to the Implicit Price Deflator for Gross Domestic Product by publication of a document in the **Federal Register**. If a significant adjustment is needed to arrive at the new actual cost for any reason other than inflation, then a proposed rule containing the new fees will be published in the **Federal Register** for comment.

Service—processing of the following:	Fee amount	30 CFR citation
(1) Change in Designation of Operator	$207	§ 550.143(d).
(2) Right-of-Use and Easement for State lessee	$3,246	§ 550.165.
(3) [Reserved].		
(4) Exploration Plan (EP)	$4,348 for each surface location; no fee for revisions.	§ 550.211(d).
(5) Development and Production Plan (DPP) or Development Operations Coordination Document (DOCD).	$5,017 for each well proposed; no fee for revisions.	§ 550.241(e).
(6) [Reserved].		
(7) Conservation Information Document	$32,372	§ 550.296(a).

* * * * *

PART 556—LEASING OF SULFUR OR OIL AND GAS AND BONDING REQUIREMENTS IN THE OUTER CONTINENTAL SHELF

■ 3. The authority citation for part 556 is revised to read as follows:

Authority: 30 U.S.C. 1701 note, 30 U.S.C. 1711, 31 U.S.C. 9701, 42 U.S.C. 6213, 43 U.S.C. 1331 note, 43 U.S.C. 1334, 43 U.S.C. 1801–1802.

■ 4. Amend § 556.106 by revising paragraph (a) to read as follows:

§ 556.106 Service fees.

(a) The table in this paragraph (a) shows the fees you must pay to BOEM for the services listed. BOEM will adjust the fees periodically according to the Implicit Price Deflator for Gross Domestic Product and publish a document showing the adjustment in the **Federal Register**. If a significant adjustment is needed to arrive at a new fee for any reason other than inflation, then a proposed rule containing the new fees will be published in the **Federal Register** for comment.

SERVICE FEE TABLE

Service—processing of the following:	Fee amount	30 CFR citation
(1) Assignment of record title interest in Federal oil and gas lease(s) for BOEM approval	$234	§ 556.701(a).
(2) Sublease or Assignment of operating rights interest in Federal oil and gas lease(s) for BOEM approval.	234	§ 556.801(a).
(3) Required document filing for record purpose, but not for BOEM approval	34	§ 556.715(a) § 556.808(a).
(4) Non-required document filing for record purposes	34	§ 556.715(b) § 556.808(b).

* * * * *

[FR Doc. 2022–18388 Filed 8–25–22; 8:45 am]

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 45

[Docket ID: DOD–2021–OS–0047]

RIN 0790–AL22

Medical Malpractice Claims by Members of the Uniformed Services

AGENCY: Department of Defense (DoD) Office of General Counsel, DoD.

ACTION: Final rule.

SUMMARY: DoD is publishing this rule to finalize the implementation of requirements of the National Defense Authorization Act (NDAA) for Fiscal Year 2020 permitting members of the uniformed services or their authorized representatives to file claims for personal injury or death caused by a Department of Defense health care provider in certain military medical treatment facilities. Because Federal courts do not have jurisdiction to consider these claims, DoD is issuing this rule to provide uniform standards and procedures for considering and processing these actions.

DATES: This final rule is in effect September 26, 2022.

FOR FURTHER INFORMATION CONTACT: Melissa D. Walters, (703) 681–6027, *melissa.d.walters.civ@mail.mil*.

SUPPLEMENTARY INFORMATION:

Background

Signed into law on December 20, 2019, section 731 of the 2020 NDAA allows members of the uniformed services or their authorized representatives to file claims for personal injury or death caused by a DoD health care provider in certain military medical treatment facilities.

Historically, members of the armed forces have been unable to bring suit against the government under the *Feres* doctrine, named for the plaintiff in *Feres* v. *United States,* 340 U.S. 135 (1950). Based on this 1950 Supreme Court decision, Active Duty military personnel may not sue the government for personal injuries suffered incident to service (generally, while on active duty). The 2020 NDAA allows Service members, with certain limitations, to bring administrative claims to seek compensation for personal injury or death resulting from medical malpractice that occurred in certain military medical treatment facilities, in addition to compensation already received under the comprehensive compensation system that currently exists for military members and their families.

A substantiated claim of up to $100,000 will be paid directly to the Service member or his/her estate by DoD. The Treasury Department will review and pay claims that the Secretary of Defense values at more than $100,000. Service members must present a claim that is received by DoD within two years after the claim accrues. However, the statute allowed Service

members to file claims in 2020 for injuries that occurred in 2017.

Legal Authority for This Rule

Based on section 731 of the NDAA, this rule finalizes in Title 32 of the Code of Federal Regulations a new part 45, Medical Malpractice Claims by Members of the Uniformed Services. Title 10 U.S.C. 2733a(f) sets forth the required contents of the rule. This rule describes the claims process, which includes: the claimant's submission of information to initiate a medical malpractice claim; the claimant's response to an adjudicator's request for new information required to substantiate the claim or to determine damages; an Initial Determination issued by DoD; the opportunity for a claimant to seek reconsideration of damage calculations in the case of clear error; and, in most cases, the opportunity for a claimant to file an administrative appeal.

Claims will be adjudicated based on uniform national standards consistent with generally accepted standards used in a majority of States in adjudicating claims under the Federal Tort Claims Act (FTCA), 28 U.S.C. 2671 *et seq.,* without regard to the place where the Service member received medical care.

Discussion of Comments and Changes

An interim final rule was published in the **Federal Register** (86 FR 32194–32215) on June 17, 2021. Comments were accepted for 60 days until August 16, 2021. A total of 93 comments were received. Summaries of the comments and the Department's responses are below. In the first section, we address general or overarching comments. In the sections that follow, we address comments related to specific portions of the regulation. The Department's responses are based not just upon the public comments but also upon the Department's experience with processing claims under the interim final rule. DoD will engage in an iterative regulatory process as it continues to receive and process medical malpractice claims. DoD will review this rule on a periodic three-year cycle in accordance with departmental retrospective review requirements.

General

The Department received a number of comments that were outside of the scope of the interim final rule.

Some comments included or consisted of personal narratives from Service members or their family members about specific medical care received from DoD. To the extent these individuals or their representatives believe that malpractice occurred, they may follow procedures in the final rule to submit a claim for adjudication.

A number of comments sought to have DoD establish an independent review or appellate process by what was described as a disinterested party or body or a third party, including review by a Federal court. One commenter recommended review through a body similar to the Independent Review Commission established by DoD to make recommendations for addressing sexual assault. Some commenters linked the lack of such a process with a lack of transparency. A law firm recommended review of DoD's final decision by a court, such as the U.S. Court of Appeals for Veterans Claims. Some commenters were concerned DoD would not follow its own procedures or the law in the absence of judicial review. Several commenters indicated that DoD would be able to make unconstitutional decisions in the absence of court review.

Title 10 U.S.C. 2733a does not include a provision for third-party or court review. Rather, the statute calls for the Secretary of Defense to allow, settle, and pay covered medical malpractice claims. The process established by the Department to implement Title 10 U.S.C. 2733a is intended to be non-adversarial. The Department has attempted to minimize claimant costs by not requiring expensive expert reports up front and affording claimants an opportunity to submit additional evidence prior to denial of a claim and, if deemed meritorious, in support of damages. The discussion below addresses adjustments made by the Department in the final rule in response to comments to increase the amount of information provided to claimants.

A few comments addressed DoD's Regulatory Analysis. One merely described the analysis as bold without more. Another generally described DoD's projections in unfavorable terms without making any recommendations. Other comments recommended that the Government Accountability Office investigate the number of deaths or disabilities incurred in non-combat healthcare settings since the United States Supreme Court decided *Feres* v. *United States* in 1950 in order to accurately project the number of malpractice claims per year. A law firm disputed DoD's estimate that seven claims a year would result in payments, but provided no rationale. The same law firm also stated that the estimated rates for attorneys and medical experts were ''grossly underestimated'' and did not appear to be consistent with those acknowledged in a majority of States, but again provided no information that would inform revised estimates. Based on the comments received, DoD is finalizing this section of the rule without changes.

A Member of Congress and some consumer advocacy groups requested that DoD pause adjudication of medical malpractice claims until the final rule has been issued. To have done so, however, would have been contrary to 10 U.S.C. 2733a(f)(3), which required DoD to prescribe an interim final rule.

Other comments outside the scope of the interim final rule were comments about the adequacy of medical coverage and disability benefits offered to the military through DoD and the Department of Veterans Affairs (VA); a comment about VA forms; a comment about the cost of life insurance; a comment about DoD's medical records system; a comment about separations through the Disability Evaluation System that the commenter believed were premature; a comment about the time taken by DoD to issue the interim final rule; issues with the medical quality assurance process and the Healthcare Resolutions Program; objections to certain medical procedures performed by DoD; comments by a Service members' organization regarding the development of the interim final rule; timeliness of responses to requests under the Freedom of Information Act; views about conditions contributing to malpractice claims and the adequacy of funding appropriated by Congress to pay claims; whether a rule about concurrent receipt of retirement and disability pay was fair; and the DoD bureaucracy in general.

