Volume 85 | Issue 1 Article 9

September 1982

West Virginia's Reimbursement Statute: The Hidden Costs of Institutionalization

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STUDENT MATERIAL

Student Notes

WEST VIRGINIA'S REIMBURSEMENT STATUTE: THE HIDDEN COSTS OF INSTITUTIONALIZATION

"Fate makes our relatives . . . "[1]

The treatment, care and maintenance received by the mentally ill[2] and the mentally retarded[3] in state hospitals do not fall into the traditional category of public welfare. Unlike other programs which assist the disadvantaged, most mental health laws impose a statutory duty on the recipient or his family to reimburse the state for all or part of the maintenance and treatment costs.[4] West Virginia is among the jurisdictions which have adopted such laws. This state has statutory provisions[5] which require reimbursement from the patient and designated family members. The amount the patient, or his family, is required to pay depends on the per patient cost at the individual institution. During the first six months of 1982, patients at the various West Virginia hospitals were billed anywhere between $10.94 and $56.00 per day for their care and maintenance.[6] The majority of patients billed made partial or no pay-

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[1] J. DELILLE, THE SHORTER BARTLETT'S FAMILIAR QUOTATIONS 99 (1962).

[2] W. VA. CODE § 27-1-2 (1980) defines mental illness as "a manifestation in a person of significantly impaired capacity to maintain acceptable levels of functioning in the areas of intellect, emotion and physical well-being."

[3] W. VA. CODE § 27-1-3 (1980) defines mental retardation as meaning "significantly subaverage intellectual functioning which manifests itself in a person during his developmental period and which is characterized by his inadequacy in adaptive behavior." Note: The terms mental illness, mental retardation, mental handicap and mental health will be used interchangeably in this note.

[4] For a collection and detailed description of each state's reimbursement statute see B. ENNIS & L. SIEGEL, THE RIGHTS OF MENTAL PATIENTS: THE BASIC ACLU GUIDE TO A MENTAL PATIENT'S RIGHTS app. A (1973) [hereinafter cited as B. ENNIS & L. SIEGEL].

[5] W. VA. CODE § 27-8-1 (1980).

[6] Unofficial data from the five mental health institutions indicate that the majority of patients make little or no contribution toward their institutional expense. The collections were as follows:

Institution	Population*	Max. Billing**	Total Payment†	Zero Pop.
Huntington	456	$11.40	37	549
Weston	520	11.50	11	330
Spencer	301	10.94	69	120
Colin Anderson	438	35.00	0	240
Greenbrier	50	56.00	0	49

* population on date of informal survey; patient population varies on a daily basis

** maximum billed per day at the named institution

† number of patients who made complete payment on the last billing; partial payments vary from billing to billing

Data collected by Dr. Robert Kerns, Department of Health, for the first half of 1982.

ments.[7]

The money collected for reimbursement, in this state, is placed in a new fund which gives health administrators an incentive for strictly enforcing the reimbursement statute.[8] Recent legislation allows the Department of Health to develop a long range plan for mental health facilities financed by collections from patients.[9] In addition to new emphasis on collection, state institutions are under judicial pressure to provide more adequate and professional custody and treatment as mandated by the legislature.[10] Improvements in physical conditions and professional treatment will indirectly increase the cost of patient care which is ultimately placed on the patient or his family.

This note focuses on the rights and responsibilities of the patient and his family under the West Virginia cost reimbursement statute.[11] The analysis includes a brief comparison between the West Virginia scheme and the more detailed Virginia provisions.[12] The note also provides estate and family financial planning suggestions to help the patient and his family cover the institutional costs. While the patient's financial responsibilities will be discussed, the key emphasis of this note is on the family, especially the parents and spouse.

I. BACKGROUND

Statutes requiring some form of reimbursement from the relatives of institutionalized patients are commonplace.[13] West Virginia, for example, has required reimbursement for the care of the mentally ill since early statehood.[14] Although the underlying purpose of these statutes is to pay the state for its cost, some patient protections have been included, such as guidelines on how much a patient's estate can be reduced,[15] time limitations on enforcement,[16] and restrictions on which family members might ultimately be liable for payment.[17] A common strand running through all these statutes, however, is that the patient or his family is solely responsible for the debt.[18] While the total cost of patient care may be offset by contributions from the federal govern-

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[7] *Id.*

[8] W. VA. CODE § 16-1-15a (Supp. 1981) (effective date Jan. 1, 1982).

[9] *Id.* The Department of Health's plan for the fund is outlined in the proposed *Interim Health Facilities Plan for the Fiscal Year 1982-83,* Admin. Reg. 16-1, Series XII (1982).

[10] *See* E. H. v. Matin, 284 S.E.2d 232 (W. Va. 1981).

[11] W. VA. CODE § 27-8-1 (1980).

[12] VA. CODE § 37.1-105 to -119. (1976 & Supp. 1981).

[13] W. VA. CODE § 58-34-1 (Barnes 1923).

[14] B. ENNIS & L. SIEGEL, *supra* note 4, at 78.

[15] *See, e.g.,* VA. CODE § 37.1-109 (1976) which provides in part that "the estate of such patient other than income shall not be depleted below the sum of five hundred dollars."

[16] *See, e.g.,* VA. CODE § 37.1-105 (1976) which provides in part that "in no event shall recovery be permitted for amounts more than five years past due."

[17] B. ENNIS & L. SIEGEL, *supra* note 4.

