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Iowa Legislative Interim Calendar and Briefing

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In This Edition

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Friday, February 8, 2015

Administrative Rules Review Committee

9:00 a.m., Room 116, Statehouse

Health Policy Oversight Committee
November 30, 2018

Co-chairperson: Senator Mark Costello
Co-chairperson: Representative David Heaton

Background. The Health Policy Oversight Committee (HPOC) of the Legislative Council was established as a permanent legislative committee of the Legislative Council under Iowa Code section 2.45. The committee is composed of 10 members of the General Assembly, consisting of five members from each house, appointed by the Legislative Council. The committee is required to meet at least two times annually during the legislative interim to provide continuing oversight for Medicaid managed care, and to ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations.

Procedural Business. The meeting was called to order at 10:02 a.m. and was adjourned at 2:53 p.m. in Room 116 of the State Capitol.

Department of Human Services (DHS) Presentations: Mr. Jerry Foxhoven, Director, DHS, and Mr. Michael Randol, Medicaid Director, DHS, provided presentations as follows:

Rate Setting 101. An overview of the capitation rate development process for Medicaid managed care including federal regulation and actuarial requirements, the data sources used, base validation processes, the components of capitation rate development, and the monitoring process (medical loss ratio).

Review of FY 2019 Managed Care Organization (MCO) Contracts. A review of the Medicaid MCO contracts for FY 2019. They noted that the contracts include funding for the increased mental health services to be provided pursuant to House File 2456, enacted by the 2018 General Assembly, as well as additional required performance measures. They also stated that in the future, the contracting period will be based on the calendar year rather than the state fiscal year in order to allow the General Assembly to budget more precisely.

Dental Wellness Plan. A review of changes to the Medicaid dental wellness plan implemented to provide preventive care to the greatest number of adult Medicaid recipients. Iowa is one of only 13 states that provide a dental plan for adult Medicaid recipients. The initial Medicaid dental wellness plan was implemented on May 1, 2014, for the Iowa Health and Wellness Plan population. In July 2017, the dental wellness plan was expanded to all Medicaid adult recipients 19 years of age and older. The dental wellness plan is now provided through two dental carriers, Delta Dental and MCNA Dental, members must complete healthy behaviors in the first year in order to keep their full benefits the following year, and each member is subject to a $1,000 per year cap for services which limitation does not apply to the costs for preventive, diagnostic or emergency dental services, anesthesia, or fabrication of dentures.

Review of Value-Based Purchasing. Mr. Jeffrey Jones, Plan President Amerigroup Iowa, Inc., and Ms. Alissa Weber, Chief Financial Officer, and KellyAnn Light-McGroary, M.D., Chief Medicaid Officer, UnitedHealthcare Community Plan of Iowa, discussed moving from a fee-for-service methodology to a value-based purchasing methodology from the perspective of an MCO, including quality-based, shared savings, and risk-based models. Ms. Sabra Rosener, Vice President, Government Relations, UnityPoint Health, discussed value-based purchasing from the perspective of a large health system. She noted that value-based purchasing, and payment of physicians for services provided to Medicare beneficiaries based on value rather than volume, began with the passage of the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Since then, providers have had to expand their pa-

tient base beyond the Medicare population to continue to meet targets and share in the savings or, as the formula moves to a risk-based methodology, avoid decreased reimbursement.

MCO Update. Mr. Jones provided an overview of the key events in 2018 and upcoming plans for 2019 for Amerigroup Iowa, Inc. Mr. Chris Priest, Interim Chief Operations Officer, Iowa Total Care, provided an overview of the progress Iowa Total Care is making to provide coverage in Iowa beginning July 1, 2019.

Public Comment. The committee received public comment in person and through submissions in writing. The public comments submitted in writing will be posted on the committee's Internet site.