Some comments were general and therefore non-actionable, such as one individual's general reference to bringing clarity to the interim final rule without any specifics being provided. Other comments referred generally to making changes to remove unspecified limits and restrictions, non-specific concerns about transparency, and statements that the interim final rule exceeded DoD's statutory authority without specifics.

One comment included questions for DoD about the source of funds used to pay claims and what statistics showed about the cost of malpractice claims. Providing answers to these questions is not within the scope of this regulatory process. We note that the sources of funding are established by statute. A substantiated claim of up to $100,000 will be paid directly to the claimant or the claimant's estate by DoD. The Treasury Department will review and

pay claims that the Secretary of Defense values at more than $100,000.

Section 45.2 Claims Payable and Not Payable in General

Comment: One individual generally expressed concerns regarding the inclusion of defenses available to the United States under the FTCA, 28 U.S.C. Chapter 171, in Section 45 .2. Several commenters suggested that DoD could deny a claim by classifying a health care provider's decision as ''discretionary.''

DoD Response: DoD made no changes. Certain exclusions from the FTCA are included in Section 45.2 because they apply to claims under this new authority as well. This includes the discretionary function exemption, which generally bars claims challenging a discretionary agency policy but would not bar claims under 10 U.S.C. 2733a involving health care providers' choices that breach their professional duty of care under Section 45.6. Section 45.2(f)(iii) lists examples of DoD policy decisions to which the discretionary function exception applies, including patient triage, disease prevention, and fitness for duty.

Comment: One individual sought a 50-year period in which to file claims instead of the current two-year period and other individuals sought to allow claims going back to 1950, the date of the U.S. Supreme Court decision in *Feres* v. *United States*. One commenter proposed allowing claims back to September 11, 2001.

DoD Response: Title 10 U.S.C. 2733a(b)(2) requires claims to be presented to the Department in writing within two years after the claim accrues. A claim accrues as of the latter of the date of the act or omission by a DoD health care provider that is the basis of the malpractice claim; or the date on which the claimant knew, or with the exercise of reasonable diligence should have known, of the injury and that malpractice was its possible cause.

Section 45.3 Authorized Claimants

Comment: A number of commenters sought to expand authorized claimants to include derivative claims by family members or other third parties, such as claims for loss of consortium. These comments generally indicated that excluding derivative claims was contrary to congressional intent. One individual expressed the view that the interim final rule discriminated against these potential claimants, thereby disincentivizing service in the Armed Forces. Consumer groups and a lawyers' association commented that wrongful death claims by family members are allowed in most, if not all, States. A lawyers' association commented that the FTCA and non-Service member claims under the Military Claims Act (MCA) allowed for derivative claims. A law firm commented that Section 45.3 appeared to preclude claims by deceased Service members as well as those Service members' families.

DoD Response: Title 10 U.S.C. 2733a(b)(1) only authorizes claims by members of the uniformed services, including claims by the representative of a deceased member of the uniformed services.

Members of the uniformed services and their representatives are subject to the requirements of Title 10 U.S.C. 2733a(b)(1). Thus, the final regulation does not permit derivative claims by family members or other claims from third parties alleging a separate injury such as loss of consortium as a result of harm to a member of the uniformed services. Family members of uniformed service members who believe they have been subjected to malpractice themselves may bring malpractice claims under different statutory provisions—either the FTCA or, if outside the United States, under the MCA.

Comment: Individuals, a law firm, and Service members' organizations indicated that trainees and participants in the Delayed Entry Program should be allowed to bring claims.

DoD Response: Title 10 U.S.C. 2733a(i)(3) requires the personal injury or death to have occurred in Federal status for the claim to be allowed under this provision. It does not include applicants or recruits who have not yet been accessed into active duty.

Section 45.4 Filing a Claim

Comment: Multiple commenters, including individuals, Service members' organizations, a law firm, a Veterans' organization, and Members of Congress commented that DoD should allow discovery to allow claimants to learn about their care and treatment. A Member of Congress requested that DoD authorize limited discovery, including the opportunity for claimants to interview or depose medical providers and sought explicit authorization in this section for claims adjudicators to conduct investigations in addition to accessing pertinent DoD records. This Member of Congress indicated alternatively that claimants be provided with the results of any interviews with health care providers conducted by DoD. Two Members of Congress indicated the rule should add a means by which claimants may submit questions they believe a claims examiner should ask a health care provider in the course of reviewing a claim and, to the extent possible, address those questions in the explanation that is provided back to the claimant. An individual made a comment to the effect that discovery promoted accountability.

Two commenters indicated that it was unfair that claimants' lawyers could not obtain access to all of DoD's records regarding claimants' medical treatment. A law firm commented that limiting claimants to their own medical records and records obtained via public records requests prevented claimants from discovering material evidence. An individual made a comment suggesting that DoD limited an individual's right to use counsel to obtain medical records and expressed concern about the time to obtain those records. Some commenters sought access to medical quality assurance records related to the healthcare provided to the claimant. One individual commented that the process lacked transparency because claimants would lack access to material that was protected by privilege, such as information protected by attorney-client privilege or medical quality assurance information.

DoD Response: Individuals, or their authorized representatives, already m/ay obtain copies of records in DoD's possession that are part of their personnel and medical records in accordance with the Privacy Act of 1974, 5 U.S.C. 552a; DoD's Privacy Act regulation at 32 CFR part 310; and DoD Manual 6025.18, ''Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.'' [1] Individuals may obtain copies of these records regardless of whether they file a claim. Once a claim is filed, the rule allows claimants to seek extensions of time for good cause shown if they are having difficulty obtaining medical records to submit in support of their claims. DoD modified the references in Section 45.4(e) to better assist individuals in understanding their rights of access to and amendment of their records.

The administrative adjudication of claims under this authority was intended to be non-adversarial. It is also consistent with the administrative adjudication of claims under the MCA, 10 U.S.C. 2733. Court-like discovery such as depositions and written interrogatories, and even ''discovery-like'' processes such as informal interviews, are contrary to that intent

[1] Available at *https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodm/602518m.pdf?ver=2019-03-13-123513-717.*

and would cause the claims process to become adversarial and protracted. DoD does not provide claimants with copies of expert reports and interview summaries in MCA claims, but instead provides claimants with the basis for the denial of a claim.

DoD agrees that claimants should be informed of the basis for an offer of settlement or informed why their claim is denied. As discussed more fully under Section 45.12: Initial and Final Determinations, in response to comments about access to information, DoD has modified Sections 45.12 and 45.13. DoD has added language to Sections 45.12 and 45.13 to ensure that claimants are provided with a meaningful basis for an offer of settlement or are provided a meaningful explanation for the denial of a claim that includes the specific basis for the denial.

DoD added language to paragraph 45.4(d) to include additional actions that may be taken by DoD in connection with substantiating a claim, such as interviews of health care providers.

DoD made no changes in response to the comment seeking medical quality assurance information, as DoD may not lawfully disclose this information in this context under 10 U.S.C. 1102.

Comment: A Veterans' organization commented that the administrative process in the interim final rule may be difficult to navigate, with different requirements depending on the type of injury. The Veterans' organization suggested simplifying the process and suggested making claims forms available online and allowing electronic filing.

DoD Response: DoD did not make any changes in the rule in response to this comment, although DoD supports making the process as easy to navigate for Service members as possible and can make changes that would be helpful as DoD gains experience in processing claims.

Comment: A Veterans' organization indicated that the provision in Section 45.4(d) that may require claimants to submit an expert opinion in support of their claims placed an unnecessary and expensive burden on Service members. The organization commented that if DoD needed additional information, it should obtain an independent medical opinion.

DoD Response: No changes were made in response to this comment. Section 45.4(d) applies when DoD already believes it has all the information necessary (which may include an expert opinion obtained by DoD) and intends to deny the claim. This provision was intended to spare claimants the expense of providing an expert report up front. Instead, DoD will issue an Initial Determination explaining that DoD intends to deny the claim and providing the claimant with the opportunity to submit an expert report. DoD administratively removed language in Section 45.4 referring to the interim final rule.

Section 45.5 Elements of a Payable Claim: Facilities and Providers

Comment: Several commenters believed that care that was outside of a military medical treatment facility should be covered. Some indicated that the limitation to care provided in military medical treatment facilities overlooked care provided to Service members in other contexts and that all situations in which medical care was provided should be covered. A law firm indicated that malpractice claims should be afforded to Service members in DoD confinement facilities.

DoD Response: No changes were made in response to these comments. Title 10 U.S.C. 2733a(b)(3) requires the act or omission constituting malpractice to have occurred in a covered military medical treatment facility. Title 10 U.S.C. 2733a(i)(1) defines ''covered military medical treatment facility'' as a facility described in 10 U.S.C. 1073d. These facilities are medical centers, hospitals, and ambulatory care centers. DoD must limit claims to those covered under the statutory definition.

Section 45.6 Element of Payable Claim: Negligent or Wrongful Act or Omission

Comment: Individuals commented that DoD should have the burden of proof when determining malpractice claims. These individuals also commented that claims should be immediately paid in cases in which the injury was determined to be a sentinel event by a regulatory agency, the care was not administered according to evidence-based practice guidelines, and where health care providers were practicing outside the scope of the state in which they are licensed.

