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The Elusive Seamless Transition

By Art Pine

Many wounded servicemembers discharged after serving in Iraq or Afghanistan must cope with confusing—and often conflicting—systems in moving from DOD medical care and disability benefits to those provided by the VA. For some veterans, it can be a nightmare.

In a perfect world, it would be a seamless transition.

Severely wounded troops returning from Iraq and Afghanistan and discharged from the service would be able to get medical care and disability compensation payments—and a full range of benefits—from the Department of Veterans Affairs immediately. Red tape would be minimal. Counselors would help servicemembers cope with the paperwork and arrange for appointments. The veterans' military medical records would be waiting at VA facilities when they got there. Help for families would be readily available. Ideally, the entire transition would take no more than a month.

Instead, over the past four years, many returning Soldiers and Marines—a good number having lost arms or legs or suffered from traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD)—have run into a bureaucratic nightmare. Confusing regulations have mandated separate physical examinations by the Department of Defense (DOD) and the VA, often with differing outcomes involving a servicemember's disability rating. The waiting time for VA compensation checks and other benefits frequently has ranged from six months to two years—and appeals can prolong the process even more. The VA's own rulings have sometimes been inaccurate or inconsistent. And veterans, some of them unable to battle the bureaucratic dragons, have often come out the losers.

Not surprisingly, the "seamless transition" problem, as it has come to be known, has exploded into a major controversy. A series of articles in the Washington Post a year ago, which highlighted the problems facing outpatients at Walter Reed Army Medical Center in Washington, has spawned several high-level investigations—including an independent review ordered by Defense Secretary Robert M. Gates and the separate Dole-Shalala report, written by a bipartisan commission—to look into the problem and make recommendations. Congress just passed legislation designed to fix some of the glitches.

Under pressure from all sides, DOD and the VA have begun working together to correct some of the problems. Over the past few months, the two departments have hired more counselors and ombudsmen to guide sick and wounded veterans through the transition process. They have established a pilot program that would provide for a single physical examination that would serve both the military and the VA. And they have placed VA-DOD "recovery coordinators" at major military installations to improve cooperation between the departments.

But some veterans' groups are skeptical that such efforts will solve the problem anytime soon. Paul Sullivan, a former VA official who now serves as executive director of Veterans for Common

Sense, a Washington-based advocacy group that has focused on the seamless transition problem, argues that while the situation "is getting better," it will take years—even decades—for the glitches to be fixed.

"The veterans don't have that kind of time," Sullivan says. "They should not have to wait."

A Major Overhaul Needed

Sullivan, a Gulf War veteran with 15 years' experience in dealing with the VA, advocates a major overhaul of the department to significantly simplify its regulations and procedures, greatly enlarge its staff, and make veterans' benefits a full-fledged entitlement program—much like Social Security—that isn't vulnerable to political whims. He also wants the VA to upgrade the qualifications of the counselors who help veterans apply for benefits, many of whom are retired senior enlisted personnel without legal training or college degrees.

The congressional watchdog agency, the Government Accountability Office (GAO), also has called repeatedly for a major overhaul of VA procedures for determining disability compensation.

By any standard, overhauling the current system wouldn't be cheap. Although no one seems to have firm figures on how much it would take to erase the problems, estimates range to tens of billions of dollars over the next few years. "You have a systemic problem that can only be solved by simplifying the system," says Linda Bilmes, a Harvard University government expert who did a study on the seamless transition problem last year. "It's inevitably going to take a long time to resolve."

Although the waiting time for VA medical care often is long, by far the lion's share of the complaints about the transition stem from the extended length of time it takes to obtain VA compensation benefits. On the whole, returning troops seem satisfied with the military medical care they receive, which is considered of high quality. And the separate VA health care system is readily available to newly discharged combat veterans, and is top-notch to boot. "I don't think I ever got a complaint about the VA's medical care," says John F. Sommer Jr., national executive director of the American Legion, reflecting an upsurge in the department's performance over the past decade. "There's little problem with the quality of health care once people get into the system."

The frustrations stem not just from the VA, but also from the whole gamut of procedures and delays, starting with the military's own medical discharge procedures. The combination has created a bureaucratic obstacle course—and, often, a financial hardship—for Iraq and Afghanistan veterans who try to make the shift. "The problem is that veterans have to navigate among four separate systems—military medicine, military disability pensions, VA health care, and VA disability compensation benefits," says Sullivan of Veterans for Common Sense. "It's terribly confusing for almost everybody."

