

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1103 Electronic Prescribing
SPONSOR(S): Health Quality Subcommittee, Mariano
TIED BILLS: **IDEN./SIM. BILLS:** SB 1830

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	9 Y, 4 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Electronic prescribing (e-prescribing) is a method by which an authorized health care practitioner electronically transmits a prescription to a pharmacy using a secure software system. Efforts have been made by states, as well as the federal government, to increase the use of e-prescribing software. For example, Congress passed legislation mandating e-prescribing for certain medicinal drugs under the Medicare Part D program and xx states enacted mandatory e-prescribing laws.

Beginning July 1, 2021, HB 1103 requires prescribers to generate and transmit all prescriptions electronically, except when electronic prescribing is unavailable due to a temporary electrical or technological failure. In such instances, written prescriptions may be used which must meet the requirements of current law.

The bill relocates language regarding electronic prescribing from existing s. 456.43, F.S., to s. 456.42, F.S., and repeals current s. 456.43, F.S, as of July 1, 2021, to improve readability by combining several provisions related to e-prescribing in a single section of law.

The bill has no fiscal impact on state or local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Electronic Prescribing

Electronic prescribing (e-prescribing) is a method by which health care practitioners use an electronic device such as a computer or tablet to enter and securely transmit prescriptions to pharmacies using special software and connectivity to a transmission network.¹ Numerous benefits have been attributed to e-prescribing including, improved prescription accuracy, increased patient safety, reduction of opportunities for fraud and abuse, and cost reduction.²

Patient Safety

An adverse drug event (ADE) is harm experienced by the patient as a result of exposure to medicine.³ Each year, ADEs account for over 3.5 million physician office visits, an estimated one million emergency department visits, and approximately 125,000 hospitalizations.⁴ Some ADEs occur without accessing hospital care, such as overdoses to opioid medications.⁵ It is estimated that about half of ADEs are preventable.⁶ Causes of errors include illegible handwriting, wrong dosage or dosage form, omission of information, and failure to identify drug allergies or drug-drug interactions.⁷

E-prescribing helps reduce such prescription errors.⁸ E-prescribing software often includes decision support that notifies the prescriber of potential prescription errors before transmission.⁹ The e-prescribing software also prompts the prescriber to verify allergies, confirm dosage accuracy, and identify drug-drug interaction before transmitting the prescription.¹⁰

Fraud

Individuals may illegally obtain prescription medication by using fraudulent, forged, or altered written prescriptions. In an effort to reduce fraud related to the use or misuse of controlled substances, Florida law requires prescribers to use counterfeit-proof prescription pads purchased from an authorized supplier for written prescriptions for controlled substances.¹¹ A counterfeit-proof prescription pad must include the following features:¹²

- A background color that is blue or green and resists reproduction;
- Printed on artificial watermarked paper;
- Resists erasures and alterations; and

¹ The Office of the National Coordinator for Health Information Technology, *What is Electronic Prescribing?*, available at <https://www.healthit.gov/faq/what-electronic-prescribing> (last visited January 14, 2020).

² Agency for Health Care Administration, *Florida's Annual Electronic Prescribing Reports*, available at <http://www.fhin.net/eprescribing/fleprescribingRpts.shtml> (last visited January 14, 2020).

³ U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, *Medication Errors and Adverse Drug Events*, (last rev. Sept. 2019), available at <https://psnet.ahrq.gov/primers/primer/23/Medication-Errors-and-Adverse-Drug-Events> (last visited January 14, 2020).

⁴ Office of Disease Prevention and Health Promotion, *Overview: Adverse Drug Events*, (last rev. Jan. 14, 2020), available at <https://health.gov/hcq/ade.asp> (last visited January 14, 2020).

⁵ Id.

⁶ *Supra* note 3.

⁷ Megan Ducker, et. al., *Pros and Cons of E-Prescribing in Community Pharmacies*, US Pharm. 2013 8(38):4-7, available at <https://www.uspharmacist.com/article/pros-and-cons-of-e-prescribing-in-community-pharmacies-42392> (last visited January 14, 2020).

⁸ Giampaolo P. Velo and Pietro Minuz, *Medication Errors: Prescribing Faults and Prescription Errors*, 67 British J of Clin Pharmacology, 624-628 (2009), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2723200/> (last visited January 14, 2020).

⁹ *Supra* note 7.

¹⁰ Id.

¹¹ Section 456.42, F.S.

¹² Rule 64B-3.005, F.A.C.

