Congress of the United States

Washington, DC 20510

February 27, 2026

Ethan Kalett
Executive Director
Office of Regulatory Oversight and Management
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Kalett:

We submit this comment on the Department of Veterans Affairs (VA) Interim Final Rule (IFR) (RIN: 2900-AS49) regarding the Impact of Medication on Evaluative Rating. This IFR was published on February 17, 2026, and was to take effect immediately; however, on February 19, 2026, the Secretary reversed course and subsequently announced on social media that he was "halting enforcement" of the IFR.[1] However, because the rule took effect upon publication, and because it appears in the Code of Federal Regulations, the IFR remains legally operative unless and until VA rescinds it through lawful rulemaking. We therefore demand VA immediately rescind the IFR in full.

The IFR makes sweeping and unprecedented changes to how VA will evaluate functional impairment when medication or treatment affects symptoms. This rule *unequivocally* negatively impacts veterans' earned benefits. The way it was promulgated, the questionable rationale offered, and the lack of evidence for its need make clear that this rule is harmful and VA should desist from promulgating similar rules in the future without proper consultation with and notification to stakeholders and Congress.

Using emergency procedures to promulgate a rule that has the effect of decreasing or denying certain benefits to veterans is unacceptable. To do so in secrecy without any warning to impacted stakeholders or to Congress is unconscionable. Compounding this grave error is the fact that VA officials testified before the House Veterans' Affairs Committee on January 14, 2026, on the very topic of evaluating disability benefits, and yet this then-forthcoming action was not mentioned at all.[2] This is a serious, intentional omission by the Department, and casts doubt on the true intention of this rulemaking.

VA claims that the Secretary found there was "good cause" under 5 U.S.C. § 553(b)(B) to publish this rule without advance notice and opportunity for comment. However, the fact that VA publicly stated it would not enforce the IFR almost immediately, and the thousands of

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[1]VA Secretary Doug Collins (@SecVetAffairs), "Effective immediately, VA is halting enforcement of the interim final rule, Evaluative Rating: Impact of Medication. VA issued the rule to clarify existing policy and protect Veterans' benefits in the wake of an ongoing court action," X.com Post, Feb. 19, 2026, 1:45 P.M., *available at* https://x.com/SecVetAffairs/status/2024555974862786684?s=20.

[2]House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs, *Hearing on "Reevaluating the Rating Schedule: Examining VA's Efforts to Modernize Disability Benefits"*, 119th Cong. (Jan. 14, 2026).

comments that quickly poured in, demonstrate that VA did not correctly judge whether public input would be necessary before implementing this action. It also directly undermines the Secretary's arguments regarding the urgent nature of this rulemaking.

VA also attempts to excuse the use of the IFR by alleging that it "simply makes explicit longstanding VA policy" and that the case of *Ingram v. Collins*,[3] "creates the immediate risk of significant disruption systemwide and delays in the adjudication and award of benefits." These statements are contradictory. If something is "long-standing VA policy" then how could there possibly be an emergency to affirm it? Furthermore, the assertion that *Ingram* created an "immediate risk" is highly suspect. The *Ingram* decision was handed down by the Court of Appeals for Veterans Claims on March 12, 2025, nearly a year ago. Furthermore, VA filed an appeal to the Court of Appeals for the Federal Circuit only after significant delay. Yet rather than continuing the judicial process as would be appropriate, VA instead chose to short-circuit it with an IFR.[4] VA offers the pretext that there was immediate need to stem the tide of unexplained and undemonstrated disruptions. Surely if those disruptions were caused by *Ingram* they would have been clear immediately after the decision was handed down last year and VA could have provided documentation of those disruptions to support regulatory action. However, VA offers no evidence whatsoever to support the need for this IFR.

The claim regarding immediate risk is further undercut by the long line of caselaw that clearly explains how VA's own policies indicate how impact of medication on disability ratings should be assessed. VA's protestations about the holdings of the Court of Appeals for Veterans Claims are misplaced. The Court has not dictated how this should be done but merely pointed VA to its own policies and diagnostic criteria. For some conditions VA has indicated in its rating criteria that medication is considered and for some it does not. The holdings of the key cases have been straightforward in that regard. For example: in *Jones v. Shinseki*,[5] the Court held that VA could not factor in medication's benefits unless the specific rating criteria for that condition expressly mentioned medication. Moreover, in *McCarroll v. McDonald*,[6] the Court refined the analysis regarding when the VA could "discount" the effects of medication.