[18] The language used in reimbursement statutes generally name the persons liable for the payments. Unless an exemption is provided in the reimbursement statute or in another statute, the patient or the liable relative is responsible despite any payments made by another source. The statutes do not contemplate outside contributions.

ment and private sources, the ultimate financial responsibility does not shift.[19]

Recognizing that patients come from a variety of financial settings, at least one legislature has authorized its Department of Health to accept less than full payment from an institutionalized patient.[20] This particular statute provides that the department must give "due regard for the financial condition and estate of the patient, his present and future needs and the present and future needs of his lawful dependents. . . ."[21] In West Virginia, each institution establishes the individual patient's cost schedule, but the patient may be exonerated if it is found "that such person is unable to pay or that payment would work an undue hardship on him or on those dependent on him."[22] If the institution is unable to collect the statutory minimum, then it may bill the patient's home county for the difference.[23]

A. *Patient's Personal Liability and the Fairness Issue*

Generally, primary responsibility for reimbursement may be placed on the patient, his committee, guardian, or estate.[24] Depending on the legislative intent, the patient's personal assets and real estate may be liquidated to provide for maintenance, if the patient does not have a spouse or dependents.[25] Additionally, under at least one court's interpretation of a reimbursement statute, the patient's committee or guardian can be compelled to use the patient's assets for his maintenance. The guardian can even be forced to invade the corpus of a trust established for the patient's benefit to reimburse the state.[26] According to this same court, the decision to invade should hinge on the patient's prospects for recovery. If the patient has a favorable chance of returning to society and becoming productive, his assets should be protected for future use. But if he has little chance of recovery and no dependents, the assets should be used to offset the state's cost for keeping him.[27] The state is not harmed by a misdiagnosis of a patient's likelihood of recovery, since it has a cause of action against the estate of a patient who does not recover and who has an outstanding debt.[28] Although it does not have first priority for assets of the estate,[29] the state will be reimbursed before any distributions are made to the heirs or legatees.

Most reimbursement statutes charge all patients' *per capita* costs, without

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[19] This note focuses solely on the patient and family role in providing reimbursement for state maintenance care costs. Contributions by federal programs and private funds encompass problems and information outside the scope of this note.

[20] *See* VA. CODE § 37.1-109 (1976).

[21] *Id.*

[22] W. VA. CODE § 27-8-1 (1980). *See infra,* note 109.

[23] W. VA. CODE § 27-8-2 (1980).

[24] B. ENNIS & L. SIEGEL, *supra* note 4.

[25] Commonwealth v. Sheriff of Nottoway County, 221 Va. 306, 269 S.E.2d 815 (1980).

[26] Commonwealth v. Sharrett, 218 Va. 684, 240 S.E.2d 522 (1978).

[27] *Id.*

[28] *See, e.g.,* VA. CODE § 37.1-117 (1976).

[29] W. VA. CODE § 44-22-1 (1982). The state stands fourth in line for the assets of a decedent following the funeral expenses, medical expenses and debts owed to the federal government.

making a distinction between the voluntarily and involuntarily committed.[30] The reasons for this blanket liability are (1) an assumption that an implied contract exists between the patient and the state;[31] and (2) that a policy judgment providing patient treatment without charge would be unjust enrichment. This logic may be appropriate when applied to the individual who voluntarily commits himself and requests treatment, but it fails when impressed upon the involuntarily committed.[32] Finding an implied contract is difficult when a resisting patient is compelled by the state to receive treatment. Under these circumstances, placing the burden of institutional costs on the unwilling patient or his family is a form of punishment. Involuntary commitments, after all, arise from two distinct proceedings brought before state officials. One is the civil commitment action, where the issue is whether the individual is dangerous to himself or others.[33] The other is a species of criminal proceeding, usually brought against the individual found not guilty by reason of insanity.[34] If this latter individual had been convicted of the crime and sentenced to a state mental facility, he would not be charged for his medical care.[35] But, since he was exonerated of the crime because of his mental condition, he is liable for the costs of maintenance.[36] Financially, at least, the patient would have been better served by a conviction.

Although distinctions have been made between convicted patients and involuntarily committed patients based on who benefits from the commitment, the distinctions seem unsound if both groups are deprived of their liberty under state mandated procedures. In West Virginia, for example, the Supreme Court of Appeals has rejected the long standing doctrine of *parens patriae* as the basis for involuntary commitments.[37] The court has ruled that the state's authority for forcing treatment on the mentally ill and retarded emanates from its police power[38] and, hence, those detained by the state are entitled to full

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[30] The language used in reimbursement statutes is usually general and begins with a "the cost of maintenance of patients admitted" or "any person who has been or who may be admitted" type clause. The basis of admission is not discussed; therefore, unless the patient has an exemption under another statutory provision he is liable for reimbursement. *See, e.g.*, VA. CODE § 37.1-105 (1976).

[31] B. ENNIS & L. SIEGEL, *supra* note 4, at 79.

[32] *Id.* at 79-81.

[33] W. VA. CODE § 27-5-2 (1980 & Supp. 1982) which reads in relevant part:

> Any adult person may make application for involuntary hospitalization for examination of an individual when said person has reason to believe . . . (2) That because of his mental illness, mental retardation or addiction, the individual is likely to cause serious harm to himself or others if allowed to remain at liberty. . . .

[34] W. VA. CODE § 27-6A-3 (1980).

[35] W. VA. CODE § 27-6A-8 (1980).

[36] *See supra* note 30.

[37] State *ex rel.* Hawks v. Lazaro, 157 W. Va. 417, 202 S.E.2d 109 (1974). *Lazaro* stemmed from an original proceeding in habeas corpus challenging the constitutional validity of the involuntary commitment statutes (W. VA. CODE § 27-5-4) (since amended). The petitioner, an inmate at Huntington State Hospital, had been confined for over two years without notice of and attendance at his commitment hearing. The court held the state could not use the doctrine of *parens patriae* to commit an individual; the state must give the patient full procedural due process since the basis for the commitment is the state's police power. Parts of the statute were declared unconstitutional.