DoD Response: DoD made no changes in response to this comment. Placing the burden of proof with DoD would be inconsistent with the requirement in 10 U.S.C. 2733a(f)(2)(B) for DoD to adopt uniform standards consistent with generally accepted standards used in a majority of States. The rule generally addresses the standard of care and indicates claimants may present evidence in support of their belief that the standard of care was not met.

If DoD has already determined that the standard of care was not met in a particular circumstance before a claim is filed, DoD would be able to engage with the claimant to determine an appropriate amount to offer in settlement without requiring any additional information to substantiate the claim.

DoD would determine whether health care providers were acting in furtherance of their duties in the military medical treatment facility. Title 10 U.S.C. Section 1094(d) mandates that, notwithstanding any State law regarding the licensure of health care providers, designated licensed individual providers may practice their profession in any location in any jurisdiction of the United States, regardless of where the provider or patient is located, so long as the practice is within the scope of the provider's authorized federal duties. This includes telemedicine providers.

Comment: A Veterans' organization suggested clarifying the reference to the preponderance of the evidence standard to advise claimants that ''preponderance of the evidence'' requires providing only that something is more likely than not. The Veterans' organization cited several court cases with varying formulations of the law.

DoD Response: DoD did not make any changes in response to this comment. Although ''preponderance of the evidence'' is a commonly-used legal standard, as the comment itself illustrates, it is subject to various descriptions and DoD does not believe it advisable to include one particular formulation over another. After more experience in adjudicating claims under this final rule, if it appears that a definition is needed, DoD will revisit this.

Section 45.7 Element of Payable Claim: Proximate Cause

Comment: Individuals, Service members' organizations, a law firm, and unions commented that DoD did not specify how it will calculate damages based upon loss of chance or failure to diagnose claims and what steps it will take to review claims in this regard.

DoD Response: DoD did not make any changes based on this comment. The rule sets out general legal standards that must be applied in light of the specific facts of each individual claim. The rule states that the portion of harm attributable to the breach of duty will be the percentage of chance lost in proportion to the overall clinical outcome and that damages will be calculated based on this portion of harm. Including more detail would be neither feasible nor appropriate.

DoD administratively modified the first sentence of Section 45.7(d)(2) to

read that ''DoD may consider medical quality assurance records'' instead of ''will consider'' for consistency with the second sentence of Section 45.7(d)(2) which states that results of medical quality assurance records ''may'' be considered.

Section 45.8 Calculation of Damages: Disability Rating

Comment: Individuals, a Service members' organization, a law firm, and unions did not believe DoD should use disability ratings established through the DoD Disability Evaluation System or by the VA in calculating damages for medical malpractice claims on the grounds that these are different systems. The law firm indicated that DoD did not have authority to hold a claim in abeyance pending DoD or VA disability determinations. An individual was concerned that disability ratings may be inaccurate.

DoD Response: DoD did not make changes due to this comment. The purposes for which these disability ratings and compensation will be used is explained in the text of the rule. In short, disability ratings and compensation are useful for purposes of assessing the extent of the harm caused by the medical malpractice and in determining lost earning capacity. DoD will only use these ratings if they are useful and pertinent to the element of damages at issue. After more experience in adjudicating claims under this final rule, if it appears that disability ratings are not useful in assessing the extent of harm caused by the medical malpractice and in determining lost earning capacity, DoD will revisit this. DoD will review this rule on a periodic three-year cycle in accordance with departmental retrospective review. Congress gave DoD broad authority to issue regulations to implement the claims process and, if a disability rating and compensation are needed for purposes of assessing damages, holding the claim in abeyance ensures these damages are calculated accurately.

Section 45.10 Calculation of Damages: Non-Economic Damages

Comment: A number of comments, including comments from individuals, a law firm, unions, consumer groups, a Veterans' organization, and Members of Congress, sought elimination of the cap on non-economic damages. A number of individuals proposed an increase to $1,000,000 and one individual proposed an increase to $3,000,000.

Commenters, including some Members of Congress, consumer groups, and a lawyers' association commented that while a majority of States capped non-economic damages in medical malpractice cases, an average of the caps in these States did not account for the fact that other States did not cap non-economic damages. Two Members of Congress commented that some States had tiered or categorized caps that allowed higher caps in cases involving severe injury or death and that DoD should consider the higher limit in these systems. One Member of Congress estimated that this would result in a limit of at least $800,000. Members of Congress indicated the Department should factor in inflation and should retroactively reopen and adjust those claims settled before issuance of the final rule.

Several commenters interpreted the rule to mean that 26 states had non-economic damage caps of $500,000 and indicated this was incorrect based on their own research. One individual indicated the cap of $500,000 was too low based on a description of an incident caused by what the individual believes to have been medical malpractice. A law firm and a lawyers' association indicated that the FTCA had no limit on damages. The lawyers' association indicated that caps on non-economic damages placed Service members at a disadvantage compared to those whose damages were not capped under the FTCA or the MCA, are unfair to Service members living in States with no cap, and did not adequately compensate those with the most severe injuries. Consumer groups stated that only 23 States have laws expressly capping non-economic damages in medical malpractice cases and some States provide exceptions for serious injury or death.

Consumer groups commented that caps on non-economic damages have a disproportionate impact on women because of the types of injuries women are likely to experience such as sexual or reproductive harm or pregnancy loss.

DoD Response: After considering these comments, DoD increased the cap on non-economic damages to $600,000. Title 10 U.S.C. 2733a(f)(2)(B) requires the regulations prescribed by DoD to adjudicate claims based on uniform national standards consistent with generally accepted standards used in a majority of States in adjudicating claims under the FTCA, 28 U.S.C. 2671 *et seq.,* without regard to the place where the Service member received medical care. This is a different standard from the FTCA. Under the FTCA, 28 U.S.C. 2672 and 28 U.S.C. 1346(b)(1), the law applied is the law of the place where the medical care was provided. A majority of States, 29, have caps on non-economic damages applicable in medical malpractice claims. The median of these caps is approximately $500,000.

The cap of $600,000 represents DoD's best approximation of the current average of the caps on non-economic damages in medical malpractice cases in those States having caps and it is consistent with the median amount. States have varying formulas for determining caps on non-economic damages and the $600,000 cap takes into account current state law in this regard. Some States periodically increase their non-economic damage caps to account for inflation, and the final rule takes these increases into account and retains the requirement for periodic updates to the cap to account for inflationary increases.

Where a State had a higher cap for more serious injuries or death, DoD used that cap, in an effort for balance with those States that appeared to allow a higher, unspecified amount in cases involving more serious injuries or death. Three States appear to have caps on noneconomic damages that combine economic and non-economic damages together under one cap. For these States, DoD used one-half the total cap in the calculation of the average on the assumption that cases involving more serious injuries or death likely would have greater economic damages, eroding the amount available for non-economic damages. Commenters did not provide a basis for calculating the proposed $1,000,000 or $3,000,000 caps. DoD cannot arbitrarily adopt a proposed cap unsupported by an articulable legal basis for doing so and, in any event, must apply generally accepted standards used in a majority of States.

DoD did not modify the interim final rule to allow reopening and adjustment of claims settled before publication of the final rule to apply the higher damages cap. Congress required the interim final rule in 10 U.S.C. 2733a(f)(3) ''in order to implement expeditiously'' the provisions of that section and was aware claims might be settled before the final rule was issued. There is no basis for reopening settled claims under 10 U.S.C. 2733a, which does not permit DoD to pay claims unless the amount tendered is accepted by the claimant in full satisfaction.

Comment: Two Members of Congress and a Veterans' organization commented that the current elements of non-economic damages should be expanded beyond the listed elements to a wider range of non-economic categories recognized elsewhere in tort law, such as for emotional distress and loss of consortium. The Veterans' organization commented that it was unclear if ''physical disfigurement''

extends to all forms of physical impairment and recommended a catchall phrase to incorporate ''other non-financial losses'' it stated were recoverable in a majority of States.

DoD Response: DoD did not change the interim final rule as a result of these comments. The rule already defines ''past and future conscious pain and suffering'' broadly to include ''mental and emotional trauma or distress'' and ''loss of enjoyment of life.'' The definition of ''physical impairment'' likewise mirrors a definition used for MCA claims, set forth at 32 CFR 536.77. As derivative claims are not permitted under 10 U.S.C. 2733a(b)(1), damages for loss of consortium are inapplicable. DoD did not add a catchall phrase. A catchall phrase in this context could lead to confusion or improper awards of damages given the requirement in 10 U.S.C. 2733a for uniform standards consistent with generally accepted standards used in a majority of States.