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Internet Site: www.legis.iowa.gov/committees/committee?ga=88&groupID=24165

HEALTH POLICY OVERSIGHT COMMITTEE

December 17, 2018

Co-chairperson: Senator Mark Costello
Co-chairperson: Representative David Heaton

Background. The Health Policy Oversight Committee (HPOC) of the Legislative Council was established as a permanent legislative committee of the Legislative Council under Iowa Code section 2.45. The committee is composed of 10 members of the General Assembly, consisting of five members from each house, appointed by the Legislative Council. The committee is required to meet at least two times annually during the legislative interim to provide continuing oversight for Medicaid managed care, and to ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations.

Procedural Business. The meeting was called to order at 8:04 a.m. and was adjourned at 11:54 a.m. in Room 116 of the State Capitol.

Department of Human Services (DHS) Presentations: Mr. Jerry Foxhoven, Director, DHS, and Mr. Michael Randol, Medicaid Director, DHS, provided presentations as follows:

Tiered Rates. The directors provided a review of the results of the work group held during the 2018 interim to review the tiered rates and make recommendations. The work group in part recommended shifting funding from the lower to the higher tiers to more adequately address the costs of members with higher acuity.

Health Homes. The directors reported on the findings of the health home work group that met two times to review the chronic conditions and integrated health homes. The work group will continue to review the Medicaid state plan amendments (SPAs) to determine if the two SPAs should be combined and DHS will continue to work with the Managed Care Organizations (MCOs) to provide better communication and assistance to providers.

Level of Care Sample Findings. The directors reviewed the findings of the level of care sample analysis, including trends and exceptions to policy provisions.

Process Improvement Work Group. The directors reviewed the work of the process improvement work group convened to work through provider issues. The group identified 150 issues categorized into eight common themes, and the issues have been prioritized for the purposes of resolution. Information from the work group is available on the DHS internet site.

July Transition Information. The directors discussed the steps being taking to transition to adding Iowa Total Care, Inc., as the third Medicaid MCO beginning July 1, 2019.

MCO Updates. Mr. Bror Hultgren, Interim Chief Executive Officer, UnitedHealthcare (UHC), provided an update regarding UHC's 2018 activities, plans for 2019, and value-based care.

Dental Wellness Plan. Ms. Gretchen Hageman, Director, Government Programs and Project Director for the Dental Wellness Plan, Dr. Jeffrey Chaffin, Vice President of Professional Relations and Dental Director, Delta Dental of Iowa, and Mr. Rene Canales, Associate Vice President of Network Development, MCNA Dental, provided updates regarding their work with the Medicaid program dental wellness plan.

Public Comment. The committee received public comment in person and through submissions in writing. The public comments submitted in writing will be posted on the committee's Internet site.

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BRIEFINGS

INFORMATION REGARDING RECENT ACTIVITIES

Internet Site: www.legis.iowa.gov/committees/committee?ga=88&groupID=24165

LEGISLATIVE TAX EXPENDITURE COMMITTEE

January 8, 2019

Co-chairperson: Senator Randy Feenstra
Co-chairperson: Representative Lee Hein

Overview. The Legislative Tax Expenditure Committee was established in 2010 pursuant to Iowa Code sections 2.45(5) and 2.48. The committee is required to conduct regular reviews of all tax credit, withholding credit, and revenue division programs. The committee may review any tax expenditure at any time but is required to review specific tax expenditures during specified years. In 2018, the committee was required to review the child and dependent care and early childhood development tax credits, property tax revenue divisions for urban renewal areas, the endow Iowa tax credits, and the redevelopment tax credits available under Iowa Code section 15.293A.

Child and Dependent Care and Early Childhood Development Tax Credits. Mr. John Good, Iowa Department of Revenue (IDR), provided background information and statistical analysis of the Iowa Child and Dependent Care (CDC) Tax Credit and the Iowa Early Childhood Development (ECD) Tax Credit. The CDC Tax Credit is 30 percent to 75 percent of the federal CDC Tax Credit for individuals whose net Iowa income is less than $45,000. The federal CDC Tax Credit is 20 percent to 35 percent of the eligible child care expenses for qualifying children under age 13 or disabled dependents. A CDC or ECD Tax Credit is claimed one time by 51.1 percent of the claimants while 10.5 percent of the claimants take either credit five or more consecutive years. Taxpayers can claim only one of the two Iowa credits in one tax year. Mr. Good explained that tax reform enacted last year (Senate File 2417) will increase the number of households eligible to claim either the CDC or ECD Tax Credit when the starting point for computing Iowa net income changes from federal adjusted gross income to federal taxable income, beginning in tax year 2023 or in a later tax year (trigger year). The increase in the number of claimants eligible for the tax credits is due to the interplay between the new higher federal standard deduction lowering federal taxable income for many Iowans, which will in effect place more Iowans below the Iowa net income threshold limit of $45,000 for claiming either tax credit.