If VA finds that its policies should be reassessed based on current scientific evidence, medical progress, and advances in condition management, it should pursue those opportunities through rigorous study, stakeholder engagement, and congressional collaboration as it has done with all previous changes to the VA Schedule for Rating Disabilities (VASR-D). Rather than, as here, secretly pursuing a blanket and unprecedented policy change where the only result is potential harm to veterans.

Veterans should be able to rely on VA's policies to understand how they will be applied in individual cases. That is the very core of fairness and due process. For VA to claim that veterans are somehow mistaken or incorrect that this IFR will impact them is nothing short of

[3] 38 Vet. App. 130 (2025).

[4] Notice of Appeal was filed by the Department of Veterans Affairs (VA) on July 29, 2025. *Ingram v. Collins*, Vet. App. No-23-1798. It is also notable that VA sought numerous extensions of time to file its opening brief, which it finally did on January 28, 2026, less than a month before this rule was published.

[5] 26 Vet. App. 56 (2012).

[6] 28 Vet. App. 267 (2016).

gaslighting, which is highly insulting to those very veterans. Through this rule VA showed that it planned to change how it rated conditions based on the impacts of medication, including in cases where that was not previously the policy. Veterans are rightly concerned about this change, especially when VA has done no work to understand how it will impact current *and future* veterans. Also, it is disingenuous to say that the IFR will not impact current benefits recipients when VA has demonstrated that it cannot be trusted to transparently promulgate policy. To the contrary, VA has demonstrated it is willing to do rulemaking without evidence and is unwilling to shoulder accountability for its policy choices when its analytical failure is exposed.

VA knows that it is treading on tenuous ground in responding to a federal court decision in such a haphazard way. VA must recognize that the broader administrative law landscape has changed. Agency deference has been eroded after the *Loper Bright*[7] decision and even agency interpretation of its own regulations may be in question. If VA were attempting to clarify its interpretation of its own regulations through this IFR, it would be prudent for the Department to consult with Congress before acting to ensure that its regulations are in line with congressional intent. Given that VA's own criteria, as noted above, are medical-condition dependent, such a sweeping change through a singular act raises serious doubt that this action would, in fact, be consistent with Congress' intent over the last several years to make it easier for veterans to access their benefits and to make those benefits more generous.

Of particular note, VA acknowledges this IFR is economically significant. The Department described it as a "major rule" under the Congressional Review Act, with an associated impact analysis that the rule will save an estimated $23 billion over ten years. Those "savings" can only be achieved by paying fewer benefits to service-disabled veterans. That is, fewer benefits related to veterans' service-connected conditions which were incurred *because of their military service*. From where did the goal to deliver fewer earned benefits to veterans arise? VA seems content to spend close to a trillion dollars on a new community care contract, it is prepared to spend hundreds of millions on a questionable massive reorganization, and it continues to throw additional money at a problematic contract for electronic health records. VA does not seek to cut costs on what it deems a priority. So why then does VA now seek savings by reneging on its fundamental purpose and mission, serving our nation's veterans, by proposing to cut the very benefits they rely upon? In addition, VA further undercuts the rationale for this rule in the impact analysis by casting doubt on the actual financial risks involved:

> While the Department models a scenario in which Ingram is broadly implemented to assess potential exposure, the Department *recognizes that actual fiscal impacts absent this rule would likely vary depending on adjudicatory practice, litigation outcomes, and claimant behavior. Accordingly, the quantified impacts should be understood as illustrative of potential risk rather than as a prediction of realized costs.*[8]

VA states that the actual fiscal impacts are variable and essentially unknown due to uncontrollable factors. That they are "illustrative of potential risk". However, VA then

[7] *Loper Bright Enterprises v. Raimondo* and *Relentless Inc. v. Department of Commerce*, 144 S. Ct. 2244 (2024).