Section 45.11 Calculation of Damages: Offsets for DoD and VA Compensation

Comment: A number of commenters, including individuals, law firms, a union, Service members' organizations, consumer groups, a lawyers' association, a Veterans' organization, and some of the Members of Congress who submitted comments sought to limit or eliminate offsets from potential malpractice damage awards for other compensation paid by the United States for the same harm. Some made comments to the effect that offsets for military benefits such as TRICARE and disability could leave Service members with little compensation for the injuries they have suffered and may discourage claims. Some commenters questioned DoD's authority to make offsets and noted that 10 U.S.C. 2733a does not explicitly reference offsets. A law firm indicated that the offsets removed incentives for improvement and accountability. Another law firm noted that the process under this rule was a non-adversarial administrative claim process involving DoD, and not a tort claim against the United States under the FTCA, so offsets should not be applied. Multiple commenters mentioned the collateral source rule in connection with offsets. A law firm commented that several of the offsets, such as Active Duty pay, housing allowance, and TRICARE, did not appear related to malpractice and including them was unfair. An individual made a similar comment.

Individuals, Service members' organizations, and unions, referencing the collateral source rule, indicated that DoD should award the cost of health care services provided or paid for by DoD or the VA as part of economic damages. The Service members' organization believed not doing so would discourage Service members from filing claims. A lawyers' association stated that courts had found the amounts of future medical payment. such as from TRICARE indeterminable. An individual and a lawyers' association indicated that individuals might not want to receive care from government health care providers for the injuries they sustained. One commenter was concerned about TRICARE's solvency and ability to cover a Service member's lifetime medical needs. Another commenter was concerned that Service members would have issues with obtaining needed care through TRICARE or the VA and that the VA might not approve needed benefits or might not approve benefits in a timely fashion. A commenter believed it would eliminate work for DoD if DoD eliminated offsets versus periodically conducting a review of offsets for purposes of making changes.

Several commenters erroneously questioned the inclusion of Servicemembers Group Life Insurance (SGLI) payments as an offset. Several commenters believed that offsets could limit a Service member from getting benefits to which that Service member was entitled and another believed that the compensation system would involve ''recouping'' benefits paid by the VA. A commenter incorrectly seemed to suggest that DoD would assume remarriage for purposes of determining offsets.

One commenter questioned whether the fact that the non-exhaustive listings of programs that did or did not offset potential malpractice damage awards would allow claimants to know what was included and thought this might be difficult to ascertain.

A lawyers' association commented that the government should bear the burden of proof with respect to offsets.

DoD Response: DoD did not make changes to this section, other than adding that the government is responsible for determining offsets, with claimants required to provide information not available to DoD but requested by DoD for this purpose. Both the interim and final rule provide for offsets from potential malpractice damage awards from compensation paid or expected to be paid by DoD or the VA for the same harm that was caused by the medical malpractice. These offsets are necessary so that the United States does not pay more than once for the same injury. Given that there is no third party involved in providing benefits other than the United States, the collateral source rule is not applicable.

Moreover, as explained in the preamble to the interim final rule, Federal law provides a comprehensive system of compensation for military members and their families in cases of death or disability incurred in military service. This system applies to all causes of death or disability incurred in service, whether due to combat injuries, training mishaps, motor vehicle accidents, naturally occurring illnesses, household events, or malpractice with limited exceptions (*e.g.,* when the member is absent without leave or the injury is due to the member's intentional misconduct or willful negligence). A medical malpractice claim under this part will have no effect on any other compensation the member or family is entitled to under this comprehensive compensation system. A chart in the Regulatory Analysis provides examples of benefits to which Service members are entitled under this system.

Nothing in the rule precludes Service members in any way from receiving benefits to which they are entitled. SGLI is listed specifically in Section 45.11(g) as a payment and benefit that is not an offset from economic and non-economic damages. It was not included as an offset because it is a benefit for which Service members have paid premiums. Nothing in the rule would permit ''recoupment'' of benefits already provided to Service members. The rule also states that DoD will not assume remarriage with respect to any lifetime payments or benefits that may terminate upon the remarriage of a surviving spouse.

Finally, but most importantly, DoD has a robust Clinical Quality Management Program which operates independently of medical malpractice claims by Service members or others (under DoD Instruction (DoDI) 6025.13 [2] and Defense Health Agency Procedural Manual 6025.13 [3]) to assess the quality of health care services, identify areas where improvements can be made, and ensure appropriate accountability.

[2] DoDI 6025.13, ''Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS),'' February 17, 2011, Incorporating Change 2 on April 1, 2020, is available at *https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/602513p.pdf?ver=2019-03-11-081734-313.*

[3] Defense Health Agency Procedural Manual, ''Clinical Quality Management in the Military Health System,'' June 27, 2022, is available at *https://health.mil/Reference-Center/Policies?query=6025.13&isDateRange=0&broadVector=000&newsVector=0000000&refVector=000000000100000&refSrc=1.*

With regard to the comment that the listings of programs that did or did not offset potential malpractice damage awards was not all-inclusive, an illustrative list was included in the rule because benefit programs are numerous and are subject to frequent changes by law or regulation. The rule allows for a process. DoD contemplates a process for determining damages that involves exchanges of information to ensure accuracy, so claimants would be informed about those damages during that time or through Initial or Final Determinations.

Section 45.12 Initial and Final Determinations

Comment: In connection with a comment about discovery, a law firm commented that the government should be required to produce all evidence that it relied upon in making its decision, as well as any evidence that supports claimant's allegations of negligence. The law firm also commented that a ''meaningful explanation,'' supported by findings of fact and conclusions of law should be provided for any claim that is denied versus a ''brief explanation for the denial of the claim to the extent practicable.'' A Veterans' organization requested removing ''to the extent practicable'' and instead requiring a brief statement of the basis for any denial. Individuals commented that there was no mechanism to ascertain whether DoD reviewed the records it should have reviewed. A number of commenters sought more information in initial and final determinations and appeals for purposes of transparency.

DoD Response: DoD agrees that claimants should be informed of the basis for an offer of settlement or informed why their claim is denied. In response to comments about discovery and access to information generally, DoD has modified Sections 45.12 and 45.13. DoD modified Sections 45.12 and 45.13 to change ''brief'' to ''meaningful,'' so that a meaningful explanation of the basis for an Initial Determination denying a claim will be provided, including the specific basis for the denial. Although this was implied in the interim final rule, DoD also added language requiring that a meaningful basis for an offer of settlement be provided. Explanations will be subject to laws pertaining to disclosure of information, as discussed in the Supplementary Information related to Section 45.4.

Comment: A law firm recommended adjusting the amount of time to cure a deficiency following receipt of an initial determination to 90 days instead of 30 days. Similarly, the law firm recommended affording Service members 90 days instead of 60 days to request reconsideration and to appeal. The law firm further recommended a provision requiring DoD to confirm Service member receipt of Initial Determinations.

DoD Response: The final rule provides 90 days to cure a deficiency instead of 30 days and allows 90 days instead of 60 days to request reconsideration and to appeal. Extending the time to cure a deficiency is consistent with DoD's intent for a claimant-friendly process that provides ample opportunity for Service members or their representatives to provide information in support of their claims and reduces the need for DoD to process requests for extension.

DoD did not adopt a requirement for DoD to confirm receipt of Initial Determinations. The interim final rule adopted a presumption of receipt for the convenience of both the Service member and DoD and to provide flexibility with respect to delivery methods. The interim final rule adopted a lenient standard for overcoming the presumption: the date of receipt is presumed to be five calendar days after mailing or emailing unless there is evidence to the contrary.

Although DoD may elect to use a delivery method confirming receipt, email ''return receipts'' are not always reliable and certified mail may be inconvenient for Service members who are not at home when delivery is attempted. A presumption of receipt establishes a clear and fixed date for calculating time and reduces administrative burden. A presumption of receipt is consistent with practices in some other judicial and administrative bodies, such as the Federal courts [4] and the Merit Systems Protection Board.[5]

Even though DoD is not adopting a requirement to confirm receipt of delivery, in response to the comment, DoD revisited the length of time for presumption of delivery. The United States Postal Service is changing its target for first class mail delivery from 1–3 days to 1–5 days.[6] DoD accordingly increased the time for presumption of receipt from five to seven calendar days after an Initial Determination was mailed or emailed. DoD also clarified in Sections 45.12(c)(1) and 45.13(a) that the time period for action begins to run upon receipt by the claimant or the claimant's representative.

DoD administratively added language in Section 45.12(a)(1) to clarify that it is the DoD Component that issued the Initial Determination that acts on requests for extension of time relating to deficient filings. DoD also administratively added language to Section 45.12(d)(4) to clarify that the DoD Component that issued the Initial Determination will review alleged clear error in connection with requests for reconsideration. These changes make it clear that these processes are not conducted by the Appeals Board.

Comment: A law firm sought the opportunity for claimants to have a virtual hearing, noting that Boards for Correction of Military Records rarely afford a hearing and, in the law firm's view, lacked due process as a result. A Member of Congress also commented that claimants should be afforded a hearing, whether in person or virtual, to better capture the claimants' full experiences, particularly with respect to pain and suffering.

DoD Response: The claims process was intended to be easy to navigate and non-adversarial. A hearing would unduly increase manpower, cost, and administrative burdens on the Department and would cause undue disruption in the delivery of health care and medical readiness. It would also cause the proceedings to become adversarial in nature and increase the decision time and expense for both the Service member and the Department. Service members may submit any evidence in any form they wish and, particularly with respect to damages, back-and-forth engagement is contemplated to ensure the Department has full and accurate information from which to make a determination.