[38] *Id.*

due process rights.[39] Although the proceedings for the commitment of the mentally ill are labeled "civil," they have the same result as criminal proceedings.[40] Yet, the confined patient is liable for the costs of his detention and the criminal is not.

Whenever a state has shown a reasonable basis for discriminating between convicted and non-convicted patients, the reimbursement statute has been held constitutional.[41] If the state bases the involuntary commitment on a patient benefit doctrine, such as *parens patriae,* then the assessment of costs may be valid. But if the state bases the commitment on its police power, as does West Virginia, then the reasonableness of charging patients, but not prisoners is thrown in doubt. In West Virginia, a patient can not be involuntarily committed unless he is likely to cause serious harm to himself or others.[42] Since both the state and society benefit as much by this action as the patient, it seems unreasonable to place the full financial burden of the confinement on the patient. Admittedly, the patient can be exonerated from paying the state, but only after establishing an inability to pay.[43] This exoneration process, in reality, only saves the state from futile collection procedures. The patient is still, at least initially, charged for services forced upon him that may benefit the state more than it does him. Since the standard for commitment is "dangerousness" as opposed to "patient benefit," the state should bear the cost of the detention as it does for the detention of others who are deprived of their liberty under the police power.

B. *Parental Liability*

At common law, parents, especially fathers, were responsibile for the care and maintenance of their minor children.[44] Some jurisdictions held that the father was responsible for adult children who were mentally or physically handicapped; a responsibility that fell to the mother upon the father's death.[45]

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[39] *Id.*

[40] W. VA. CODE § 27-5-4(j)(1) (Supp. 1982).

[41] *In re* Nelson, 98 Wis. 2d 261, 296 N.W.2d 736 (1980); *In re* Klisurich, 98 Wis. 2d 274, 296 N.W.2d 742 (1980). In *Nelson,* the court distinguished between the defendant who was convicted and institutionalized and the defendant who was found not guilty by reason of mental defect and institutionalized, and the reason for assessing costs to the non-convicted:

> All are receiving care or services which insure primarily to their benefit as opposed to the public. It cannot be denied that among this group of persons there are those whose confinement will be of some value to society. This benefit, however, may reasonably be viewed as secondary to an overriding purpose of treatment designed to benefit the individual.
>
> It is not irrational or arbitrary to shift the economic burden from the taxpayer to those persons who receive services at the expense of the state. It is also a rational exercise of legislative authority to require the public to pay for articles which primarily benefit society. *See, e.g.,* those services supplied by prisons.

98 Wis. 2d 261, 270-71, 296 N.W.2d 736, 740 (1980).

[42] W. VA. CODE § 27-5-4(j)(1) (Supp. 1982).

[43] W. VA. CODE § 27-8-1 (1980).

[44] *See, e.g.,* Commonwealth v. Shepard, 212 Va. 843, 188 S.E.2d 99 (1972); Brady v. Brady, 151 W. Va. 900, 158 S.E.2d 359 (1967); Robinson v. Robinson, 131 W. Va. 160, 50 S.E.2d 455 (1948).

[45] Commonwealth v. Shepard, 212 Va. 843, 188 S.E.2d 99 (1972). The court noted that a com-

Since few institutions existed for anyone except lunatics and convicts,[46] this approach probably developed from the practice of caring for disabled children at home, rather than from any planned legislative scheme.

Today, responsibility for children normally ends at the age of majority.[47] The presumption is one of non-support after the child reaches majority and the child must rebut the presumption to obtain support.[48] If the child is committed while a minor, a common law duty to provide care can be raised by the state. A statutory responsibility may also exist depending on the status of the parents and their financial resources.[49] If the minor patient has assets of his own, they usually will be used before the parents are required to contribute to the costs of institutionalization. If the minor patient, however, has no assets of his own, the parents may be held responsible.

The legislature should consider placing some limitations on the liability of parents, especially if there are other children at home. An example of an appropriate limit would be reducing the parents' share when the child is educable.[50] Since the state has a duty to provide free public education to children of this age group anyway, parents should not be forced to pay twice. Unfortunately, at least one state has not seen the unfairness of the double payment possibility and requires parents to pay the costs of their children's educational as well as institutional needs.[51]

Intertwined with the issue of education costs is the question of whether a duty exists requiring parental contribution for incapacitated adult children. Unless the reimbursement statute specifically limits liability to minor children, the parents may be presumed to have a duty to support incapacitated adult children.[52] At least one state court has required a parent to pay maintenance costs for an institutionalized adult child, relying on a supposed common law

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mon law duty existed requiring a father to support an adult mentally incapacitated child and extended this duty to the mother. *See also* Indemnity Ins. Co. v. Nalls, 160 Va. 246, 168 S.E. 346 (1933) (institutionalized incompetent child allowed to recover for accidental death of father because he had a duty to support her); *but see, In re* Houghton Estate, 114 N.H. 33, 314 A.2d 674 (1974). Interpreting the statutory duty to provide care for mentally ill adult children in an action against the parent's estate, the court held:

> The general rule at common law is that there is no liability on the part of a parent for the support of a mentally incompetent adult child confined to a public institution. When such liability is imposed by statute it will be strictly construed as in derogation of the common law.

114 N.H. 33, 35, 314 A.2d 674, 675-76 (1974).

[46] State *ex rel.* Hawks v. Lazaro, 157 W. Va. 417, 430-31, 202 S.E.2d 109, 119-20 (1974).