[8] U.S. Department of Veterans Affairs, *Regulatory Impact Analysis for RIN 2900-AS49(IF), Evaluative Rating: Impact of Medication* (Feb. 9, 2026) *[emphasis added]*.

immediately tries to claim fiscal impacts in each category of disability as if they are actual costs. This is insincere at best given the lack of evidence to support this whole endeavor, let alone the cost. Moreover, it is grossly reactionary to then address these potential risks by issuing an IFR that fundamentally rewrites how VA determines disability ratings for disabled veterans.

The modern disability rating and compensation schedule has its roots in America's involvement in World War I when veterans who returned home were injured and had conditions that prevented them from sustaining themselves. The then-Bureau of Veterans Affairs created a schedule of disability and compensation based upon the reduction in veterans' earning capacity due to these disabilities. Later, the schedule was amended to reflect the loss of income from the specific occupations that veterans had held prior to their military service.

Over time, more veterans entered the military before they had begun a career. This led to challenges when attempting to determine a disability rating based on the particular disability's impact on the prior occupation. A shift was made to determine the rating for a disability based on the injury alone. A new schedule, published in 1945, set the basis for the current schedule for disability ratings which is based on systematic medical evaluations. In 1946, Congress authorized the new schedule to replace all previous schedules.[9] This law authorized that all future ratings be based on the new 1945 Schedule for Rating Disabilities.

The increased reliance on medical evidence in conjunction with science provided the basis for the systematic rating schedule. The new schedule provided specific diagnostic codes, and disabilities were indexed numerically. Several publications have noted that the 1945 Schedule for Disability Ratings has remained the basis for all subsequent revisions to the Schedule for Disability Ratings, including the current schedule embodied in 38 U.S.C. §1155 and the combined ratings table in 38 C.F.R. 4.2523.

The history of disability ratings pre-dates the establishment of the Department, and changes to them have always involved Congress. That makes the IFR stand out in an unfavorable way, especially as VA seems to have deliberately avoided bringing this matter to Congress. As previously mentioned, VA testified at a January 14, 2026, hearing before the Disability Assistance and Memorial Affairs Subcommittee of the House Committee on Veterans Affairs. In its written hearing testimony VA stated:

> In 2003, the Government Accountability Office (GAO) deemed VA's disability program high-risk because VA had not systematically updated the VASR-D. In response, VA developed a Modernization Plan in 2009 with the goal of comprehensively updating all 15 body systems of the VASRD.[10]

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[9] Pub. L. 458, 79th Cong, 2nd Sess. (June 27, 1946).

[10] House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs, Testimony Submitted for the Record of Nina Tann, Executive Director, Compensation Service, Veterans Benefits Administration (VBA), Department of Veterans Affairs, *Hearing on "Reevaluating the Rating Schedule: Examining VA's Efforts to Modernize Disability Benefits"*, 119th Cong. (Jan. 14, 2026).

At the time of that hearing, VA had completed 11 of the 15 body systems. Of note, this process has historically been done through the traditional rulemaking process established by the Administrative Procedures Act. VA provided written testimony that, "VA established workgroups that included medical and VA policy subject matter experts. VA used the groups' analyses of established medical research to begin the rulemaking process, which involves drafting and publishing a proposed and final rule for each body system."[11]

In that same hearing, Ranking Member Morgan McGarvey pointed to a distinct lack of veteran service organization presence in the room. And Iraq and Afghanistan Veterans of America testified to the need to have veterans at the table. They testified that VSOs have been advocating for over a decade to review quality of life indicators and on the need to look beyond general compensation due to the totality of effects that military service has. In a survey of their members, Iraq and Afghanistan Veterans of America saw over 50 percent of members cited the need to improve the disability rating process. They also testified that VSO involvement in the process could go a long way to restoring integrity, accuracy, and fairness to the system, as VSOs are the ones who translate the policy to their general members.

The most recent rulemaking is a stark departure from that traditional, collaborative process, even as veterans themselves acknowledge the desire to participate in this process. By attempting to enact this rule through an interim final rule at the start, VA intentionally cut out veterans and their voices. VA also intentionally shut out VSOs who are in a unique position to both shape the content of any potential change and alleviate any confusion among those they represent. Instead, the veteran community was left to feel attacked and insulted, and rightfully so.