DoD administratively clarified in Section 45.12(c)(1) that it is the DoD Component which issued the Initial Determination that grants an extension of time for good cause.

45.13 Appeals

Comment: One individual commented that DoD should allow for an appellate process and another commented there was no right of appeal.

DoD Response: No changes were made as a result of this comment. The rule at Section 45.13 establishes an appeals process. To the extent these comments were seeking an appellate process outside of DoD, this is

[4] Rule 5(b) of the Federal Rules of Civil Procedure provides that service is complete upon mailing or by emailing (unless the email does not reach the person to be served). *https://www.uscourts.gov/rules-policies/current-rules-practice-procedure/federal-rules-civil-procedure.*

[5] Under 5 CFR 1201.22(b)(3), correspondence that is properly addressed and sent to the appellant's address via postal or commercial delivery is presumed to have been duly delivered to the addressee. The presumption may be overcome by the circumstances of a particular case.

[6] *https://crsreports.congress.gov/product/pdf/IN/IN11776.*

addressed in the section titled ''General,'' above.

Comment: Individuals, Service members' organizations, a Veterans' organization, and unions sought the opportunity to submit additional evidence in support of a claim on appeal. Some stated that the inability to submit additional evidence on appeal affected the opportunity for a fair assessment of the claim. The Veterans' organization indicated additional information might become available or that claimants' medical conditions may change, noting that the VA's and the Social Security Administration's administrative processes allow for new evidence on appeal. The Veterans' organization linked this comment to a lack of a discovery mechanism in the rule. A Member of Congress commented that claimants should be afforded a hearing on appeal to provide an actual opportunity to be heard if they are dissatisfied with the earlier disposition of their claims. Another Member of Congress indicated that a hearing on appeal imparted more information than could be captured in written statements and allowed traumatic experiences to be heard and acknowledged. A law firm stated that the opportunity for an oral presentation was used in what it characterized as almost every other non-adversarial claims process used by the Federal government.

DoD Response: DoD did not change the rule to permit additional evidence to be submitted on appeal. DoD modified Sections 45.12 and 45.13, adding language to ensure that claimants are provided with a meaningful basis for an offer of settlement or with a meaningful explanation for the denial of a claim that includes the specific basis for the denial. Claimants have ample opportunity to provide any information they wish at the Initial Determination stage. When a claimant initially does not submit an expert report in support of his or her claim and DoD intends to deny the claim, DoD will provide a meaningful explanation for the intent to deny the claim that includes the specific basis for the denial and provides the claimant with an opportunity to submit an expert report. Appellate review limited to the record below is consistent with procedures in many other appellate bodies, such as the Federal courts of appeal.

Comment: Some commenters stated that there was no transparency on who is going to sit on the Appeals Board, such as whether members are medical experts, legal experts, or Commanding Officers, and were concerned that Appeals Board members would not fully consider the record in an unbiased manner.

DoD Response: In response to the comments, DoD modified the rule to indicate that the Appeals Board is comprised of attorneys, in addition to the current language indicating that Appeals Board members are comprised of DoD officials who are ''experienced in medical malpractice claims adjudication'' and who ''have not had any previous role in the claims adjudication under appeal.'' In part in response to concerns about timeliness, and in part as an administrative matter, DoD adjusted the final rule to increase the number of Appeals Board members and allow for panels of members. This will permit more appeals to be considered simultaneously in light of the requirement that an Appeals Board member considering a claim not have had a previous role in adjudicating the claim.

DoD administratively clarified in Section 45.13(a) that it is the DoD Component which issued the Initial Determination that grants an extension of time for good cause and not the Appeals Board.

45.15 Other Claims Procedures and Administrative Matters

Comment: A law firm and two Members of Congress commented that the rule should include a timeline for DoD to process claims, in part so claimants would have some sense of how long they would need to wait and to give DoD a benchmark for progress.

DoD Response: This comment was not adopted. Unlike other statutes, 10 U.S.C. 2733a does not provide a right to go to court after a certain period of time. Similar to other adjudicative processes, too many variables preclude a reliable estimate. DoD has structured a process designed to allow claimants the time necessary to present information, including seeking extensions of time for good cause shown. DoD has expanded some time frames in the final rule in a manner favorable to claimants in response to comments. Exchanges of information, particularly with respect to damages, will take time in complex cases. DoD believes putting estimates in the final rule that turn out to be unrealistic for any number of reasons will only lead to claimant frustration. DoD is committed to adjudicating claims in a timely manner and will continue to endeavor to do so.

Comment: A Veterans' organization sought to include a requirement for DoD to respond to records requests within 45 days because claims must be presented within two years of accrual and because records may be needed to submit a viable claim.

DoD Response: This comment was not adopted. Responses to records requests are governed by processes outside of this rule. Moreover, DoD has established a process which requires very little information to be submitted at the time a claim is filed, with opportunities to submit additional evidence during the Initial Determination phase.

Comment: A Member of Congress requested that the rule be clarified to ensure that those issuing Initial Determinations and the attorneys advising them have expertise in medical malpractice and receive specialized training related to the military medical system.

DoD Response: DoD did not include language in the final rule on this topic, as these are matters internal to DoD and related to the regulation of the practice of law within DoD. Nonetheless, DoD shares the Member of Congress' interest in ensuring quality decisions are made by persons with appropriate training and expertise.

Comment: One commenter suggested that there be dedicated points of contact for Service members and their representatives to contact about their claims. DoD did not make changes to the rule based on this comment, as this can be addressed outside the rule, such as by including points of contact on communications about the claim.

DoD Response: DoD administratively modified Section 45.15(f) to state that the phrase ''DoD Components'' may include, but is not limited to, Military Departments.

Regulatory Analysis

The public comments received were not relevant to the RIA; therefore, DoD is finalizing the RIA with no further revisions.

a. Executive Order 12866, ''Regulatory Planning and Review,'' and Executive Order 13563, ''Improving Regulation and Regulatory Review''

Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health. and safety effects; distribution of impacts; and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This final rule has been determined to be a significant regulatory action, although

not economically significant. Accordingly, it has been reviewed by the Office of Management and Budget as required by these Executive Orders.

b. Summary

This interim final rule implements requirements of the NDAA for Fiscal Year 2020 permitting members of the uniformed services or their authorized representatives to file claims for personal injury or death caused by a DoD health care provider in certain military medical treatment facilities. Because Federal courts do not have jurisdiction to consider these claims, DoD is issuing this rule to provide uniform standards and procedures for considering and processing these actions administratively.

c. Affected Population

At the end of Fiscal Year 2019, there were approximately 1,400,000 Active Duty, 390,000 Reserve and National Guard, and 250,000 other uniformed Service members eligible for DoD healthcare benefits or around 19% of the total eligible beneficiary population. These uniformed Service members will be able to file claims with DoD alleging malpractice. There were approximately 8,140,000 other eligible beneficiaries to include retirees, retiree family members, and family members of Active Duty Service members. These other eligible beneficiaries currently may file claims with DoD alleging malpractice.

d. Costs

As a result of the rule, individuals who believe they were subjected to malpractice may consider filing a claim. In determining whether to file a claim, individuals may consult with medical professionals and attorneys and we assume that most claimants will have attorneys. We estimate that this will require 5 hours for individuals to locate an attorney, view and download pertinent medical records, and discuss the case with an attorney (or a medical professional for claimants without attorneys). At a mean hourly rate of $27.07 based on data from the Bureau of Labor Statistics (BLS), the cost of this activity is $135.

The cost for a consultation with a medical professional, whether directly by the claimant or through an attorney varies by the type of professional. Based upon information available from consultations and reports obtained in malpractice claims against the government and estimates of time spent by DoD in similar activity when handling those claims, we estimate a typical review of records would take about 3 to 5 hours (and include reviewing journals in support of the professional's opinion), with an additional 2 to 4 hours to write a report (if such a report is submitted with a claim, which is not required). The Department will assume for purposes of this analysis that the same type of professional would be consulted as the professional against whom the malpractice is alleged (*e.g.,* a doctor providing an opinion about the standard of care if a doctor is alleged to have committed malpractice). Most medical malpractice claims are brought on a contingent fee basis so there is no initial cost to the claimant. Based on similar claim analysis activity in handing malpractice claims, we estimate an attorney might spend 17–26 hours analyzing a claim before filing. We use BLS data to value time spent by these individuals, and we adjust mean wage rates upward by 100 percent to account for overhead and benefits. This implies hourly rates of $206.12 for physicians, $76.94 for nurses, $111.62 for physician assistants, and $143.18 for lawyers. As a result, the estimated cost for medical review would be approximately $231 to $1,855, and the estimated cost for attorney time would be approximately $2,434 to $3,723.