[47] Cutshaw v. Cutshaw, 220 Va. 638, 261 S.E.2d 52 (1979) (parent has no duty to support a child after his eighteenth birthday unless he contracts to do so).

[48] Welsh v. Welsh, 222 Pa. Super. 585, 296 A.2d 891 (1972).

[49] *See, e.g.*, VA. CODE § 37.1-110 (Supp. 1981); W. VA. CODE § 27-8-1 (1980).

[50] This note is confined to a discussion of the reimbursement statutes in general, and not to the specific question of who bares the cost of institutional education expenses. Persons interested in this aspect of mental health care may wish to read *Medley v. Ginsberg*, 492 F. Supp. 1294 (S.D. W. Va. 1980) and related cases for the status of educational rights of the mentally handicapped.

[51] Levine v. Department of Institutions and Agencies, 84 N.J. 234, 418 A.2d 229 (1980).

[52] *See supra* note 45.

duty.[53]

C. *Spousal Liability*

A husband and wife were reciprocally responsible for the care and maintenance of each other at common law.[54] West Virginia and Virginia have carried forth into their statutes this obligation on institutional reimbursement.[55]

The contract which is created under the marital ritual is the key to spousal support statutes.[56] When people marry they assume the responsibility of mutual caring and support. Whether viewed as a contractual obligation or a statutory duty, the support requirement places a permanent burden on the supporting spouse.

The extent of support required from spouses depends on their financial resources[57] and on the number of other dependents for which they are responsible.[58] Needless to say, placing the institutional costs on the marriage partners can create the same long-term financial strains which would result if parents were required to support institutionalized adult children. When one spouse is committed, the other obviously faces a range of financial problems. Apart from the obvious emotional trauma, the spouse may be responsible for the costs of confinement and care. Additionally, the problems may be compounded if someone other than the non-institutionalized spouse is appointed as guardian, and they disagree over the proper management of the estate. If the couple owned assets jointly, then the spouse would be unable to dispose of the property without court proceedings,[59] resulting in aggravating delays and added legal fees. If the patient is unable to pay the costs, the spouse may be required to contribute all the marital holdings and even funds from non-marital resources. Even if the spouse's contribution is reduced to allow for the support of other dependents,[60] a long term commitment to an institution would eventually return the burden to the spouse and possibly lead to financial ruin.

An even greater problem arises when both the husband and wife are institutionalized;[61] admittedly, an unusual circumstance. Combined costs may destroy family assets which would otherwise be available for use if one or both spouses recover. If separate guardians are appointed for each spouse, problems

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[53] *Id.*

[54] Snyder v. Lane, 135 W. Va. 887, 65 S.E.2d 483 (1951) (action by wife's committee for reimbursement from husband for her institutional costs held valid under common law duty, as well as statutory duty).

[55] W. VA. CODE § 27-8-1 (1980); VA. CODE § 37.1-110 (Supp. 1982).

[56] 135 W. Va. 887, 65 S.E.2d 483 (1951).

[57] *See, e.g.*, VA. CODE § 37.1-109 (1976).

[58] *Id.*

[59] The spouse would only be able to give indefeasible title with court permission and approval. This could only be secured after a *guardian ad litem* proceeding in which the interests of the patient were advanced by a disinterested advocate.

[60] *See, e.g.*, VA. CODE § 37.1-109 (1976).

[61] For an excellent discussion of the problems arising for institutional costs and spousal liability under federal programs, *see* Note, *To Deem or Not to Deem: Evaluating and Attributing Available Spousal Income to an Institutionalized Medicaid Applicant*, 67 VA. L. REV. 767 (1981).

may arise over the division of the couple's assets and the distribution for maintenance costs. Finally, assets may be consumed to the point that they are insufficient to provide for the support of unemancipated children. Fortunately, some states have anticipated this last problem and placed a limit on the amount by which a patient's personal estate may be reduced.[62]

D. *Children and Other Relatives Liability*

At common law, no duty existed requiring children to support their parents.[63] Where the duty has been recognized, its genesis has been found in reimbursement statutes. Not surprisingly, the extent of the child's liability has largely turned on the court's interpretation of the legislative intent.

Attempts to place the cost burden for parents and other relatives on designated family members have met with various results.[64] The general rule is that children are not responsible for their parent's institutional costs.[65] Some courts, however, have recognized a child's duty of support. In a 1980 Virginia decision,[66] for example, the court, in dicta, noted that children were responsible for the institutional costs of their parent. Other states have adopted the same position through statutory enactment. Normally, the duty to support does not arise until the child reaches majority.[67]

At least one statute holds the children, together with other family members, both jointly and severally liable for care and maintenance costs.[68] Joint and several liability means that each family member would be totally responsible for the costs if the other members were exonerated or beyond the jurisdiction of enforcement agencies. Otherwise each member would be required to contribute equally. This type of provision could create a major breach in family harmony if certain members are forced to pay all or more than an equal share of the parent's support. Since the determination of who pays is based on the assets of the responsibile person, those children with more assets, higher incomes, and fewer dependents could be assessed more than their less advantaged siblings. If one or more of the siblings refused to pay or shifted their assets, then the remaining siblings would be forced to pay the entire amount. Siblings or family members who are non-residents or aliens could avoid contribution entirely if they had no assets within the institution's state.[69] Residency then, rather than financial ability or moral responsibility, would determine who reimburses the state.

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[62] VA. CODE § 37.1-109 (1976).

