Mr. H, a Medicare beneficiary and veteran of the U.S. Navy, was severely injured in a tornado on March 29, 1997. He suffered severe craniofacial trauma for which he underwent removal of his left eye, removal of portions of the left frontal lobe of his brain, and extensive cranial facial reconstruction. At the time of the injury, he was diagnosed with organic brain disease that causes him to suffer from severe migraines. Shortly thereafter, he became eligible for Medicare on account of his disability. Since the tornado, Mr. H has required pain medication to manage the incapacitating headaches that cause seizures when left untreated. As a result, he has developed a tolerance to pain medications, causing most pain killers to be ineffective in managing his acute migraines. For six years, Mr. H was using Actiq, which is indicated by the FDA to treat breakthrough pain in cancer patients, to manage his migraines and reduce the risk of seizing. Before the enactment of Medicare Part D, Mr. H received coverage of his Actiq prescription under the state Medicaid program, TennCare. Initially, when Medicare Part D was enacted and Mr. H was forced to enroll in a Medicare prescription drug plan, Humana covered his Actiq prescription. In October 2006, however, Mr. H was suddenly told by his pharmacist that Humana was denying coverage. Mr. H did not receive notice that his coverage would change, nor did he receive a transitional supply. Because he could not afford to pay for his Actiq prescription out-of-pocket, Mr. H's prescribing physician, Dr. B, prescribed Fentora, which is also indicated by the FDA to treat breakthrough pain in cancer patients, as a replacement for the Actiq. Fentora has also proven to successfully ease Mr. H's pain. Initially, Humana provided coverage of Mr. H's Fentora prescription, but in January 2007, ended this coverage without prior notification or transition fill. Because his Fentora prescription costs approximately $1,500 a month, Mr. H cannot afford to pay for it out-of-pocket. As a result, he visits the emergency room (ER) on a biweekly basis so that he can receive the medication at the hospital and avoid suffering from a seizure caused by his extremely severe pain. Maximus Federal Services has denied his appeal for Part D coverage and MRC is representing him in his appeal for review by an Administrative Law Judge.


1. How should the judge rule in this case? Should he rule that Mr. H have his drugs funded or not?
2. What ethical principles do you base your decision on?