Property Tax Revenue Divisions for Urban Renewal Areas. Mr. Tony Girardi, IDR, provided background information on Iowa's urban renewal law and a description of his ongoing research into the efficacy of tax increment financing (TIF). Mr. Girardi described the use of tax increment financing in other states and noted differences in Iowa's urban renewal law. He stated that 15 states require a TIF district to meet a "but for" test under some circumstances, 32 states (including Iowa) finance TIF through general obligation bonds, and 14 states exclude school districts or allow a school district to opt out of a TIF district. While noting the limited research on tax increment financing, Mr. Girardi assessed the economic effects of TIF through Iowa's urban core-based statistical areas, and provided statewide historical property assessment data and property valuation growth by county data. Mr. Girardi concluded there is no correlation between TIF and economic growth, except for a slight correlation between TIF and industrial concentration, but he also acknowledged the limitations of tax increment financing research. He noted that the size of a metropolitan area and the educational background of the workforce are more predictive of economic growth than TIF.

Ms. Carrie Johnson, Iowa Department of Management (DOM), and Mr. Ted Nellesen, DOM, provided an update on the Annual Urban Renewal Report (AURR). Ms. Johnson and Mr. Nellesen reviewed the data found in the AURR, including but not limited to TIF use by city and county, projects by type and by year, TIF debts by type, annual appropriations to pay off TIF debt, and TIF district ending cash balances.

Redevelopment Tax Credits. Mr. Matt Rassmussen, Iowa Economic Development Authority (IEDA), presented a report to the committee detailing the Brownfield and Grayfield Redevelopment Tax Credit Program which provides an investment tax credit for redevelopment projects in Iowa that meet the definition of either a brownfield or grayfield. Under the program, an owner's equity investment in a grayfield project can receive up to a 12 percent tax credit for a qualifying investment or up to 15 percent if the project meets the requirements of a green development. A brownfield can receive up to a 24 percent tax credit for a qualifying investment or up to 30 percent if the project meets the requirements of a green development. "Qualifying investment" means costs that are directly related to a qualifying redevelopment project and are incurred after the project has been registered and approved by the IEDA Board and only includes the purchase price, the cleanup cost, and the redevelopment costs. Applications for the credits are scored based on financial need, feasibility, and overall quality. Mr. Rasmussen noted that IEDA is considering a rule change that would remove the bonus points awarded upon re-application if an applicant was turned down the previous year. Mr. Rasmussen detailed the application and review process and provided examples of how the program is being used throughout the state.

Mr. Zhong Jin, IDR, provided background information and statistical analysis of the program and discussed other states' tax credit programs. He analyzed the number of redevelopment tax credits claimed by each tax year. Mr. Jin detailed the amount of credit transfers administered by IDR. He noted that a person transferring a credit for a brownfield or grayfield project receives 93 cents on the dollar.

Endow Iowa Tax Credits. Ms. Nichole Hansen, IEDA, described the Endow Iowa Tax Credit Program to the committee, a charitable giving incentive program administered by IEDA. The program was established in 2003 to encourage individuals, businesses, and organizations to make lasting investments in their communities when they establish permanent, endowed funds at an Iowa community foundation. The Endow Iowa Tax Credit is a 25 percent tax credit available to all Iowa taxpayers who make a qualifying charitable contribution. Ms. Hansen stated that the program continues to experience high demand. Currently, only $900,000 of the $6,000,000 of authorized credits remain available for the remainder of 2019. To qualify, gifts must be made to a permanent endowment fund, established for the benefit of an Iowa charitable purpose, at a qualified community foundation. Gifts can be of any size but tax credits granted to a single taxpayer shall not exceed 5 percent of the aggregate amount of tax credits authorized. Ten percent of the aggregate amount of tax credits authorized in a calendar year are reserved for those endowment gifts in amounts of $30,000 or less. Credits are nonrefundable but can be carried forward for up to five years. Iowa's community foundations reported a 6.89 percent growth in permanent endowment assets in 2017.