The cost to a Service member or an authorized representative for the filing itself will vary based on the amount of information the Service member includes with his or her filing. A basic letter stating the factual basis for the claim and including a demand for a specified dollar amount would cost the claimant postage ($0.55 per claim, or $27.50 for an estimated 50 claims) and possibly minimal photocopying. Claimants will likely choose to use certified mail, requiring additional postage of $3.35 per claim (or $167.50 for an estimated 50 claims per year). Two affidavits are likely required, one containing a statement from the claimant indicating he or she consulted with a health care professional and obtained an opinion from that health care professional that the medical standard of care was breached and one affirming that a representative is authorized to represent the claimant. Those entitled to legal assistance under 10 U.S.C. 1044 (such as Active Duty Service members, retired Service members, and survivors) would be able to obtain notarial services at no cost. Most likely, those filing claims would fall into one of these categories and so could obtain notarial services at no cost. However, this rule results in societal costs associated with these notarial services. We estimate that notarial services will require the equivalent of 20 minutes of paralegal time. Using BLS data, and adjusting upward by 100 percent to account for overhead and benefits to arrive at an hourly rate of $54.44 implies $18.14 in costs per claim. Finally, although not required, a claimant could submit any other information he or she chooses, which would result in a variable cost. DoD assumes that pertinent medical records outside its system would be fairly recent and could be accessed via web portals, resulting in a cost to the claimant of only the cost of printing and postage. If the claimant elects to submit receipts, the claimant would need to pay the cost of printing or photocopying, as well as postage.

In 2020, DoD received 149 malpractice claims filed by Active Duty beneficiaries under the process in this part and 173 malpractice claims filed by other beneficiaries under either the FTCA or MCA. Section 2733a(b)(4) requires claims to be presented to DoD within two years after the claim accrues, although section 731 of the Fiscal Year 2020 NDAA allowed claims accruing in 2017 to be filed in 2020. In future years, when three years' worth of claim filings are not compressed in the same year and the requirement for consultation with a health care professional in certain circumstances in advance of filing takes effect, DoD would anticipate around 50 claims per year. Based on information related to malpractice claims not filed after consideration, we estimate that 90% of the claims considered by individuals and their attorneys will not be filed. As a result, we estimate that 500 claims will be considered, and that 50 claims will be filed by Service members per year.

The categories of costs for considered claims are described above. In sum, we estimate costs of $2,822 to $5,735 per claim. This implies total costs of $1,401,102 to $2,857,602 each year for considered claims.

Next, we estimate costs associated with processing claims. Many steps in processing a claim will be the same for DoD whether or not the claim has merit. Based on activity in non-medical malpractice claims, we anticipate 3 hours of paralegal time for activities such as logging in claims, sending acknowledgment letters, mailing certified letters containing the outcome of a claim, drafting vouchers for payment, and filing/data entry. Assuming a GS–11 paralegal at the step 5 salary rate of $81,634 based on the 2020 Washington, DC, locality pay table (an hourly rate of $39.12) and the total value of labor including wages, benefits, and overhead being equal to 200 percent of the wage rate, the cost for this

paralegal activity per claim is $234.72. We estimate that the approximately same amount of time that a claimant's attorney would spend analyzing a claim (17–26 hours of attorney time) would be spent by DoD attorneys to analyze the claim, conduct legal research, consult with experts, and draft a determination. Assuming a GS 13/14 at an average GS 13/14 salary of $127,788 based on the 2020 Washington, DC, locality pay table (an hourly rate of $61.23) and the total value of labor including wages, benefits, and overhead being equal to 200 percent of the wage rate, this attorney activity would cost $2,081 to $3,184 per claim.

Of these 50 claims, for purposes of this analysis, based on historical malpractice claims data involving non-Service members, we assume 27% of claimants will have claims for which DoD determines malpractice occurred, or 14 claims. For these claims, based on time spent by DoD on the damages portion of current malpractice claims against the government, DoD estimates claimants' attorneys and DoD attorneys will spend 6–8 hours respectively on matters pertaining to damages. This results in a cost per claim of $859 to $1,145 for claimants' attorneys and $748 to $997 for DoD attorneys.

Of submitted claims, DoD estimates that claimants will appeal all claims that do not result in a payment of damages, resulting in 36 appeals annually. Note that this is described in more detail in the transfers section. We estimate it will take around the same amount of time spent on initial determination activities for appeal activities, or 17–26 hours per claim for both claimants' attorneys (at a cost of $2,434 to $3,723) and DoD attorneys (at a cost of $2,081 to $3,184) and 3 hours per claim by DoD paralegals (at a cost of $235). This implies total annual costs of $171,000 to $257,112 for appeals.

As a result, we estimate total annual processing costs for these 50 claims to be $309,284 to $458,036.

In summary, total estimated annual costs of this interim final rule are $1,710,386 to $3,315,638.

e. Transfers

Regardless of the number of claims in which malpractice occurred, the only claims in which damages will be awarded are those which exceed the offsets for any payment to be made. Subject to some exceptions such as insurance benefits for which Service members have paid premiums, benefits received through the DoD and VA comprehensive compensation system applicable to all injuries and deaths will be applied as an offset in calculating malpractice damages to prevent a double recovery. Because of these offsets, regardless of the number of claims filed, the only claims pertinent for purposes of payments made by the government are those that would exceed applicable offsets.

We estimate 7 claims per year will result in additional payments made to individuals, which is the number of claims anticipated to involve additional payments after offsets are applied. To help explain how we reached this estimate, we prepared the following tables as notional examples to illustrate what benefits are available under the existing comprehensive compensation system, both those that are offset and those that are not, and the value of these benefits in Fiscal Year 2020. In addition to the benefits in the above tables, disability retirees and survivors receive healthcare for life through TRICARE. In Fiscal Year 2020, based on information from the Office of the Assistant Secretary of Defense for Health Affairs, the average value of the TRICARE benefit for an under-65 retiree family of three was $14,600 per year. Benefits provided through the Social Security Administration, such as Social Security disability benefits and Social Security survivor benefits, are also in addition to the above tables. Calculations in the tables were provided by the Office of Military Compensation Policy, within the Office of the Under Secretary of Defense for Personnel and Readiness.

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Table 1: Notional Examples of Benefits Following a Service Member's Death on Active Duty – Fiscal Year 2021 Values

	Type of Payment	Description	(a) O-5[7] (16 Years of Service) (YOS) Married (age 38) with Two Children	(b) E-6 (10 YOS) Married (age 29) with Two Children	(c) E-4 (3 Years of Service) Married (age 22) with One Child
			Amount	Amount	Amount
ONE-TIME PAYMENTS	**Service Members Group Life Insurance (SGLI)**	Life insurance. All members are automatically covered unless declining coverage. Amount shown assumes member elected maximum coverage. Payment is tax-free.	$400,000	$400,000	$400,000
	Death Gratuity	Immediate tax-free payment to eligible survivors of members who die while on active duty or certain inactive duties. Amount does not vary.	$100,000	$100,000	$100,000
	Total Immediate Payments		**$500,000**	**$500,000**	**$500,000**

	Type of Payment	Description	(a) O-5[7] (16 Years of Service) (YOS) Married (age 38) with Two Children	(b) E-6 (10 YOS) Married (age 29) with Two Children	(c) E-4 (3 Years of Service) Married (age 22) with One Child
			Amount	Amount	Amount
RECURRING ANNUAL PAYMENTS	**Survivor Benefit Plan (SBP)**	Annuity paid to the surviving spouse for life, or until remarriage if surviving spouse remarries prior to age 57. This payment is offset by Dependency and Indemnity Compensation (DIC), if DIC is paid to the spouse.[8]	$41,304 ($25,013 after DIC offset)	$17,274 ($984 after DIC offset)	$10,679 (fully offset by DIC)
	Dependency and Indemnity Compensation (DIC)	Tax-free monetary benefit paid to eligible survivors of military members who died in the line of duty or eligible survivors of Veterans whose death resulted from a service-related injury or disease. Paid by Department of VA.[9]	$24,362.40	$24,362.40	$20,326.56
	Special Survivor Indemnity Allowance (SSIA)	Paid to the surviving spouse if the spouse is subject to an offset of SBP due to receipt of DIC.[10]	$3,924	$3,924	$3,924
	Total Annual Recurring Payment for First Year	SBP (decreased by the amount of DIC) + DIC + SSIA. Amount shown is in 2020 dollars.	$53,299	$29,270	$24,250

	Type of Payment	Description	(a) O-5[7] (16 Years of Service) (YOS) Married (age 38) with Two Children	(b) E-6 (10 YOS) Married (age 29) with Two Children	(c) E-4 (3 Years of Service) Married (age 22) with One Child
			Amount	Amount	Amount
	Estimated Lifetime Sum of Annual Payments	Assumptions: • Spouse lives to age 87, but does not remarry prior to age 57. • SBP (offset by DIC) is paid to the spouse for life rather than to the children. • DIC for child ends 10 years after the death of the member when children reach age 19 (note: for the E-4, it assumes 15 years after death of the member) and resumes when the spouse reaches age 65. • Average annual cost of living adjustment is 2.75%.	$4,842,372	$3,151,453	$3,749,434
	Total Estimated Government-Provided Direct Benefits (Immediate + Recurring Payments)		**$5,342,372**	**$3,651,453**	**$4,249,434[11]**

[7] In these tables, ''O–5'' refers to an officer grade; ''E–4'' to an enlisted grade.

