NCOA Congressional outreach brief: legal basis and case for repeal of VA Interim Final Rule (RIN 2900-AS49)

Opening

Members of Congress have a shared duty to protect a **veteran-centric, non-adversarial** benefits system. The VA's Interim Final Rule, **"Evaluative Rating: Impact of Medication"** (effective **February 17, 2026**, comments due **April 20, 2026**) should be **withdrawn/repealed** so veterans are never again put in a position where adherence to treatment appears to threaten earned compensation.

1) What the rule does

The rule amends **38 C.F.R. § 4.10** (Functional impairment) by adding two operative sentences directing that:

- examiners **will not "estimate or discount"** improvement from medication/treatment, and
- if medication/treatment **lowers** disability level, the **rating is based on that lowered level**.

VA frames this as a "clarification" of longstanding practice tied to statutes governing compensation for service-connected disability and average impairment of earning capacity (**38 U.S.C. § 1110** and **38 U.S.C. § 1155**) and to Part 4's rating principles.

2) The legal backdrop VA is trying to override

VA's preamble explicitly targets a line of Court of Appeals for Veterans Claims (CAVC) precedent most notably:

- **Jones v. Shinseki (2012)**: when the diagnostic code does not contemplate medication, the Board generally cannot deny a higher rating by relying on medication's ameliorative effects.
- **McCarroll v. McDonald (2016, en banc)**: refined the Jones framework in the context of diagnostic codes that do reference medication.
- **Ingram v. Collins (2025)**: VA describes this decision as forcing "baseline severity" (unmedicated) estimates and returns for "contrafactual" development, which VA argues is speculative and disruptive.

VA's stated rationale is that Ingram could be applied across **500+ diagnostic codes** and require re-adjudication of **350,000+ pending claims**, overwhelming adjudication capacity.

3) Procedural posture: Why Congress should scrutinize the process

A) VA used "interim final rule" + "good cause" to skip advance notice/comment

VA invoked the Administrative Procedure Act's **"good cause"** pathway to publish with immediate effect, arguing delay would be impracticable and contrary to the public interest because of systemic disruption from Ingram.

Why this is vulnerable and why Congress should act: Courts have repeatedly emphasized that APA good cause is **narrowly construed** and "reluctantly countenanced."

When the policy change is high-impact and foreseeable, especially where the regulated/ affected population is millions of veterans Congress has strong grounds to withdrawal/ repeal

B) VA also treated it as a "major rule" under the Congressional Review Act (CRA), yet made it immediately effective

VA states OIRA deemed it a **major rule** (≥ $100M annual effect) but VA invoked CRA good cause to forgo the typical delayed effective date.

Congressional leverage: CRA provides a direct mechanism for disapproval by joint resolution, after which the rule **"shall not take effect (or continue)"**.

4) Veteran-best-interest case for repeal (VA's justifications rebutted point-by-point)

Rationale #1: "Rate the disability as it actually exists in daily life."

VA's claim: compensation should reflect actual functional impairment at exam time; unmedicated baselines invite "prognostication."

Rebuttal (veteran-centric reality):

1. **Treatment adherence ≠ cure.** Medication can suppress symptoms but does not erase underlying pathology, chronicity, flare patterns, or functional instability, especially in PTSD, migraines, chronic pain, musculoskeletal conditions, and cardiovascular disease. This is precisely why major VSOs warned the change would **penalize compliance** and create an "illusion of bona fide improvement."

2. **"Snapshot" exams mismeasure fluctuating disability.** A medicated C&P presentation can understate baseline limitations and the real-world consequences of missed doses, breakthrough symptoms, side effects, tolerance, and contraindications (all common in long-term management). VFW specifically raised concerns about fluctuating conditions and safeguards.

Rationale #2: "We must correct 'erroneous' court interpretations (Ingram/Jones line)."

VA's claim: the courts misconstrued the role of medication; VA is "free to amend or clarify" its regulations.

Rebuttal (rule of law and reliance):

1. **Reliance interests are massive.** For more than a decade, veterans, VSOs, and accredited representatives operated under the Jones framework. Abrupt reversal without advance notice undermines trust and the stability Congress expects in a benefits system.

Rationale #3: "Administrative burden: 350,000 claims / 500+ codes."

VA's claim: without the rule, VA faces systemic delays, retraining burdens, and re-adjudications.

Rebuttal (Congress should not accept 'backlog' as a reason to cut earned benefits):

1. **Administrative convenience is not a legitimate justification for reducing accurate compensation.** The solution to workload is resourcing, workflow reform, and clear exam guidance not a policy that shifts risk onto disabled veterans.

Rationale #4: "It won't impact current ratings."

Claim heard publicly: that current ratings would not be automatically reduced.

Rebuttal: Even if there are no *automatic* reductions, the rule would still affect:

- **new claims**,
- **increases**, and
- **re-exams/revaluations** precisely the situations where veterans seek rightful adjustments as conditions worsen with age. (This was a core concern raised in coverage and by VSOs.)

5) Why repeal aligns with veteran health, safety, and suicide-prevention realities (with statistics)

VA's own suicide-prevention reporting underscores that many veterans live with interlocking, treatment-dependent burdens:

In Behavioral Health Autopsy Program (BHAP) reviews of VHA-reported veteran suicide deaths (2021–2023), the most frequently identified factors included:

- **Pain: 52.3%**
- **Sleep problems: 51.5%**
- **Increased health problems: 43.1%**
- **Recent declines in physical ability: 34.8%**

These are exactly the domains where medication is commonly prescribed and closely managed. Any federal disability policy that can be reasonably perceived as penalizing treatment adherence risks:

- discouraging care engagement,
- worsening instability in chronic conditions, and
- eroding trust in VA systems—outcomes that are directly in tension with suicide-prevention priorities documented by VA.

This is not claiming the rule that causes suicide; it is stating a hard policy fact: the rule targets how medication-mediated functioning is rated, while VA's own data shows pain/sleep/health decline are common factors in reviewed suicide deaths. Congress should not accept a regulatory design that increases perceived "treatment penalty" risk in that context.

6) What Congress can do immediately

1. **Demand withdrawal** and require VA to re-issue as a proposed rule (NPRM) with full notice/comment, clinical input, and VSO collaboration.

2. **Use CRA**: introduce a **joint resolution of disapproval** so the rule cannot “take effect (or continue).”

3. **Oversight + appropriations guardrails**: prohibit VA from using funds to implement or rely on medicated-state rating as a default absent explicit diagnostic-code language and veteran-protective standards.

4. **Codify a veteran-protective baseline rule** for conditions where medication masks severity and/or produces significant side effects ensuring evaluators consider functional impairment across typical life, flare frequency, and treatment burden.

Closing

Congress should insist that VA benefits policy never puts veterans in the position real or perceived of choosing between **health** and **earned compensation**. The fastest path to restoring trust is straightforward: **withdraw this interim final rule, preserve veteran-protective standards in law, and in the future include partnership with VSOs, clinicians, and Congress** so this kind of rushed, high-impact rulemaking does not recur.