Ms. Angela Gullickson, IDR, provided background information and statistical analysis of the program. Ms. Gullickson also provided information on similar programs in other states. She noted that only four other states have similar credits. The data provided by Ms. Gullickson included for each year of the program the total amount and number of credits awarded, the range of credit amounts awarded, and the average credit amount. Ms. Gullickson also provided annual foundation donation data, donor demographic information, and information about unclaimed awards by household tax liability.

Tax Credit Update. Ms. Amy Harris, IDR, presented background information about other tax credits that are not required to be reviewed by the Tax Expenditure Committee. She provided information about the Adoption Tax Credit, the Volunteer Firefighter, EMS & Reserve Peace Officer Tax Credit, the Solar Energy System Tax Credit, the Farm to Food Donation Tax Credit, the E15 Plus Gasoline Promotion Tax Credit, the Biodiesel Blended Fuel Tax Credit, the E85 Gasoline Promotion Tax Credit, the School Tuition Organization Tax Credit, the Tuition and Textbook Tax Credit, and the Workforce Housing Tax

Incentive Program. She noted the largest tax credit not required to be reviewed by the committee is the Workforce Housing Tax Incentive Program, and the least utilized tax credit is the Farm to Food Donation Tax Credit.

Public Comment and Committee Discussion. There was no public comment during the public comment portion of the meeting. The committee briefly discussed the presentations made during the meeting and discussed the importance of the committee going forward.

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Internet Site: www.legis.iowa.gov/committees/committee?ga=88&groupID=594

ADMINISTRATIVE RULES REVIEW COMMITTEE

January 8, 2019

Chairperson: Senator Mark Chelgren
Vice Chairperson: Representative Megan Jones

PHARMACY BOARD, *Universal Practice Standards—Protection from Exposure to Hazardous Drugs*, 12/19/18 IAB, ARC 4172C, AMENDED NOTICE.

Background. This rulemaking adopts national minimum standards for the proper handling of hazardous drugs to protect health care workers, patients, and the environment. The standards are established by the United States Pharmacopeial Convention and enforced by the federal Food and Drug Administration. The rulemaking establishes an enforcement date of December 1, 2019, for Iowa pharmacies, which matches the federal enforcement date.

Commentary. Ms. Erin Cubit made a public comment on behalf of the Iowa Hospital Association. She stated that protecting health care personnel from exposure to hazards is a top priority for hospitals and acknowledged that the federal standards are important. But she explained that there are two issues that make compliance with the federal standards difficult: the cost of compliance and the amount of time allowed for compliance. She and Ms. Jennifer Nutt, also representing the Iowa Hospital Association, explained why compliance by hospitals would be problematic. They described the financial cost, the high demand for contractors to do the necessary remodeling, and the need for additional supplies and education of workers. Ms. Nutt described specific costs that would be borne by certain hospitals and asked that the compliance date be moved back at least 18 months.

Mr. Casey Ficek made a public comment on behalf of the Iowa Pharmacy Association. He thanked the board for clarifying the enforcement date, but he said association members had told him that compliance by that date would be difficult. He asked that the board include a process whereby pharmacies could establish plans for compliance over time rather than require immediate compliance on December 1, 2019.

Committee members asked Mr. Andrew Funk, representing the board, what the board's preferred solution to the concerns raised by the commenters would be. He stated that the board would prefer a delay in enforcement, but noted that the compliance date is a federal requirement and explained that affected parties have had notice about the date. Committee members asked if the board would prefer to implement a delay on its own or have the committee impose a session delay on the rulemaking. He stated that he would need to ask the board for an answer. Committee members told him to communicate to the board that the committee recommends an 18-month delay on enforcement, and he agreed to do so.

