal, patient and business communities. Again, this type of governance structure shields the Board from the whims of politics and also enjoys the flexibility – in hiring decisions and administration processes – of an entity outside government.

This Board would oversee the entire Patients' Compensation System, which would also include a Medical Review Council, Compensation Council and necessary administrative staff. Members of the Medical Review Council would include various medical experts from academia and practice. They would represent or have the ability to call on medical specialties of all types and would report to the Patients' Compensation Board. States might consider placing a representative from the state's medical licensure authority to the Medical Review Council for consistency. The Medical Review Council would examine claims on their merits, providing a recommendation to the board as to whether or not a claim should be compensated. Nominations to the Medical Review Council would need to be approved by the Patients' Compensation Board.

Similarly, the Compensation Council would include actuaries and other professionals with experience developing compensation schedules for medical injuries. If a claim is determined eligible for compensation by the Medical Review Council, members of the Compensation Council would provide a recommendation for economic and non-economic damages to the Board based on pre-determined schedules. As with Medical Review Council members, Compensation Council appointees would need to be confirmed by the Patients' Compensation Board.



Administrative Processes

As with the Patients' Compensation System structure, the administrative processes for claims will probably vary by state. An appropriate administrative process would include the following elements:

- A claim can be filed without the necessity of a lawyer.
- A patient advocate is provided to assist the claimant in understanding and following the process.
- A member of the administrative staff makes an initial assessment of the claim.
- If the patient disagrees with the initial staff assessment, the claim is reviewed by the full Medical Review Council.
- If the Medical Review Council determines that there was medical negligence, the Compensation Council recommends appropriate compensation to the patient.
- The Patients' Compensation Board makes the final determination on the claim, relying heavily on the recommendations of the Medical Review Council and the Compensation Council.
- Decisions of the Patients' Compensation Board can be appealed to the state court system. However, any review by a court would be under a highly deferential standard of review, meaning that it will be difficult and rare to overturn a decision of the Board.

This administrative process will significantly reduce the time it takes for patients to receive compensation. While it takes between four to five years on average to resolve a claim in the current medical malpractice system, similar "no-fault" processes in Sweden resolve patients' claims, on average, within six to eight months.[20]

Compensation

Under the Patients' Compensation System, compensation is awarded to patients with regard to both economic and non-economic damages. The Board will be responsible for determining the value of particular injuries for particular individuals, but will base its decisions on a predetermined schedule. Ideally, the Board would undertake a process – much like the federal regulatory process – through which hearings are held, draft standards are published, comments are received and only then are decisions made. Whether or not a cap or limit on compensation exists will be up to the Board.

The amount of the compensation award will be generally based on earnings, expected follow-on medical and rehabilitation costs, as well as reasonable support needs. In addition, the Board will also consider non-economic damages, including pain and suffering.[21]