The Nuts and Bolts

Here's how the system works.

Under longstanding regulations, seriously wounded troops are returned to one of a handful of military hospitals for medical treatment and recovery—primarily Walter Reed Army Medical Center in Washington, the National Naval Medical Center at Bethesda, Maryland, and Brooke Army Medical Center in San Antonio. After surgery or other treatment, they're put into rehabilitation programs for a while and then kept on as outpatients. Eventually, the military services' own physicians decide they've essentially done all they can for the medium-term, and it's time to decide whether the servicemember should remain in the military or be discharged or retired.

When that time comes, physicians on a medical evaluation board, or MEB, from the individual's service review the case and decide whether they think the servicemember involved is fit for duty. If he (or she) is deemed fit, he's kept on active-duty and transferred back to a "Warrior Transition Unit" that helps manage his rehabilitation schedule and prepares him for another duty assignment. If he's not deemed fit, the board recommends that he be separated from the service. For those who are considered unfit, the next step is to decide whether the servicemember should be "medically retired" or merely discharged. Physicians on a physical evaluation board, or PEB, decide how disabled the servicemember has been made by the single specific injury that made him unfit for duty—a loss of limb or a serious head wound, for example. If it's 30 percent or more, the servicemember is offered retirement status, with a lifetime package that includes a pension, medical treatment for himself and his family, commissary privileges, and an array of other benefits.

Those given disability ratings of zero to 20 percent are not offered retirement but instead are discharged, and given a lump-sum severance payment. DOD often informally advises these servicemembers to apply to the VA for medical care and compensation, where they have a prospect of receiving a higher disability rating.

Not Always Easy

But doing that isn't always easy. Although veterans of Iraq and Afghanistan are entitled to temporary VA medical care without conditions, they must undergo a separate physical exam to decide how much, if anything, they'll receive in compensation and benefits from the VA's Veterans Benefits Administration. They have to fill out significant amounts of paperwork. They must submit their complete medical records from the military, which often are incomplete or even illegible. And they are responsible for keeping their appointments with physicians, clinics, and bureaucrats, no matter what their physical or mental condition.

Bewildering for many veterans is that the VA's own medical examination uses different criteria for assigning a disability rating than do the military's physical examination boards, and each of the four services has its own individual standards. DOD's physical evaluation is concerned only with the single specific injury (such as the loss of a limb) that has made the servicemember unfit for duty. By contrast, the VA examination looks at all the veteran's physical and mental ailments to determine the extent to which all of his service-connected impairments have limited his capacity to function in the civilian workforce—and thus what his lifetime compensation payments ought to be. So while the PEB might score a Soldier or Marine at 20 percent, the VA could assign a score of 80 percent. To add to the problem, the just-discharged veteran faces an often-dizzying array of potential problems.

The VA uses an electronic recordkeeping system, but until recently DOD medical records were largely kept on paper. Thus information can't be transferred between the two departments automatically. In most cases, newly discharged servicemembers must carry their paper records to the VA by hand. If the records aren't complete, it's often difficult for an individual veteran to obtain the missing portions. If he overlooks a report—or doesn't know that it exists—he may never find out about the omission.

The menu of VA and other government benefits—including education grants and Social Security disability payments—is so large and complex that even experienced veterans' advocacy groups have trouble coping with it. The application form alone that veterans must fill out to obtain VA benefits is 26 pages long; the program descriptions and regulations fill a book half an inch thick; and the manual that staffers use to compile disability ratings is two inches thick.

Time-Consuming Process

The process of making appointments with physicians, lab technicians, counselors, and bureaucrats is time-consuming and requires frequent follow-up by the veteran, particularly for

those with multiple impairments, which involve several specialists and rehabilitation clinics. Dealing with the bureaucracy also is a problem. Veterans' organizations say their constituents too often receive letters that are contradictory or in error. It often takes hours of work and attention to straighten things out.

"It's like being on the phone with your health insurance company all day, every day," says Meredith Beck, national policy director for the Wounded Warrior Project, an advocacy group based in Jacksonville, Florida, that has focused on the seamless transition problem.