[8] Amount shown is annual. The spouse SBP annuity is 55% of what retired pay would have been had the member retired with a full disability retirement on the date of his or her death. SBP is adjusted annually for cost-of-living. The amount reflected is for 2020 and assumes the spouse receives the full amount of SBP. SBP is subject to offset if the spouse also receives DIC (only for the portion of DIC payable to the spouse. If SBP is paid to the children instead of the spouse, there is no offset but the annuity ends when all children reach the age of majority).

[9] Basic Monthly Rate for 2020 is $1,340.14 plus $332.00 per child age 18 or younger. $16,081 is payable as DIC for the spouse which is offset against SBP.

[10] SSIA is only received if SBP is reduced by the amount of DIC. If children receive SBP in full while the spouse receives DIC, no SSIA is paid.

[11] The total payout for the spouse of the E–4 is higher than that for the E–6 because the spouse is 7 years younger, but both live until age 87.

Table 2: Notional Estimates of Monthly DoD and VA Disability Benefits for a Member Permanently Injured on Active Duty – Fiscal Year 2021 Values

Type of Payment	Description	(a) O-3 (Over 8 YOS) Age 30, Married Male with Two Children with 100% Disability	(b) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 100% Disability	(c) O-3 (Over 8 YOS), Age 30 Married Male with Two Children with 50% Disability	(d) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 50% Disability
		Monthly	*Monthly*	*Monthly*	*Monthly*
DoD Disability Retired Pay Calculated Based on Disability Percentage (Before VA Offset)	Disability retired pay under Chapter 61, Title 10, U.S.C., is determined by multiplying the disability percentage (maximum 75 percent) by the retired pay base, which is the average of the highest 36 months of pay that member received.[12]	$4,542	$2,519	$3,028	$1,679
Retired Pay Calculated Based on Years of Service	A disability retiree has the option of choosing to have retired pay calculated based on the disability percentage (A) or based on longevity of service (B). In most cases, the disability percentage results in a greater amount of retired pay.-Longevity retired pay is calculated by multiplying years of service by the average of the highest 36 months of pay by the applicable retirement program multiplier.[13]	$1,211	$671	$1,211	$671

Type of Payment	**Description**	**(a) O-3 (Over 8 YOS) Age 30, Married Male with Two Children with 100% Disability**	**(b) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 100% Disability**	**(c) O-3 (Over 8 YOS), Age 30 Married Male with Two Children with 50% Disability**	**(d) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 50% Disability**
VA Disability Compensation	A tax-free monetary benefit paid to veterans with disabilities that are the result of a disease or injury incurred or aggravated during active military service. The benefit amount is graduated according to the degree of the disability on a scale from 10 percent to 100 percent (in increments of 10 percent).[14]	$3,492	$3,492	$1,086	$1,086
DoD Disability Retired Pay (After VA Offset)	A retiree must waive a portion of his or her gross DoD retired pay, dollar for dollar, by the amount of his or her VA Disability Compensation pay.	$1,049	$0	$1,941	$592
Total Monthly DoD and VA Compensation	VA Disability Compensation + DoD Disability Retired Pay After VA Offset.	$4,541	$3,492	$3,027	$1,678
		Annual	*Annual*	*Annual*	*Annual*
Annual DoD and VA Compensation	Total Monthly DoD and VA Compensation x 12 months.	**$54,492**	**$41,904**	**$36,324**	**$20,136**
Lifetime DoD and VA Compensation After Disability Retirement	Annual total multiplied by the number of years of projected life. The life expectation for a male 30-year-old retired officer is 54.5 additional years. The life expectation for a female 26-year-old retired enlisted member is 56.5 additional years. Amounts shown are in 2020 dollars without	**$2,969,814**	**$2,367,576**	**$1,979,658**	**$1,137,684**

Type of Payment	Description	(a) O-3 (Over 8 YOS) Age 30, Married Male with Two Children with 100% Disability	(b) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 100% Disability	(c) O-3 (Over 8 YOS), Age 30 Married Male with Two Children with 50% Disability	(d) E-6 (Over 8 YOS) Age 26, Married Female with Two Children with 50% Disability
	taking into account annual cost-of-living adjustments (COLA) (i.e., the present value). The current COLA estimate used by the DoD Board of Actuaries for calculating future military retired pay is 2.75 percent per year.				

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We estimate that 7 claims per year would have damages that would exceed the offset amount of $1.1 million. We used the notional example in Table 2(d), the lowest of the estimates in the notional examples, as the basis for the $1.1 million offset. For the Table 2(b) example of the married enlisted member with two children in the grade of E–6 who is medically retired with a 50 percent disability rating, the current value of her lifetime compensation would be $1,142,430. In addition to the $1,142,430 paid, benefits include medical care for the retired Service member and her family. All these amounts would offset any damages award.

We then estimated the number of claims likely to exceed $1.1 million using claims data from non-Service member claims under the FTCA or MCA. In 2019 and 2020, the Military Departments had 14 claims from retirees or dependents under the FTCA or MCA with damages that exceeded $1.1 million, whether through settlement or an adverse court judgment. The average amount payable for these 14 claims over 2 years was approximately $2.7 million. In one year, therefore, we estimate that 7 claims by Service members would go forward that exceed the $1.1 million threshold for payable damages. Assuming 7 claims per year going forward exceeding $1.1 million, and average damages of $1.6 million (the difference between the average amount of $2.7 million paid per claim in the non-Active Duty claims and the estimated $1.1 million in offsets per Service member claim), the additional payments made by the U.S. Government because of section 731 are estimated to be $11.2 million per year. Of this, the first $100,000 for each claim would be paid by DoD and the remainder paid by the Treasury Department, for an estimated total of $0.7 million to be paid by DoD based on 7 claims and $1.05 million to be paid by the Treasury Department.

As the tables above illustrate, Government paid benefits would not be a factor, as this claims process would have no impact on what the benefits Service member is already receiving, has received, or is entitled to receive in the future based on his or her injuries.

Total transfers from the U.S. government to claimants are estimated to be $11.2 million per year.

f. Benefits

Absent the claims process established by section 731, Service members would not have the opportunity for potential monetary payments above the amounts they currently receive through current DoD and VA benefits. In addition to providing an additional potential compensation remedy, the claims process reinforces DoD Clinical Quality Management Program procedures for appropriate accountability of DoD health care providers. National Practitioner Data Bank (NPDB) reporting includes cases where DoD compensation is paid through the Disability Evaluation System or survivor benefits attributable to medical malpractice by a DoD health care provider and now, under this part, paid malpractice claims. Reports to the NPDB are accompanied by reports to State licensing boards and certifying agencies of the health care providers involved. The claims process further provides an opportunity for DoD to identify opportunities for improvement in the delivery of healthcare, potentially preventing harm to others based upon measures taken by DoD as a result of a claim even if the claim does not result in the payment of monetary damages. Finally, this process is only applicable in certain cases of medical malpractice.

[12] For simplicity of calculation, each member is assumed to have 12 months of service ''over 8 years'' and 24 months of service ''over 6 years'' in the same paygrade they currently hold, with a retirement date of December 31, 2019. Prior to retirement, each member was covered under the High-3 retirement program.

[13] For members who entered service prior to January 1, 2018, the applicable multiplier is 2.5 percent unless the member elected to opt into the Blended Retirement System or elected the Career Status Bonus and converted to the REDUX retirement program. For these examples, all members are assumed to have remained under the legacy ''High-3'' retirement program with a 2.5 percent multiplier.

[14] Rates for veteran + spouse + child + additional child at *https://www.benefits.va.gov/COMPENSATION/resources_comp01.asp#BM05.*

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 *et seq.*), the Office of Information and Regulatory Affairs designated this final rule as not a major rule, as defined by 5 U.S.C. 804(2).

Public Law 96–354, ''Regulatory Flexibility Act'' (5 U.S.C. 601)

This final rule is not subject to the Regulatory Flexibility Act (5 U.S.C. 601) because it is not a notice of proposed rulemaking under 5 U.S.C. 601(2).

Assistance for Small Entities

This final rule does not impose requirements on small entities.

Section 202, Public Law 104–4, ''Unfunded Mandates Reform Act''

Section 202 of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1532) requires agencies to assess anticipated costs and benefits before issuing any rule whose mandates require non-Federal spending in any one year of $100 million in 1995 dollars, updated annually for inflation. This final rule does not mandate any requirements for State, local, or tribal governments, nor affect private sector costs.

Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

It has been determined that this final rule does not impose new reporting or recordkeeping requirements under the Paperwork Reduction Act of 1995.

Executive Order 13132, ''Federalism''

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This final rule does not have a substantial effect on State and local governments.

List of Subjects in 32 CFR Part 45

Medical, Malpractice, Claims, Uniformed Services.

Accordingly, the interim final rule adding 32 CFR part 45 which was published at 86 FR 32194–32215 on June 17, 2021 is adopted as a final rule with the following changes:

PART 45—MEDICAL MALPRACTICE CLAIMS BY MEMBERS OF THE UNIFORMED SERVICES [AMENDED]

■ 1. The Authority for part 45 continues to read as follows:

Authority: 10 U.S.C. 2733a.