Action. No action taken.

Next Meeting. The next committee meeting will be held in Room 116, Statehouse, on Friday, February 8, 2019, beginning at 9:00 a.m.

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Internet Site: www.legis.iowa.gov/committees/committee?endYear=2018&groupID=705

Purpose. *Legal update briefings are prepared by the nonpartisan Legal Services Division of the Legislative Services Agency. A legal update briefing is intended to inform legislators, legislative staff, and other persons interested in legislative matters of recent court decisions, Attorney General Opinions, regulatory actions, federal actions, and other occurrences of a legal nature that may be pertinent to the General Assembly's consideration of a topic. Although a briefing may identify issues for consideration by the General Assembly, a briefing should not be interpreted as advocating any particular course of action.*

MEDICAL MALPRACTICE: IOWA'S INFORMED CONSENT LAW

Filed by the Iowa Supreme Court
June 15, 2018
Andersen, et al. v. Khanna, et al.
No. 14-1682
www.iowacourts.gov/courtcases/1202/embed/SupremeCourtOpinion

Factual and Procedural Background. In 2004, Dr. Sohit Khanna performed the surgical Bentall heart procedure on Alan Andersen without any prior experience or training in the procedure. Complications from the procedure arose which resulted in Andersen being in a coma and receiving a second heart surgery and a heart transplant. Andersen and members of his family (Andersen) brought a lawsuit against Dr. Khanna and Dr. Khanna's employers (Dr. Khanna) after he underwent the heart procedure.

Andersen sued Dr. Khanna on the basis that Dr. Khanna was negligent and that he failed to obtain informed consent in two respects: 1) he failed to properly advise Andersen of the risks and dangers of the procedure due to the presurgery condition of his heart and 2) he failed to advise Andersen that he had limited experience in performing a Bentall heart procedure.

Dr. Khanna filed a motion for partial summary judgment on the informed consent claims, alleging a physician does not have a duty to disclose physician-specific characteristics or experience in obtaining a patient's informed consent. Dr. Khanna's motion did not explicitly mention the other informed consent allegation. The district court ruled in favor of Dr. Khanna, holding that there is no duty to disclose physician-specific characteristics or experience under Iowa's informed consent law. At that point in the case, the informed consent claim based on Dr. Khanna's lack of experience was removed as an issue in the case by the district court, but the informed consent claim based on Dr. Khanna's failure to advise Andersen of the risks and dangers of the procedure remained an issue in the case.

The following year, Dr. Henri Cuenoud, a defense expert witness, during a deposition, described Andersen's heart as being in poor condition prior to the surgery and stated that he would have quoted a higher risk of a bad outcome ("25% chance of not making it") to Andersen than Dr. Khanna did. Based on those grounds, Andersen filed a motion to reconsider the ruling on the motion for partial summary judgment on informed consent, and the district court granted the motion. The ruling allowed Andersen to present evidence of Dr. Khanna's awareness of Andersen's increased mortality risk and apprising Andersen of the mortality risk. In doing so, the ruling made clear that Andersen could pursue an informed-consent claim based on the increased mortality risk due to the presurgery condition of Andersen's heart. The same ruling also ruled on a motion in limine requesting the court bar any reference to or evidence of allegations of lack of informed consent and negligent credentialing, and that Dr. Khanna was not qualified. The district court sustained the motion as to negligent credentialing, and held that Dr. Khanna's qualifications could be pursued by Andersen in the context of a general negligence claim, along with the issue of informed consent.

The first two trials resulted in mistrials. At the pretrial conference to the third and final trial, the parties disagreed whether the issue of informed consent based on Dr. Khanna's failure to disclose a material risk due to the presurgery condition of Andersen's heart was still an issue in the case. The district court's written order following the pretrial conference did not resolve the issue. Andersen did not present evidence of such a claim in his case-in-chief, and Dr. Khanna did not move for a directed verdict at that time. The district court held a discussion outside of the presence of the jury regarding informed consent and Dr. Cuenoud's potential testimony. The district court determined the informed consent issue had been closed and would not be reopened. After Dr. Cuenoud testified, Dr. Frazier Eales, an expert witness, testified for the defense. Andersen argued that his testimony opened the door to an informed-consent argument. The district court disagreed.