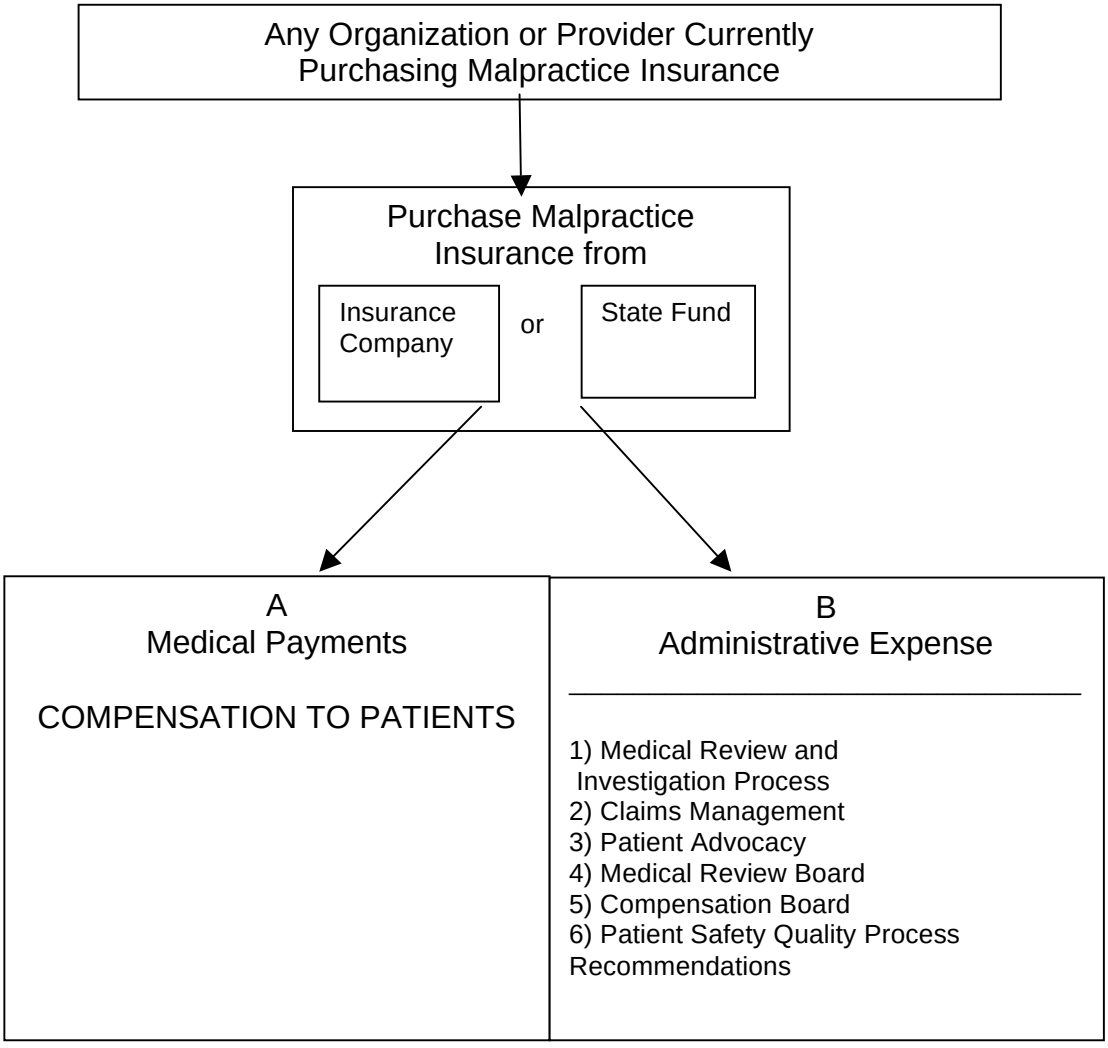
Financing

The Patients' Compensation System would be funded through providers' purchase of insurance. As with the workers' compensation system today, providers would be required to obtain insurance through a private insurer or, if the state chooses, a state-sponsored fund. The amount of a contribution from a provider would be determined by a formula which includes the number of patients serviced, past safety records and similarly relevant data. Providers could also demonstrate their ability to self-insure, assuming they obtain a level of reinsurance to protect against potential insolvency. As is the case with workers' compensation funds, self-insured providers would have to qualify for this designation with a governing board, would have to prove appropriate financial ability to cover any losses, and would have to contribute to a self-insurers' fund in order to insure against insolvency of a self-insurer.

The current paradigm of medical malpractice insurance would naturally shift, however, as new patterns and standards for compensation emerge. While it can be anticipated that insurance costs could decrease as the system is implemented and legal action declines, along with corresponding legal costs, providers would have far more certainty with regard to costs. States could choose to finance the minimal administrative costs of the Patients' Compensation System as they see fit; however, they may consider assessing a surcharge on medical malpractice insurance. Unlike today's medical malpractice insurance system, insurers in the Patients' Compensation System would be required only to bear risk, not to address claims.

Finally, in assessing the cost implications of a Patients' Compensation System, it is worth noting that even if a state chooses to design the system so that the financing of the system is cost-neutral (the current spending in the state on the current tort-based medical malpractice system is roughly equal to the spending on patient compensation and administrative costs), the real cost savings will be achieved over time through the reduction of defensive medicine by the provider community in the state.