■ 2. Amend § 45.4 by revising paragraphs (b)(5), (d), and (e) to read as follows:

§ 45.4 Filing a claim.

* * * * *

(b) * * *

(5) If the claimant is not represented by an attorney, unless the alleged medical malpractice is within the general knowledge and experience of ordinary laypersons, an affidavit from the claimant affirming that the claimant consulted with a health care professional who opined that a DoD health care provider breached the standard of care that caused the alleged harm. Alternatively, if the claimant is represented by an attorney, unless the alleged medical malpractice is within the general knowledge and experience of ordinary laypersons, the claim must include an affidavit from the attorney affirming that the attorney consulted with a health care professional who opined that a DoD health care provider breached the standard of care that caused the alleged harm.

* * * * *

(d) *Substantiating the claim.* Under section 2733a(b)(6), DoD is allowed to pay a claim only if it is substantiated. The claimant has the burden to substantiate the claim by a preponderance of the evidence. Upon receipt of a claim, DoD may require that the claimant provide additional information DoD believes is necessary for adjudication of the claim, including the submission of an expert opinion at the claimant's expense. DoD may determine an expert opinion is not necessary when negligence is within the general knowledge and experience of ordinary laypersons, such as when a foreign object is unintentionally left in the body or an operation occurred on the wrong body part. DoD may take other steps necessary to adjudicate the claim accurately, including conducting interviews of health care providers.

(e) *No discovery.* There is no discovery process for adjudication of claims under this part. However, claimants may obtain copies of records in DoD's possession that are part of their personnel and medical records in accordance with the Privacy Act of 1974, 5 U.S.C. 552a; DoD's Privacy Act regulation at 32 CFR part 310; and DoD Manual 6025.18, ''Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs.'' Claimants are not entitled to attorney work product, attorney-client privileged communications, material that is part of a DoD Quality Assurance Program protected under 10 U.S.C. 1102, pre-decisional material, or other privileged information.

■ 3. Amend § 45.7 by revising paragraph (d)(2) to read as follows:

§ 45.7 Element of payable claim: proximate cause.

* * * * *

(d) * * *

(2) DoD may consider medical quality assurance records relevant to the health care provided to the patient. DoD's Clinical Quality Management Program features reviews of many circumstances of clinical care. Results of any such reviews of the care involved in the claim that occurred before or after the claim was filed may be considered by DoD in the adjudication of the claim. As required by 10 U.S.C. 1102, DoD medical quality assurance records are confidential. While such records may be used by DoD, any information contained in or derived from such records may not be disclosed to the claimant.

■ 4. Amend § 45.10 by revising paragraph (c) to read as follows:

§ 45.10 Calculation of damages: non-economic damages.

* * * * *

(c) *Cap on non-economic damages.* In any claim under this part, total non-economic damages may not exceed a cap amount. The current cap amount is $600,000. Updates to cap amounts in subsequent years will be published periodically, consistent with changes in prevailing amounts in the majority of the States with non-economic damages caps.

* * * * *

■ 4. Amend § 45.11 by revising paragraph (a) to read as follows:

§ 45.11 Calculation of damages: offsets for DoD and VA Government compensation.

(a) *In general.* Total potential damages calculated under this part, both economic and non-economic, are reduced by offsetting most of the compensation otherwise provided or expected to be provided by DoD or VA for the same harm that is the subject of the medical malpractice claim. The general rule is that prospective medical malpractice damage awards are offset by DoD or VA payments and benefits that are primarily funded by Government appropriations. However, there is no offset for U.S. Government payments and benefits that are substantially funded by the military member. DoD is responsible for determining offsets, but claimants must provide information not available to DoD, but requested by DoD for the purpose of determining offsets.

* * * * *

■ 5. Amend § 45.12 by revising paragraphs (a)(1), (c), (d)(2), and (d)(4) to read as follows:

§ 45.12 Initial and Final Determinations.

* * * * *

(a) * * *

(1) DoD will provide the claimant 90 calendar days following receipt of the Initial Determination to cure the deficiency, unless an extension of time is granted for good cause by the DoD Component which issued the Initial Determination. The date of receipt of the Initial Determination will be presumed to be seven calendar days after the date the Initial Determination was mailed or emailed, unless there is evidence to the contrary.

* * * * *

(c) *Denial of claim—absence of an expert report.* Where applicable, if the claimant initially does not submit an expert report in support of his or her claim and DoD intends to deny the claim, DoD will issue an Initial Determination stating that DoD will issue a Final Determination denying the claim in the absence of an expert report or manifest negligence. DoD will provide a meaningful explanation for the intent to deny the claim that includes the specific basis for the denial.

(1) DoD will provide the claimant 90 calendar days following receipt of the Initial Determination by the claimant or, if the claimant is represented, by the claimant's representative, to submit an expert report, unless an extension of time is granted for good cause. The date of receipt of the Initial Determination will be presumed to be seven calendar days after the date the Initial Determination was mailed or emailed, unless there is evidence to the contrary.

(2) If the claimant does not timely submit an expert report, DoD will issue a Final Determination denying the claim. A Final Determination issued under this paragraph (c) may not be appealed.

(d) * * *

(2) The Initial Determination may be in the form of a certified letter and/or an email. The Initial Determination may take the form of a grant of a claim and an offer of settlement or a denial of the claim. Subject to applicable confidentiality requirements, such as 10 U.S.C. 1102, privileged information, and paragraph (a) of this section, DoD will provide a meaningful basis for an offer of settlement or will provide a meaningful explanation for the denial of a claim that includes the specific basis for the denial.

* * * * *

(4) The claimant may request reconsideration of the damages calculation contained in an Initial Determination if, within the time otherwise allowed to file an administrative appeal, the claimant identifies an alleged clear error—a definite and firm conviction that a mistake has been committed—in the damages calculation. The DoD Component that issued the Initial Determination will review the alleged clear error and will issue an Initial Determination on Reconsideration either granting or denying reconsideration of the Initial Determination and adjusting the damages calculation, if appropriate. The Initial Determination on Reconsideration will include information on the claimant's right to appeal under the procedures in § 45.13.

■ 6. Amend § 45.13 by revising paragraphs (a), (b), and (d)(1) to read as follows:

§ 45.13 Appeals.

(a) *In general.* This section describes the appeals process applicable to Initial Determinations under this part, which include Initial Determinations on Reconsideration. With the exception of Initial Determinations issued under § 45.12(a), in any case in which the claimant disagrees with an Initial Determination, the claimant has a right to file an administrative appeal. The claimant should explain why he or she disagrees with the Initial Determination, but may not submit additional information in support of the claim unless requested to do so by DoD. An appeal must be received within 90 calendar days of the date of receipt of the Initial Determination by the claimant or, if the claimant is represented, the claimant's representative, unless an extension of time is granted for good cause by the DoD Component that issued the Initial Determination. The date of receipt of the Initial Determination will be presumed to be seven calendar days after the date the Initial Determination was mailed or emailed, unless there is evidence to the contrary. If no timely appeal is received, DoD will issue a Final Determination.

(b) *Appeals Board.* Appeals will be decided by an Appeals Board administratively supported by the Office of the General Counsel, Defense Health Agency. Although there may be, in DoD's discretion, multiple offices that initially adjudicate claims under this part (such as offices in the Military Departments), there is a single DoD Appeals Board. The Appeals Board will consist of DoD attorneys designated by the Defense Health Agency from that agency and/or the Military Departments who are experienced in medical malpractice claims adjudication. Appeals Board members must not have had any previous role in the claims adjudication under appeal. The Appeals Board will consider cases in panels designated by the General Counsel of the Defense Health Agency of not fewer than three and no more than five Appeals Board members. Appeals are decided on a written record and decisions will be approved by a majority of the members. There is no adversarial proceeding and no hearing. There is no opposing party. The Appeals Board may obtain information or assessments from appropriate sources, including from the claimant, to assist in deciding the appeal. The Appeals Board is bound by the provisions of this part and will not consider challenges to them.

* * * * *

(d) * * * (1) Every claimant will be provided a written Final Determination on the claimant's appeal. The Final Determination may adopt by reference the Initial Determination or revise the Initial Determination, as appropriate. If the Final Determination revises the Initial Determination, DoD will provide a meaningful explanation of the basis for the revisions.

* * * * *

■ 7. Amend § 45.15 by revising paragraph (f) to read as follows:

§ 45.15 Other claims procedures and administrative matters.

* * * * *

(f) *Authority for actions under this part.* To ensure consistency and compliance with statutory requirements, supplementation of the procedures in this part is not permitted without approval in writing by the General Counsel of the Department of Defense. The General Counsel of the Department of Defense, under DoD Directive 5145.01, ''General Counsel of the Department of Defense,'' may delegate in writing authority for making Initial and Final Determinations, and other actions by DoD officials under this part. As used in this part, and at DoD's discretion, ''DoD'' or ''DoD Components'' may include, but is not limited to, Military Departments.

Dated: August 22, 2022.

Patricia L. Toppings

OSD Federal Register Liaison, Department of Defense.

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