[63] Department of Mental Hygiene v. Kirchner, 60 Cal.2d 716 n.4, 388 P.2d 720 n.4, 26 Cal. Rptr. 488 n.4, (1964), *vacated on other grounds*, 380 U.S. 194, *on remand*, 62 Cal.2d 586, 400 P.2d 381, 43 Cal. Rptr. 329 (1965).

[64] *Id.*

[65] *Id.*

[66] *In re* Jefferson, 221 Va. 306, 269 S.E.2d 815 (1980).

[67] *See, e.g.*, VA. CODE § 37.1-110 (Supp. 1982).

[68] *Id.*

[69] *See* W. VA. CODE § 27-8-1 (1980) which provides that if the liable person does not reside in the state or has no available assets, the liability is transferred to another relative.

II. The Virginia Approach: Making It Work

A. *The Statute*

The Virginia General Assembly has developed a detailed statutory scheme[70] for assessing and collecting the costs of mental health care provided by the state. Reimbursement can be sought from both institutionalized patients and out-patients[71] as long as the action is brought within sixty months from the time the service is provided.[72] The Department of Mental Health and Mental Retardation has the authority to set the *per capita* cost for the particular service rendered,[73] determine through investigation the legally liable person's ability to pay,[74] assess or contract with the legally liable person,[75] and enforce payment of the expenses.[76] Funds collected by the department are placed in an account used for departmental operations, research, and training.[77]

The enforcement provision[78] lists the order of liability and defines the "legally liable" persons. The legally liable persons are primarily the patient or his estate and, if his assets are not sufficient, then "the father, mother, husband, wife, child or children of the patient, provided the child or children have attained the age of majority."[79] Such legally defined persons are jointly and severally liable.[80] The department has discretion in collecting the debt and seeking reimbursement "from the several sources as appears proper under the circumstances and may proceed against all of such sources."[81] Additionally, the department is not required to seek reimbursement or institute proceedings when it determines that "such proceedings would be without effect, or would work a hardship on such patient, or the person legally liable for his support."[82] When making this determination, the department is instructed to consider "the financial condition and estate of the patient, his present and future needs and the present and future needs of his lawful dependents."[83]

Once the patient's or relatives' ability to pay is established and payment is not made, the department must proceed against the legally liable person in a court having *in personam* jurisdiction.[84] Provision is made by statute for a hearing and order,[85] modification of the order,[86] appeal from the order,[87] and

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[70] Va. Code § 37.1-105-19 (1976 & Supp. 1982).
[71] Va. Code § 37.1-105 (Supp. 1982).
[72] *Id.*
[73] *Id.*
[74] Va. Code § 37.1-108 (1976).
[75] Va. Code § 37.1-109 (1976).
[76] Va. Code § 37.1-110 (Supp. 1982).
[77] Va. Code § 37.1-106 (1976).
[78] Va. Code § 37.1-110 (Supp. 1982).
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] Va. Code § 37.1-116 (1976).
[83] Va. Code § 37.1-109 (1976).
[84] Va. Code § 37.1-110 (Supp. 1982).
[85] Va. Code § 37.1-112 (1976 & Supp. 1982).

enforcement of the order.[88] In addition to enforcement against the living person liable for the debt, the department may bring an action against the estate of a deceased patient[89] for outstanding costs of care and maintenance and for any unsatisfied portion of a judgment entered under the reimbursement act.

B. *Judicial Enforcement*

In three recent cases the Supreme Court of Virginia has upheld actions brought under the reimbursement statute by the Department of Mental Health and Mental Retardation to collect debts stemming from patient care and maintenance. The actions were brought to compel reimbursement from a patient's committee and trust fund,[90] a deceased patient's estate,[91] and an incapacitated adult patient's incompetent mother,[92] respectively. Although the Virginia mental health scheme is based on the state's police power, the court upheld the legitimacy of the reimbursement statute.[93] Thus, under the statute,[94] the state may require reimbursement from trusts, children and parents as well as other family members.

III. West Virginia: Where Is It Going?

West Virginia's reimbursement statute differs from the Virginia scheme in both scope and complexity. While Virginia has provided a detailed, step-by-step procedure, West Virginia limits liability and merely summarizes enforcement procedures.

A. *The Statute*

West Virginia's reimbursement statute[95] provides that "the state hospitals, through the director of health, shall have a right of reimbursement, for all or

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[86] Va. Code § 37.1-113 (1976 & Supp. 1982).

[87] Va. Code § 37.1-114 (1976).

[88] Va. Code § 37.1-115 (1976).

[89] Va. Code § 37.1-117 (1976 & Supp. 1982).

[90] Commonwealth v. Sharrett, 218 Va. 684, 240 S.E.2d 522 (1978).

[91] Commonwealth v. Sheriff of Nottoway County, 221 Va. 306, 269 S.E.2d 815 (1980). The state had brought an action against a mental health patient for his maintenance costs. The patient died and the state pursued the suit against his estate. The court held that the state's claim survived the patient's death and attaches to his estate. The state was allowed to recover.

[92] Commonwealth v. Shepard, 212 Va. 843, 188 S.E.2d 99 (1972).

[93] Commonwealth v. Sheriff of Nottoway County, 221 Va. 306, 269 S.E.2d 815 (1980). Reviewing the reimbursement statute and its results, the court noted:

> The public policy underlying this statutory complex is plain. Mental health is a legitimate goal of the State. Under its police powers, the Commonwealth constructs, staffs, supplies and operates hospitals to promote that goal. The General Assembly has devised a plan to fund the services provided patients in State facilities. Costs not financed otherwise are to be paid by the patient or those legally liable for his support to the extent payment does not cause a financial hardship. Only when all other receipts leave a deficit does the cost fall upon the public fisc.