For a servicemember who is suffering from mild traumatic brain injury or from PTSD, the process is especially daunting, Beck says. It's hard enough to navigate the system when your mental faculties are in place, but having a mental disability that makes it difficult for you to concentrate, for instance, makes following the process almost impossible, she says. Family members rarely have the expertise or familiarity with the system to be of much help. As a result, some veterans end up cash-strapped for months until the cash payments begin to flow. Others fall through the cracks entirely.

Both the GAO and veterans groups say the system isn't equipped to handle claims involving TBI, PTSD, and other mental problems efficiently. Critics say there's such a stigma attached to mental illnesses in the military that many returning soldiers won't report them.

What Went Wrong

The roots of the whole seamless transition problem go well back into bureaucratic history. The DOD and VA procedures that have created it have been in force for decades—some dating back to the end of World War II. But the volume of returning veterans wasn't sufficient to clog the system then, and even during the Vietnam War the problem didn't come to public attention. Many seriously wounded Soldiers and Marines simply died on the battlefield, and the ones who did come home and were discharged, rather than retired, were sent to VA hospitals, where they were treated as inpatients.

The post-9/11 attack on Afghanistan and invasion of Iraq (in 2001 and 2003, respectively) changed all that—dramatically. To begin with, the conflicts have gone on far longer than most top policymakers anticipated. In both wars, expectations were for a quick military victory, followed by a handover of power to the countries' own governments. A lengthy occupation, opposed by insurgents using IEDs, car bombs, and suicide bombers—and, eventually, extended and repeat deployments—weren't even on the drawing boards. Top U.S. generals and senior Bush administration officials spoke of a quick campaign of "shock and awe" in Iraq, followed by a prompt withdrawal of American troops.

At the same time, improvements in military medicine have enabled a far greater share of seriously wounded troops to survive and return home for treatment. Better body armor protects more U.S. warfighters against explosions and bullets. Today's highly skilled medics can treat battlefield injuries more successfully, using new techniques such as one-handed tourniquets and clotting bandages. And rapid evacuation by helicopter is a matter of course. Today, only 10 percent of those wounded in battle ultimately die, compared to 30 percent in Vietnam. At the same time, the proportion of those losing arms or legs has doubled—to 6 percent, from 3 percent before.

To add to the strain on stateside facilities, the combination of near-miracle medical technology and heightened pressures for cost cutting has changed the way American medicine treats such cases—and perversely contributes to the seamless transition problem. Where previous generations of wounded veterans had been treated almost entirely in hospitals, now they're released to go home and return for medical attention solely as outpatients.

Finally, the long occupation and the frequency of injuries from car bombs, IEDs, and suicide bombers have brought a sharp increase in cases of TBI and PTSD that the military had little experience in recognizing and treating in previous conflicts. (Those who suffered from PTSD during the Vietnam War were discharged and sent to VA hospitals.) It often compounds the physical wounds that the troops who served in Iraq and Afghanistan bring home.

Overwhelming the System

The combination of factors quickly overwhelmed both the military and the VA—and seriously exacerbated the glitches in the transition process. Before 2001, the year that the United States attacked Afghanistan, the number of pending claims for disability compensation stood at 69,000, and only a third of them had been in process for more than six months. By Fiscal Year 2007, which ended 30 September, the number had soared to 392,000 pending claims, and the VA was taking an average of 181 days to process them. For servicemembers who choose to appeal the VA's initial decision, the average time taken to resolve the case topped 650 days.

"It's too long, no doubt about it—much longer than I would like," concedes retired Navy Vice Admiral Daniel L. Cooper, the VA undersecretary who heads the department's Veterans Benefits Administration, the VA branch that deals with compensation and benefits. He says the department hopes to bring processing time down in coming months.

By early 2004, the potential magnitude of the seamless transition problem was clearly apparent. Veterans' groups were reporting increasing numbers of serious problems. The GAO was issuing reports pointing out significant failures in the system. And lawmakers were regularly expressing outrage about cases involving their constituents.

Once the war in Iraq began, in March 2003, there were other pressures that made tackling the seamless transition problem elusive. With the conflict already proving more difficult than Washington had anticipated, the Bush administration was reluctant to spotlight the greater-than-expected casualties. At the same time, the federal Office of Management and Budget, faced with mushrooming domestic spending and a push for a smaller military, was leaning on departments and agencies to hold down nonmilitary spending. The VA sharply underestimated its own needs in FY 2006 and 2007, and had to seek billions of dollars in supplemental appropriations. The rival and often lethargic DOD and VA bureaucracies showed little real enthusiasm for cooperating with one another to help fix the problems. And no one at the top—anywhere in government—was really pushing for a major overhaul.