- The word “void” or “illegal” must appear on any photocopy or reproduction;

Health care practitioners and health care facilities must return unused counterfeit-proof prescription to the vendor to be destroyed.¹³ Even with these precautions, there is still the danger of a legitimate prescription pad being stolen from a health care practitioner’s office or a health care facility and fraudulent prescriptions written.¹⁴

E-prescribing eliminates the risk of stolen prescription pads and, with the two-factor authentication required by the U.S. Drug Enforcement Administration (DEA), may further reduce unauthorized or altered prescriptions.¹⁵

Efficiency

E-prescribing creates efficiencies for prescribers, patients, and pharmacies. For prescribers, e-prescribing can be integrated into electronic health records, which includes patient information such as clinical notes, laboratory results, and clinical decision support functions.¹⁶ E-prescribing also improves the accuracy of prescriptions and helps guide clinical decision-making by checking the appropriateness of a prescription and connecting to a patient’s health insurance for its formulary.¹⁷ Prescribers have also indicated that less time is spent resolving issues with pharmacies, including prior authorizations and refill requests, allowing more time to be spent on patient care.¹⁸ The software also automates certain tasks which allows staff to perform other functions. Such efficiencies may ultimately lower overall operating costs.

Patients may also benefit from e-prescribing efficiencies due to the ability of the prescriber to check for drug interactions, drug allergies, and whether a particular drug is covered by their insurance. This may enable patients to reduce copayment expenses or inconvenience associated with requesting an alternate medication from the prescriber if the drug prescribed is not covered or too expensive.¹⁹

Finally, pharmacies will likely benefit from e-prescribing efficiencies because it reduces the time spent on interpreting a prescription. Pharmacists must contact prescribers if a prescription is illegible or inconsistent, which affords the pharmacist more time to counsel patients.²⁰

Cost Savings

As noted above, ADEs result in many emergency room visits and hospitalizations, as well as additional visits to the prescriber’s office. Although e-prescribing will not prevent all ADEs,²¹ they may reduce the number of ADEs due to improved prescribing and the assistance of decision support systems.²² The efficiencies noted above may also lead to a reduction to overall operating costs. For example, one health system in Michigan estimated that it saved \$3 million after implementing e-prescribing.²³

¹³ Id.

¹⁴ U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, *A Pharmacist’s Guide to Prescription Fraud*, (Feb. 2000), available at <https://www.deadiversion.usdoj.gov/pubs/brochures/pharmguide.htm> (last visited January 14, 2020).

¹⁵ National Association of Chain Drug Stores, *Opioid Abuse Epidemic: Solutions from the Front Lines of Care*, (last rev. May 2019), available at <https://www.nacds.org/pdfs/government/2017/Opioid-Policy-Oct-2017.pdf> (last visited January 14, 2020).

¹⁶ Amber Porterfield, et. al., *Electronic Prescribing: Improving the Efficiency and Accuracy of Prescribing in the Ambulatory Care Setting*, *Perspect. Health Inf. Manage.* 2014 Spring: 11 (Apr. 2014), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/> (last visited January 14, 2020).

¹⁷ Academy of Managed Care Pharmacy, *Concept Series Paper on Electronic Prescribing*, available at <https://amcp.org/sites/default/files/2019-03/Electronic%20Prescribing.pdf> (last visited January 14, 2020).

¹⁸ *Supra* note 16.

¹⁹ Id.

²⁰ *Supra* note 7.

²¹ Some ADEs are unavoidable even if the medication is properly prescribed and administered. These are often known side effects of a medication. See *supra* note 3.

²² *Supra* note 3.

²³ Annie Hahn and Annesha Lovett, *Electronic Prescribing: An Examination of Cost Effectiveness, Clinician Adoption, and Limitations*, *Universal J of Clin Med* (2)(1):1-24 (2014), available at <http://www.hrpub.org/download/20131215/UJCM1-16900871.pdf> (last visited January 14, 2020).