221 Va. at 311, 269 S.E.2d at 819.

[94] Va. Code § 37.1-110 (Supp. 1982).

[95] W. Va. Code § 27-8-1 (1980).

any part of such maintenance from each patient or from the committee or guardian of the estate of the patient, or the estate of the patient if deceased." Principal liability for care and maintenance costs rests on the patient. Although the statute remains open to judicial interpretation, a literal reading of the language indicates that the hospital can proceed against the patient's assets if the patient does not provide voluntary payment. The hospital may also proceed against a guardian or committee holding assets belonging to the patient. Under this section, if the patient dies before his costs are reimbursed, the hospital may proceed against his estate. If the patient's assets are insufficient to meet his costs, then the hospital may proceed against "the patient's husband or wife, or if the patient is an unemancipated child, the father and mother, or any of them."[96] The two classes expressly made responsible for reimbursement are spouses and parents of unemancipated children; both of which were liable for care and maintenance at common law.[97]

Although parents are clearly responsible for the care and maintenance of their unemancipated minors under the statute, the duty parents owe to unemanicipated adult children is unanswered by the West Virginia statute. If by "unemancipated" the legislature meant below the legal age of majority, then the parent ceases to be legally liable after the child's eighteenth birthday.[98] But if the legislature intended "unemancipated" to be determined by the period the child is dependent on the parent, then the parent could be responsible for a lifetime.

Support for the argument that the "unemancipated child" clause is restricted to children under the age of legal majority is provided by the language in the prior statute dealing with reimbursement.[99] Prior to the 1967 amendment[100] the section[101] provided for liability by the patient, his committee, guardian or estate "or if such estate be insufficient, from the patient's husband, wife, children, father and mother, or any of them."[102] Even older statutory language specifically broke down the reimbursement status of minors and adults.[103] By modifying the older reimbursement statute, the legislature restricted liability generally and exempted the patient's children specifically. The legislature also included "unemancipated child" language which significantly narrowed the language previously used.[104] To date, this provision has not come

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[96] *Id.*

[97] *See, e.g.*, Brady v. Brady, 151 W. Va. 900, 158 S.E.2d 359 (1967) (a common law duty exists to support an infant son); Snyder v. Lane, 135 W. Va. 887, 65 S.E.2d 483 (1951) (common law duty exists to support and maintain incompetent wife).

[98] W. VA. CODE § 2-3-1 (1979).

[99] *See*, W. VA. CODE § 2672 [27-8-1] (1955); W. VA. CODE § 2678 [27-5-2] (1943).

[100] Act of March 1, 1976, ch. 109, 1967 W. Va. Acts 747.

[101] W. VA. CODE § 2672 [27-8-1] (1955).

[102] *Id.*

[103] W. VA. CODE § 2678 [27-5-2] (1943) provided in part:

> . . . if the inmate be a minor, from his guardian; or, if he have no estate, or it be insufficient, from his father; or if he have not father or his estate be insufficient, from his mother. If the inmate be an adult, from his or her estate, but if such estate be insufficient, and the inmate be a wife, from the estate of her husband . . . .

[104] Act of March 1, 1967, ch. 109, 1967 W. Va. Acts 747, (codified at W. VA. CODE § 27-8-1

under judicial scrutiny, so an interpretation of "unemancipated child" as it applies to the reimbursement statute is not available.

The legislature delegated the responsibility for determining each patient's ability to pay to the Director of Health, who, in turn, was authorized to issue administrative rules on reimbursement methods.[105] Ideally, these rules should indicate the board's interpretation of the "unemancipation" language and the extent this section is to be enforced. But, unfortunately, neither the board nor the Director of Health has promulgated or published any rules available to the public regarding determination of financial ability of the patient or his responsible relative.[106] This failure to provide accessible and understandable guidelines raises an equal protection question with respect to the statute's application. Since each institution determines the patient's or responsible relative's ability to pay,[107] a patient or relative could possibly have a different status at each institution.

An inter-departmental guideline does exist which provides a formula for determination of ability to pay.[108] This guide does not specifically name who is liable for payment. Rather the guide instructs an institutional representative to "establish financial responsibility and ability to pay by interviewing the patient and conferring with the escort representative.[109] The guide notes that "the maximum liability of parents for the *treatment of a child as long-term patient* shall not exceed the cost of caring for a normal child at home."[110] No provision is made in the guide for termination of billing when the child reaches majority. Because liability decisions and billings are made by the receiving institution, parents could be treated differently on an institutional basis, especially if the patient was admitted before reaching majority.

Currently, if the first relative indicated to be liable by the statute does not reside in West Virginia and has no assets that can be reached in the state, "the other relatives shall be liable as provided by this section."[111] The family members designated in the section are parents and spouses, and it is unclear who is intended by the "other relative" language. Under a literal reading of the stat-

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(1980).

[105] W. VA. CODE § 27-8-1 (1980).

[106] The most recent rules and regulations promulgated by the Department of Health and on file with the Secretary of State's office became effective January 6, 1975. The requirement for promulgated rules did not exist until 1977. Act of April 9, 1977, ch. 102, 1977 W. Va. Acts 396, (codified at W. VA. CODE § 27-8-1 (1980). The 1975 rules do not provide any guidelines for determination of patient or family member liability. Regulation search, Office of the Secretary of State of West Virginia, Charleston, West Virginia (April 16, 1982).

[107] W. VA. CODE § 27-8-1 (1980) provides the "state hospitals, through the director of health, shall have a right of reimbursement." Each individual hospital assesses costs and makes collections from its patients or those legally responsible. Interview with B. C. Eakle, Assistant Director, Administrative Services, West Virginia Department of Health and Kay Howard, of the Department's Health Facilities Evaluation Program, in Charleston, West Virginia (April 16, 1982).