Slow Start

As might be expected, the government's reaction—in the VA, DOD, the White House, and Congress—wasn't instantaneous. In August 2003, then-VA Secretary Anthony Principi formally recognized the problem and put together a "Seamless Transition Task Force" to tackle it within the department. The group eventually issued a report, but little was done by the time Principi left at the end of 2004.

What changed the equation was the February 2007 Washington Post series on Walter Reed, written by Dana Priest and Anne Hull. The articles became best known for exposing the dilapidated, mold-infested temporary housing units in the medical center's Building 18, in which severely wounded servicemembers and their families were living, but the most telling part of the series described the bureaucratic run-around they had received from hospital personnel who had been tasked with arranging for outpatient rehabilitation care, military disability ratings, and VA benefits.

"The Post series was about Walter Reed, but it described the same kinds of symptoms that exist in the seamless transition problem," says retired Lieutenant General Charles H. Roadman II, a

former Surgeon General of the Air Force who later served on an independent DOD-appointed commission charged with investigating conditions at Walter Reed.

Walter Reed "brought the problem into the national consciousness" and led to a speedup in efforts to deal with the problem, says Paul Rieckhoff, executive director and founder of Iraq and Afghanistan Veterans of America, a New York-based advocacy group that has focused on the seamless transition problem.

The horror stories are legion. Newspapers all over the country have been running articles about returning Soldiers and Marines who have experienced serious difficulties in obtaining medical care and compensation benefits, which often leave them in a major financial bind, and seriously depressed.

Federal officials contend that some of the difficulties nationally may have been exaggerated. Although the United States has sent 1.6 million combat troops to Iraq and Afghanistan since hostilities began, there have been 66,000 cases over that period in which servicemembers have been wounded, injured, or taken ill on the battlefield. The total number of Iraq and Afghanistan veterans who have lost a limb is about 730—much lower than popular perceptions suggest.

Indeed, there's a serious dispute over how big the seamless transition problem is. The VA's Vice Admiral Cooper estimates that after eliminating those wounded and severely ill Iraq and Afghanistan veterans who are granted medical retirements—and thus receive pensions from the military—the number adversely affected by the lack of a seamless transition to the VA amounts to fewer than 2,000 a year.

But Sullivan of Veterans for Common Sense argues that that definition is too narrow—and misleading. "It's true that there are about 2,000 servicemembers a year who are in the 'very seriously wounded' category," he says, "but the VA is now treating some 264,000 veterans of the two conflicts," and even those who qualify for military medical care may apply for VA disability compensation payments, which particularly benefit those in lower ranks. "The VA didn't prepare for this massive influx of claims," he says. "It's trying to narrow the definition so they can say there's no problem."

Taking It Seriously

In the wake of the Washington Post series, all sides have begun taking the problem more seriously. The Bush administration has ordered three separate investigations of the system by bipartisan commissions that have released reports this year—a special Independent Review Group named by Defense Secretary Gates, which looked into the situation at Walter Reed and Bethesda; the President's Commission on Care for America's Returning Wounded Warriors, known popularly as the Dole-Shalala commission; and the Veterans' Disability Benefits Commission set up by Congress with members appointed by the President.

Together, they have recommended a number of steps designed to ease the strain on the system: DOD and the VA should work together to streamline procedures for determining disability compensation, collaborate on providing more assistance to help returning veterans cope with the transition, bolster support for families, work toward making their electronic record-keeping systems compatible with one another, and do more to identify and treat post-traumatic stress disorder and mild traumatic brain injury.

Congress has stepped into the fray, passing legislation, called the Wounded Warriors Act, last December designed to write some of the commissions' recommendations into law. They range from streamlining and standardizing the procedures for calculating disability compensation and benefits to requiring DOD and the VA to develop joint policies on managing servicemembers' health care, including developing fully interoperable electronic health records. The law also mandates the development of a comprehensive DOD-VA policy to deal with TBI and PTSD. And

it extends to five years the period for which newly discharged combat veterans can receive free medical care from the VA. Under previous law, the limit was two years.

The VA and DOD also have begun working together to fix the process on their own. Secretaries of the two departments have been meeting every Tuesday as part of a special joint Senior Oversight Group to hammer out proposals for streamlining their procedures and providing more help to severely wounded or ill veterans.