As of the date of this comment, nearly 19,000 public comments have been submitted in response to this IFR. Some of them are absolutely heartbreaking and we urge VA to recognize the true harm that this rule could inflict on veterans and their families. In the best-case scenario veterans will have to decide between continuing their medication and protecting their physical health or stopping their medications to protect their financial health. This is an impossible choice that no one in America should be forced to make, let alone the brave women and men who have pledged their lives to defend our freedoms. For example, one commentor noted that:

> *Any system that ties compensation to how a veteran looks while medication is suppressing symptoms creates a perverse incentive to avoid medication before an examination. For heart failure and arrhythmia related conditions, this is medically dangerous… For severe chronic diseases such as advanced cardiac conditions with implanted defibrillators and chronic heart failure, medication is not curative. It is life sustaining. A rating policy should not create pressure to interrupt treatment to avoid the appearance of improvement.*

Another states that:

> *Veterans may feel discouraged from initiating or adhering to treatment if improvement could reduce compensation. Temporary stabilization may be mistaken for sustained improvement in conditions that are episodic or*

[11] *Id.*

> *fluctuating. The policy may shift the disability system away from its long-standing veteran-centric and non-adversarial intent.*

Additionally, this IFR poses dangerous risks to the most vulnerable veterans, including those who are insecure or experiencing homelessness. Veterans with a history of homelessness have significantly elevated odds of lifetime suicide attempt, posttraumatic stress disorder, major depressive, generalized anxiety, and drug use disorders.[12] Medication treatment for mental illness is highly imperfect, both in terms of effectiveness at controlling the underlying condition, and in side effects. The changes from previous practice that the IFR would institute would come without any basis for understanding the impact on the most vulnerable veterans. The scheme envisioned by the IFR also raises significant concerns regarding how extremely low-income, homeless, or housing insecure veterans would afford their medications if they were considered to no longer be disabled.

Medication and treatment can alleviate symptoms; they do not erase service-connected injury and illness. Veterans should never be forced to weigh medical stability against financial stability. VA must rescind this IFR and end all ill-considered and harmful actions that would decrease the earned benefits of veterans.

Sincerely,

Mark Takano
Ranking Member
House Committee on
Veterans' Affairs

Nancy Pelosi
Member of Congress

Timothy M. Kennedy
Member of Congress

Delia C. Ramirez
Member of Congress

[12] Nichter, B., Tsai, J., & Pietrzak, R. H., *Prevalence, correlates, and mental health burden associated with homelessness in U.S. military veterans. Psychological medicine*, *53*(9), 3952–3962 (2023).

James R. Walkinshaw
Member of Congress

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Member of Congress

Marilyn Strickland
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Jim Costa
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Steven Horsford
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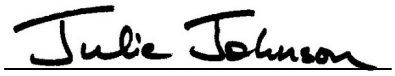

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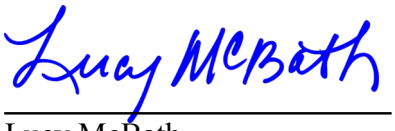
Member of Congress



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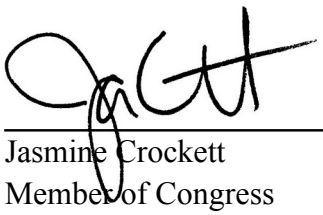

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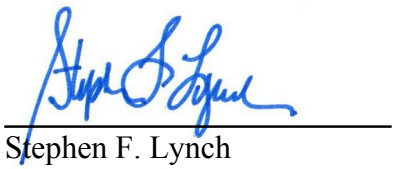

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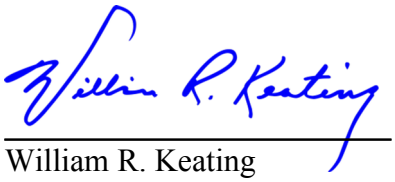

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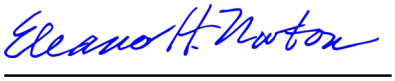

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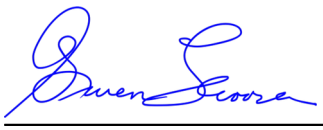
Member of Congress



Gwen S. Moore
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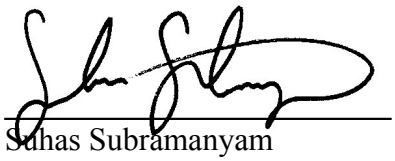

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