The district court did not instruct the jury on informed consent. The jury concluded Dr. Khanna was not negligent in performing the Bentall heart procedure. Andersen appealed the jury's decision. The Iowa Supreme Court (Court) transferred the case to the Iowa Court of Appeals (Court of Appeals). The Court of Appeals affirmed the district court. Andersen applied for further review. The Court granted the application for further review.

Issues. The Court considered four issues on appeal: (1) whether the district court erred in granting partial summary judgment when it held a physician does not have a duty to disclose information about the physician's lack of experience or training; (2) whether the district court erred when it did not allow Andersen to proceed on an informed-consent claim based on Dr. Khanna's failure to disclose Andersen's material risk due the condition of his heart prior to surgery; (3) whether the jury's finding that Dr. Khanna was not negligent precludes Andersen's informed-consent claims; and (4) whether the district court erred when it denied Andersen's request to amend a jury instruction to include an additional, separate specification of negligence.

Analysis. The Court quoted *Pauscher v. Iowa Methodist Medical Center,* 408 N.W.2d 355, 350 (Iowa 1987), to state "Under the patient rule, 'the physician's duty to disclose is measured by the patient's need to have access to all information material to making a truly informed and intelligent decision concerning the proposed medical procedure.'" The Court stated that the element of an informed consent claim at issue in this case was the existence of a material risk or information unknown to the patient. The Court disagreed with the district court's finding as a matter of law that a physician's lack of experience or training is never material to a patient's decision to submit to a medical procedure. The Court explained there should not be a categorical exclusion of a particular type of information, such as a physician's personal characteristics, but rather a district court must apply the objective reasonable patient standard to the undisclosed information in the particular case to determine if the failure to disclose that information breached the physician's duty.

The Court rejected Dr. Khanna's "bright line" approach for several reasons. First, the Court stated the duty to disclose personal information is imposed only when it is material. Second, Iowa Code section 147.137 creates a presumption of informed consent when there is a signed writing addressing the enumerated subjects, but this informed consent statute does not preempt common law. Dr. Khanna also asserted that expanding the duty to disclose would lead to several problems. The Court stated that physicians would not be required to provide statistics of outcomes, but rather information about experience or training, just as expert witnesses do at trial. The Court rejected as unpersuasive arguments and court cases cited by Dr. Khanna that restrictively interpret the informed-consent doctrine.

The Court concluded that a physician's experience and training can be material. First, lack of experience or training can lead to complications. Second, evidence of a physician's training and experience could be relevant because it could indicate the physician failed to disclose material information. Finally, the Court reasoned that requiring physicians to disclose their experience and training on a particular procedure will encourage physicians to gain as much training and experience with the procedure as possible.

The Court concluded that the jurisprudence which it found more persuasive was the jurisprudence that interpreted informed-consent doctrines in a broader fashion and it found those to be more in line with Iowa's informed-consent doctrine. The Court reviewed cases which cited a physician's experience and training and cases which cited other personal information about a physician. The Court agreed with other courts that whether a physician's particular characteristics are material will depend on the facts and circumstances of the case and whether those facts and circumstances create or increase a material risk to the patient. Like other courts, the Court concluded that this is usually a jury question.

The Court reasoned that Dr. Khanna's failure to disclose the risk of the surgery due to the presurgery condition of Andersen's heart was still an issue in the case during the trial at the time of Dr. Cuenoud's testimony. As such, admission of the testimony would have been relevant and not unduly prejudicial. Everyone at trial, including the judge, knew that evidence supporting this claim was to come from Dr. Cuenoud. When the district court ruled during the third and final trial that Dr. Cuenoud's testimony on that topic could not be admitted into evidence, the Court held the district court abused its discretion. The Court held that Andersen should have been allowed to rely on the cross-examination testimony of Dr. Cuenoud to support his informed consent claim that Dr. Khanna failed to disclose information about the risk of surgery due to the presurgery condition of Andersen's heart. The Court concluded the district court misapplied the prior rulings of the district court when it precluded Andersen from soliciting testimony about informed consent from Dr. Cuenoud and, in doing so, the district court abused its discretion. This ruling, the Court held, was prejudicial to Andersen.