In November, the two departments announced a pilot project in the Washington, D.C., area that will experiment with a single medical examination that can be used both by the military services and by the VA. Physicians from the VA will perform examinations that embrace the services' own standards, and military boards will use the data to determine whether a servicemember is fit for duty and whether he should be discharged or retired. The VA hopes to cut in half the time it takes to go through the physical examination process.

The Army and Marine Corps have established Warrior Transition units for returning troops, in which a team of physicians, nurses, and case managers watches over each servicemember's care and helps him with the recovery process. The DOD and VA have set up early application Benefits Delivery at Discharge programs under which soon-to-be-discharged troops can begin applying for VA benefits two to six months before their discharge, enabling them to start receiving benefits within a month after their separation. They've hired special coordinators and ombudsmen to help smooth the bureaucratic process for newly separated veterans.

"We are taking this very, very seriously," says retired Navy Rear Admiral Patrick W. Dunne, the VA's assistant secretary for policy and planning, in an assurance that's repeated frequently by officials in DOD and the VA alike.

And authorities are about to launch a feasibility study on how to make the DOD and VA computer systems interoperable so that medical records can easily be transferred from one department to the other. A big problem in the past has been bureaucratic inertia, but the two systems also have serious structural differences that make it difficult to integrate them. After some initial improvements, VA and DOD physicians can read each other's records, look at x-rays and peruse reports, but they can't enter information of their own or search for a specific result or entry. Both agencies agree that more must be done.

Uncertain Outcome

It's difficult to judge whether what's already on the books or in policymakers' sights will be sufficient to solve the problem. Stephen L. Jones, the principal deputy assistant secretary of defense for health care and a former Capitol Hill staffer, asserts that there still is enough impetus from last year's political brouhaha over the transition issue to keep the momentum going for the foreseeable future. "I hope that some of [the system's critics] are noticing the improvement already," he says.

But critics question whether what is being done is really enough. Roadman, the former Air Force Surgeon General, for one, cautions that the pilot projects, if successful, must be expanded rapidly, without the usual bureaucratic delays. "There's a tendency to 'pilot' things to death," he notes.

There also is the risk that the momentum may be interrupted by political events—the lame-duck year of the current administration, the 2008 election, and the months of organizational efforts in any new administration.

"My fear is that something big will happen to distract Congress and the public from focusing on the problem," says Beck of the Wounded Warrior Project. "This is a difficult situation. It's not as clearly fixable as the mold on the wall of Building 18 at Walter Reed."

How quickly and how well the current plethora of steps—many of them substantial by any measure—will bring the disability benefits system closer to seamless transition for veterans returning from Iraq and Afghanistan still isn't clear. Much will depend on whether all the players involved can maintain the momentum between now and the time the new administration is in place. The VA has a new secretary, retired Army Lieutenant General James B. Peake, a physician and decorated Vietnam War veteran, who will play a key role between now and then.

Mr. Pine, a former naval officer, is a veteran journalist who has worked as a Washington correspondent for the Baltimore Sun, Washington Post, Wall Street Journal, and Los Angeles Times. He is a frequent contributor to Proceedings.

Bureaucratic Nightmares: A Sampler

The Gunny's Run-Around

When Marine Corps Gunnery Sergeant Tai Cleveland was injured during his deployment for Operation Iraqi Freedom four years ago, it wasn't supposed to be all that serious. "At your age, everybody has back pain," a military physician told him.

Thrown by a comrade during a hand-to-hand combat training exercise in August 2003, Cleveland landed on his back wearing a full field pack and armor, striking his head in the process. Doctors prescribed Motrin and Valium, but the pain only worsened, and the Gunny suffered chronic headaches. He began walking with a limp.

Shipped back to the States, Cleveland was sent to Walter Reed Army Medical Center in Washington D.C., where an MRI revealed that he had several fractured vertebrae, previously undetected. By November 2004, he could barely walk. Surgeons performed a spinal fusion, but the bracing rod became undone and lodged in his spinal canal, so they had to perform the operation again. Even so, "You're going to walk again," doctors assured him.

But the Gunny's condition worsened rapidly. The back pain and headaches persisted, and Cleveland became paralyzed from the waist down. As his wife, Robin, tells it, he also had begun to experience emotional difficulties—frequent loss of memory and flashes of anger at ordinary happenings or smells. And he began blaming everyone he saw. After two years as an inpatient at Walter Reed and confinement to a wheelchair, the Marine Corps began pressuring him to take retirement.