[108] Guideline, Interviewing Patient and/or Responsible Party(s), provided by Colin Anderson Center administrative office (April 13, 1982). [Attached Appendix II].

[109] *Id.* at 1.

[110] *Id.* at 2.

[111] W. VA. CODE § 27-8-1 (1980).

ute only three persons can be liable beyond the patient himself: the spouse, the father and the mother. If the spouse resides outside the state and has no attachable assets, there can be no one else liable.[112] If one parent resides outside the state and has no attachable assets, then only the parent can be held liable.[113] If the parent of a married child is considered responsible, then the emancipation issue surfaces again because married individuals are considered emancipated from their parents.[114] Identical language existed in previous versions of the reimbursement statute,[115] so it is likely that the legislature merely rewrote the sentence naming the legally liable persons.

While the statute may be unclear regarding parents and other relatives, it expressly places support responsibility on the spouse. Interpreting a provision[116] similar to the current reimbursement statute, the Supreme Court of Appeals noted in *Snyder v. Lane*[117] that a spouse's obligation of maintenance and support was not satisfied by medical care and treatment received by the wife while confined in a hospital at the state's expense. The court stressed the common law duty, as well as the statutory duty, for support of the spouse.[118]

The Department of Health and its predecessors lacked any direct monetary incentive for enforcement of the statute since monies collected were deposited in the state's general revenue fund.[119] This lack of monetary incentive combined with the director's right to "exonerate any person . . . thereof in whole or in part, if the director finds that such person is unable to pay or that the payment would work an undue hardship on him or on those dependent upon him"[120] has resulted in superficial enforcement.[121] If the department had been actively enforcing the statute by legal means, the Supreme Court of Appeals would have had occasion to deal with the many problems in the reimbursement statute by now.

B. *The Future*

The underlying reason for maintenance reimbursement statutes such as West Virginia's is to allow the state to offset the cost of providing mental health services. The financial burden is placed on those persons receiving the most benefit from the services. When the legislature determines the classes which will bear the support burden, the classes should be defined with care

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[112] W. VA. CODE § 27-8-1 (1980) designates liable persons as being the spouse, father and mother. Unless the legislature intended to make parents responsible for married emancipated children, the only other person in a marriage is the other spouse and if that spouse is outside the state or has no assets then no one else can be liable.

[113] *See id.* The same logic that finds only two persons in a marriage, finds only two parents. If one parent is not liable, that leaves only the other parent.

[114] *See, e.g.*, Kirby v. Gillian, 182 Va. 111, 28 S.E.2d 40 (1943).

[115] W. VA. CODE § 27-8-1 (1955); W. VA. CODE § 27-5-1 (1949).

[116] W. VA. CODE § 27-5-1 (1949).

[117] 135 W. Va. 887, 65 S.E.2d 483 (1951).

[118] *Id.*

[119] *See generally* W. VA. CODE § 27-8-2 (1980).

[120] W. VA. CODE § 27-8-1 (1980).

[121] *See supra* note 8.

and clarity. Since it is not unrealistic that long-term institutionalization will deplete the assets of the patient, the statute should provide adequate notice to all persons who are now or could in the future be held liable for the patient's maintenance and care expenses. Notice would allow the financially liable family members to utilize numerous estate and family financial planning techniques to prevent financial strain in the event they are assessed the cost of the patient's care and maintenance.

The legislature should review and revise the reimbursement statute to clarify the legally responsible family members and to give the Department of Health more guidance for enforcement. By directing the monies collected under the statute into a long-term health facilities account,[122] the legislature has provided an incentive for enforcement. The funds collected will become even more important to the department if state revenues decline and federal supplemental programs are reduced or eliminated.[123] Enforcement and collection would be enhanced by a more defined statutory scheme. Whatever means are used to modify the statute, the most important aspect should be the definition of legally responsible relatives and the extent of their liability. The responsible family members have a right to know their legal position and be able to make financial decisions based on this knowledge.

The viability of the reimbursement statute may become more important in the near future. Federal cut-backs or limited state resources may force the legislature to place more emphasis on statutes that bring revenues to the state or individual departments. The Department of Health has already been given an incentive to increase collections.[124] A change in public attitude toward the economically disadvantaged may force more cuts in social spending and move hospital officials to take a look at strictly enforced reimbursement. Unless the legislature or the courts find a reason to provide these services free of cost, the institutionalized may find themselves paying more and more.

IV. Survey of Family Planning Tools

Family financial or estate planning[125] could prove helpful to the party paying for mental health care in three situtations. First, a person may realize that he or she is suffering from some mental problem and may ultimately require institutionalization. Second, family members may realize that the person is suffering from a mental health related problem and may require future institutionalization. Finally, the family or family member caring for a mentally ill or

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[122] *See* W. Va. Code § 16-1-15a (Supp. 1981).

[123] *See supra* note 9.

[124] W. Va. Code § 16-1-15a (Supp. 1981) provides that the director of health shall deposit all revenues collected by the hospitals into a fund designed to finance a five-year health facilities plan. *See supra* note 9.

[125] Family estate planning is the disposition or arrangement of one's affairs in the manner best calculated to maintain and protect the family in the present and future. The plan which provides the greatest family welfare is the plan best suited to the individual family. H. Harris, Family Estate Planning Guide, 2 (1957). The estate planning techniques described here may have certain tax ramifications. The practitioner should take the tax ramifications into consideration when explaining the advantages and disadvantages of each plan to the client.

mentally retarded person may realize that at some future point the person may require institutionalization when the family or family member is no longer capable of caring for him. In each situation, due to legal liability or moral responsibility, the affected person may wish to plan for future care and maintenance and thereby reduce the financial impact when institutionalization occurs. The extent of financial planning will depend on the assets available to the future patient or the planner. But even limited planning is helpful to eliminate or decrease problems which arise when an unexpected financial burden is placed on the patient or his family.