PATIENTS' COMPENSATION SYSTEM FINANCING PROCESS



Quality and Safety in Patient Care

Medical malpractice reform and efforts to enhance quality and patient safety must go hand-in-hand. As government and private health programs increasingly emphasize quality, transparency and accountability, it is key to ensure the Patients' Compensation System captures relevant data that can be used to improve patient care. Specifically, many preventable medical errors are a result of the environments in which physicians and nurses practice or faulty systems of care. More information about when and why errors occur can help providers identify patterns and address these weaknesses. More accessible, yet private, information on adverse events combined with advances in technology can drive the evolution of safer care practice models. In addition, increased levels of patient safety will naturally address a portion of the health care system's medical malpractice issues: If fewer patients are subject to medical errors, fewer patients will bring claims. The Patients' Compensation System presents a unique opportunity to establish effective communication between physicians, hospitals and insurers to increase patient safety and improve the ability to analyze adverse events.

As such, the Patients' Compensation System would track data on all claims in a blind database that would protect the privacy of all providers and patients. This data would be used to inform best practices and could be shared with providers, patients and Patients' Compensation Systems in other states.

Information in this database could not be used to punish providers. In a separate database, the Patients' Compensation System would track claims ruled as malpractice. These files will be more detailed and will be transferred to state licensure boards for review.

Considerations in Crafting Patients' Compensation System Legislation

As discussed previously, the current U.S. workers' compensation system as well as various international examples and medical malpractice proposals help inform the Patients' Compensation System. Yet, as with any policy concepts, this analysis necessarily cannot fully consider the possible legal implications of such a large-scale reform of the traditional tort system. While helpful, relying too heavily on state workers' compensation systems as a legal guide in crafting Patients' Compensation System legislation may be problematic because of the inherent structural differences between injuries to workers and injuries to patients. Individual states, however, can each explore the legal approach necessary to capture the core elements of a Patients' Compensation System within the confines of existing state law.

Conclusion

The Patients' Compensation System is an alternative to the traditional medical tort system that draws upon what works in the U.S. workers' compensation system, other nations and within innovative medical malpractice solutions tested and proposed by others. At its core, the Patients' Compensation System is designed to lower health care costs, cut down on unnecessary tests and procedures and improve the quality of patient care through a state-driven system that provides prompt, fair resolution of malpractice claims without the hassle of the litigation process.

Specifically, eliminating physicians' fear of personal financial liability will reduce the incentive for physicians to order unnecessary tests and procedures, driving down health care costs. In addition, the Patients' Compensation System will ensure all patients will receive fair, timely compensation through an easily navigable administrative process that will cost them less and yield compensation quicker and more often than today's litigation-based system. Finally, and perhaps most importantly, the Patients' Compensation system will focus on improving the overall quality of patient care by encouraging the reporting of medical errors and providing data-driven resources so the medical community can learn from avoidable errors in a safe, confidential environment.

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[18] Ibid.
[19] The Federal Reserve Board, "FAQs" http://www.federalreserve.gov/generalinfo/faq/faqbog.htm, accessed February 25, 2011.
[20] National Center for Policy Analysis, "Medical Malpractice Reform," 2007.
[21] While the workers' compensation systems hold many lessons for medical malpractice reform, its limitations in the area of compensation should not be overlooked. Generally, workers' compensations systems do not compensate an employee for all of his or her losses. Instead, the system usually covers only medical and hospital expenses and a percentage of lost income. Indeed, while workers' compensation systems are intended to provide workers with sufficient benefits to allow them to exist without becoming burdensome to society, in practice, workers' compensation acts generally only provide enough so that workers are prevented from becoming destitute. In contrast, successful plaintiffs in traditional tort actions for negligence are entitled to recover not only hospital and medical expenses, but the full amount of lost income and additional damages for subjective measures such as pain and suffering. As Patients' Compensation System boards evaluate appropriate compensation for claims, they should be mindful of this discrepancy.