"Everything was setting him off," Mrs. Cleveland recalls.

He finally was separated from the Marines in January of last year, with a pension—based on rank and time-in-service—that was well below what he had expected.

The disappointments continued when Tai Cleveland applied for VA benefits, his wife says. VA officials wouldn't approve any compensation payments for months because they said he wasn't really retired and couldn't qualify for benefits. The department sent its letters and notices to the wrong mailing address, and the Clevelands never received them. VA physicians in Richmond seemed not to take the case seriously, Mrs. Cleveland says. (One physician told the Gunny, "There's nothing wrong with your arms. I'll have you back to work in two weeks or so.") And while the VA finally assigned Gunny Cleveland an 80 percent temporary disability rating, by December of last year he still hadn't received his final disability determination, which presumably will fully take into account his TBI and other impairments.

Meanwhile, Mrs. Cleveland says, the toll on the entire family has been enormous. Even apart from the strains you'd expect when a father comes home in the Gunny's condition, the financial and personal hardships were enormous. Mrs. Cleveland, an accountant who ran her own business in Alexandria, Virginia, had to shut down her firm to care for her husband, now 42, and take him back and forth to medical appointments—losing \$45,000 worth of income that had been earmarked to help pay college tuition for two of her children. The Clevelands depleted their savings. And they eventually had to ask a service-related charity for help.

"Tai took the brunt of it, but the family took the collateral damage," Mrs. Cleveland says.

The Strung-Out Corporal

In July 2005, Marine Corporal Kevin Blanchard returned from Iraq on a gurney.

A combat engineer, he'd been hit by a roadside bomb and taken to a nearby field hospital. Filled with shrapnel, and with his left leg amputated below the knee, he was flown back to Washington for treatment. During a year at the National Naval Medical Center in Bethesda and Walter Reed Army Medical Center, he underwent surgery 30 times, along with treatment for mild traumatic brain injury, and spent weeks on end in rehabilitation. He was finally medically retired in July 2006. In line with standard procedures, he received a relatively small pension based on only his most critical ailment—loss of his leg—and on his rank and time-in-service.

It took yet another year for Corporal Blanchard, now 25, to get his full disability compensation benefits from the VA, which would reflect his full array of service-connected ailments and would be linked to his limited ability to work in the civilian world without regard to his rank and years of service.

"I didn't receive any response to my VA application for two full months," he says. "Then I called my VA case manager, and it took another three months to get an appointment" for initial processing. The various stages of the processing procedure were "spaced out over four more months," he says, with a temporary lower-level payment until the full 100 percent disability was approved. In the meantime, Corporal Blanchard says, he drew down the savings he'd managed to put away while he was still on active duty.

"They should have been able to do something [to expedite his claim] right there at the hospital [Bethesda or Walter Reed]," he says.

The Confused Marine

Marine Corporal Ruben Ramirez knew he wasn't himself when he left Iraq in 2004 for his next duty station in Japan, but he brushed it off as inconsequential. It was only when he got back to the United States in May 2005 that he realized just how sick he'd been. Plagued by nightmares, anxiety attacks, and frequent thoughts of suicide, he would lock himself in his room and struggle with bouts of severe depression.

After leaving the service in mid-2005, Mr. Ramirez went to the VA for a checkup, and came out with a diagnosis that jolted him—severe post-traumatic stress disorder, liver damage, bilateral hearing loss, and tinnitus (permanent ringing in the ears). After some time in a VA psychiatric center, he applied for medical care and compensation payments. Unable to work, he was hoping that a federal check each month would help pay the bills.

But two years later the VA denied his entire claim for disability compensation payments, Mr. Ramirez says—contending that he had contracted these ailments before he joined the Corps in 2001, and leaving him without any disability benefits at all. They also sent him a bill for part of his physical exam. He says he can't afford to get private care and isn't eligible for military medical care. He's on the last of his medicine now. (Ironically, the Social Security Administration, using the same military medical records, later awarded him a modest disability pension, a small fraction of what VA might have approved.)

"I don't understand," he says. "I know I didn't have these problems before I joined the Corps, or I never would have been able to sign up in the first place. Their own doctor said they were real. You don't get PTSD without going to Iraq or some other war zone. We saw enough there to make it stay with you for a good long time."

—Art Pine