A. *The Patient Planner*

The individual who anticipates future mental impairment or the inability to manage his resources due to institutional placement has several estate planning options open to him. He can execute a power of attorney which both designates the person whom he wishes to manage his financial affairs at some future point and establishes guidelines for protecting his assets and providing for his institutional costs.[126]

As a second alternative, the individual can place all his assets in a form of concurrent ownership[127] with a spouse or other family member. This measure allows the other person to manage the assets, if needed. It also places many financial resources outside the distributive estate of the patient and, hence, avoids depletion due to the patient's institutional debt.[128] Co-ownership has certain disadvantages which could defeat the purpose for its creation, such as reversion to the patient if the other person dies first and, depending on the other person's status, liability for the patient's costs from his own assets.[129]

For the individual with considerable assets the most appropriate alternative is to create a living or *inter vivos* trust with himself as the primary beneficiary.[130] An *inter vivos* trust "can be established to serve as standby machinery providing protection in case of future disability, but without interfering significantly with the settlor's (i.e., the person creating the trust) control or enjoyment of his property in the meantime."[131] If the settlor's desire, however, is to use the income for his maintenance and have the principal reserved for his heirs or beneficiaries, this intent may be frustrated in states which allow for invasion of the corpus to cover costs.[132] An individual considering an *inter vivos* trust should consult a capable lawyer and select a reliable trustee, such as a bank or trust company, to avoid drafting and fiduciary problems. Individuals

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[126] R. ALLEN, E. FERSTER & H. WEIHOFEN, MENTAL IMPAIRMENT AND LEGAL INCOMPETENCY, 154-57 (1968).

[127] *Id.* at 157-60.

[128] *Id.* at 159.

[129] *Id.*

[130] *Id.* at 150-54.

[131] *Id.* at 150.

[132] *See, e.g.*, Commonwealth v. Sharrett, 218 Va. 684, 240 S.E.2d 522 (1978) (trust could be invaded for maintenance and care of patient); Commonwealth v. Shepard, 212 Va. 843, 188 S.E.2d 99 (1972) (committee's assets could be invaded for the patient and her adult institutionalized son).

who do not wish to pay for the creation of a trust can transfer their assets to another in hopes the beneficiary will provide their care and maintenance. This type of planning "rests upon the transferor's confidence in the transferee and in the latter's ability and willingness to perform according to the understanding."[133] This type of agreement is difficult to enforce and, therefore, is not advisable.[134]

The remaining two alternatives for future planning are the simplest. The individual can dispose of all his worldly assets and let the state or his relatives become totally responsible for his future care, or he can merely do nothing, letting the state, the courts and his relatives face the problem when he is no longer able to do so. While these alternatives do not qualify as financial planning in the traditional sense, they seem to reflect the approach taken by most individuals facing future institutionalization.

B. *Family Planners*

Similar devices such as those available to the individual planner are available to the family members of the institutionalized or future patient. A combination of planning on the part of the future patient and the responsible family members produces the best results. However, if the future patient refuses to participate the family can still make provisions for future liability. Although, the future patient may have financial resources, the family should consider the available options because when his assets are depleted the remaining costs may be transferred to them.

Financial planning for the family members of a future patient is the most difficult task due to the uncertainty of commitment, the reluctance to tie up valuable assets for a long period, and the family members' current needs. The best planning results can be obtained by discussing the family situation with an investment counselor or an estate planning lawyer.

C. *Estate Planning*

Many families care for their disabled children at home without extensive governmental support. Due to death and other causes, the family or family member may not be able to provide life-long care for the mentally ill or mentally retarded relative. When faced with this situation, family members may wish to provide funds for future institutional costs.

Although the following alternatives are geared primarily toward the parents of mentally disabled children, they can easily be adapted for other family members. In his treatise on estate planning for the parents of a mentally retarded child,[135] Professor Lawrence A. Frolik lists five major options for distributing the parent's estate. These options are: 1) disinheriting the disabled

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[133] Allen, *supra* note 126, at 160.

[134] *Id.*

[135] Frolik, *Estate Planning for Parents of Mentally Disabled Children*, 40 U. PITT. L. REV. 305 (Spring 1979).

child and providing solely for non-handicapped children; 2) leaving the child an outright gift; 3) providing for the child through a gift and a corresponding moral obligation to a possible guardian or family member; 4) leaving money in a trust for the child; and 5) using a sophisticated discretionary trust in an attempt to avoid or minimize the loss of federal assistance or to avoid being charged for otherwise gratuitous state benefits.[136] The option used is probably influenced by the number of non-handicapped children, financial resources, and the probability of institutionalization.

The motive for financial planning may differ between family members legally liable for institutional costs and those who consider future support a moral obligation, but the methods for achieving either are the same. Timely financial planning will enable all family members to more adequately meet the future costs of mental health care.

V. Conclusion

West Virginia's reimbursement statute should be revised to clarify legal responsibility placed on the patient's family members. The legislature may wish to consider a statutory scheme similar to the Virginia provisions. Any modification or amendment must consider the financial impact on the family and the enforcement ability of the Department of Health. By consulting with patients, family members and Department of Health officials, the legislature should be able to design an adequate mental health reimbursement statute that is fair to the patient, his family and the state.

Samme L. Gee

[136] *Id.* at 321.