The Court reasoned that other courts and its own case law were persuasive in holding that claims for negligence and informed consent are independent claims for relief. A physician need not violate a standard of care or otherwise be negligent in order for a patient to recover under a theory of informed consent. The Court stated that with regard to the informed-consent claim about the presurgery condition of Andersen's heart, Dr. Khanna should have disclosed the exact injury Andersen suffered, regardless of whether Dr. Khanna performed the procedure according to the applicable standard of care. The Court stated that with regard to Dr. Khanna's lack of experience, Andersen should have the opportunity to develop the theory of injury and damages before the claims are summarily dismissed.

The Court reasoned that the district court did not err when it refused to give a specific jury instruction on negligence because the district court instructed the jury to consider Dr. Khanna's training and experience when considering each specification of negligence. The jury could use Dr. Khanna's lack of training or experience to help the Court decide if he was negligent. However, even if Dr. Khanna was unqualified to perform the Bentall heart procedure, as long as he did not breach the standard of care of a qualified cardiovascular surgeon, he could not be found negligent.

Majority Opinion by Justice Wiggins (Joined by Justices Hecht, Appel, and Zager). The Court held that the district court erred in granting partial summary judgment when it held a physician does not have a duty to disclose information about a physician's lack of experience or training prior to performing a Bentall heart procedure on a patient because that information may be deemed to be material by

a reasonable person. The Court held that the district court misapplied the law of the case when it prevented Andersen from putting forward evidence from Dr. Cuenoud to support his informed consent claim, and in doing so, the district court abused its discretion. The Court also held that negligence and informed consent are alternative forms of relief and as such, the finding by the jury that Dr. Khanna was not negligent did not preclude Andersen's informed consent claims. Finally, the Court held that the district court did not err when it refused to give a specific jury instruction on negligence.

Disposition. The Court vacated the decision of the Court of Appeals, affirmed the district court's judgment as to Andersen's specific negligence claims, reversed the district court's judgments removing Andersen's informed consent claims from the case, and remanded the case to the district court to proceed on the informed consent claims.

Concurrence in Part and Dissent in Part by Justice Waterman (Joined by Chief Justice Cady and Justice Mansfield). Justice Waterman dissented with regard to the part of the majority opinion that held that the jury verdict finding for Dr. Khanna that he was not negligent did not preclude Andersen's informed consent claims. Justice Waterman concluded that a jury verdict of no negligence precludes recovery for nondisclosure of Dr. Khanna's inexperience. Justice Waterman reasoned that the court cases cited by the majority and those cited by the dissent hold that the undisclosed risk must materialize into injury and it must be causally related to injury in order for there to be liability. Justice Waterman reasoned that the risk presented by Dr. Khanna's inexperience was that he might fall below the standard of care performing the surgery, but the jury held in the negligence ruling that he did not. As such, Justice Waterman reasoned that the risk never materialized which prevented an informed-consent claim.

Justice Waterman also dissented from the majority's opinion which concluded that Dr. Khanna had a duty to disclose his inexperience with a specific procedure. Justice Waterman reasoned that the legislature specified the disclosure requirements for informed consent in Iowa Code section 147.137 and stated he would not add requirements that the legislature chose to omit. Justice Waterman stated that the statute does not impose a requirement to disclose physician-specific information including success rates or the number of times a physician has performed a procedure. Justice Waterman discussed cases from across the country and concluded that most courts reject a requirement for a physician to disclose personal experience in an informed consent case. Finally, Justice Waterman reasoned that the majority's decision was flawed for multiple practical reasons and urged the legislature to overrule the decision.

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