Cost of Implementation

The cost of an e-prescribing system is based on the number of prescribers using the system and the options included in the system. It is estimated that the cost for of a full electronic health record (EHR) system that includes e-prescribing for an office with 10 full-time prescribers is approximately \$42,332 for implementation and \$14,725 for annual maintenance.²⁴ According to an industry analysis of e-prescribing software costs, the annual cost of a stand-alone e-prescribing system that meets the Drug Enforcement Administration's requirements for electronically prescribing controlled substances (EPCS) ranges from \$170 to \$650.²⁵ The fee for initial set-up of the software may be included; however, some vendors may charge additional fees for set-up and for a token for the two-factor authentication. A health IT management consulting company identified the estimated cost of adding on EPCS functionality to the most widely used EHR systems.²⁶

EHR	EPCS Setup (One-time fee)	Annual Ongoing Cost
Allscripts Professional	\$340 per provider	\$150 per provider
Allscripts Touchworks	\$6,000 per practice	\$150 per provider
Amazing Charts	\$0	\$250 per provider
Athena	\$0	\$0 per provider
Cerner	Varies based upon # of providers	
DrFirst	\$90 per provider	\$75 per provider
eClinicalWorks	\$250 per provider	\$0 per provider
e-MDs	\$225 per provider	\$120 per provider
Epic	Varies based upon # of providers	
GE Centricity	\$0	\$5,988 per provider
Greenway Intergy	\$150 per provider	\$90 per provider
Greenway PrimeSuite	\$150 per provider	\$90 per provider
NewCrop	\$150 per provider	\$150 per provider
NextGen	\$0	included in ePrescribing
Practice Fusion	\$0	included in ePrescribing

²⁴ *Supra* note 16.

²⁵ The U.S. Drug Enforcement Administration requires electronic prescribing software for controlled substances to have two-factor authentication to verify the identity of the prescriber and protect such credentials from misuse (21 C.F.R. 1311). See Eclinicworks, *E-prescribing of Controlled Substances-Slick.pdf*, available at <https://www.eclinicalworks.com/wp-content/uploads/2016/11/ePrescribing-of-Controlled-Substances-Slick.pdf>; RxNT, *ERX*, available at <https://www.rxnt.com/eprescribing/>; California Dental Association, *How to Start Prescribing Controlled Substances Electronically*, (Sept. 12, 2018), available at <https://iframe.cda.org/news-events/how-to-start-prescribing-controlled-substances-electronically> (last visited January 14, 2020).

²⁶ HealthTech Zone, *Three Factors Contributing to Lagging Provider Adoption of EPCS*, (Apr. 2018), available at <http://www.healthtechzone.com/topics/healthcare/articles/2018/04/03/437665-three-factors-contributing-lagging-provider-adoption-eps.htm> (last visited January 14, 2020).

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, authorized incentive payments through Medicare and Medicaid to health care practitioners and hospitals for meaningfully using EHRs to help offset some of the costs related to the adoption of electronic health record systems.²⁷ The incentive program consists of two stages. Stage one required the electronic capture of clinical data, including transmitting at least 40 percent of eligible prescriptions electronically.²⁸ In stage two, health care providers must demonstrate meaningful use for a full year; stage two retains the objective that eligible prescriptions be transmitted electronically.²⁹ Participants could choose to participate under Medicare or Medicaid, but could only participate in one of the programs. The maximum incentive available under Medicare was \$44,000 across five years and under Medicaid, \$63,750 across six years.³⁰

Incentive payments for the Medicare program ended in 2016, and Medicaid will pay incentives through 2021.³¹ The Centers for Medicare and Medicaid Services subsequently launched the Promoting Interoperability Program and implemented a merit-based incentive program to reward value and outcomes.³² The focus of the program is on interoperability, improved flexibility, and placing emphasis on the use of electronic exchange of health information between patients and providers.³³ Promoting interoperability objectives, which includes the use of e-prescribing and EHRs, may account for up to 25 percent of the final score for the merit-based incentive.³⁴

According to the Office of the National Coordinator for Health Information Technology (ONC), approximately 80 percent of office-based physicians in Florida have adopted EHRs that meet the criteria for meaningful use.³⁵ The ONC also found that, as of June 2017, 97 percent of hospitals of Florida hospitals had adopted EHRs that meet the criteria for meaningful use.³⁶

E-Prescribing System Design Errors

Practitioners and researchers identify several issues related to the design of an e-prescribing system. Some systems may lack appropriate alerts and other systems may not have alerts configured in a meaningful way so that a prescriber receives an overload of alerts.³⁷ Other issues are related to the interface or screen design of the software. In such cases, errors may occur in the use of drop-down boxes and automatic fill functions which may lead to more manual entry and editing of prescriptions.³⁸ Additionally, these systems may be configured to bundle prescriptions for transmission or to transmit at a time other than the time of entry.³⁹ For example, the system may allow users to input prescriptions

²⁷ Medscape, *EHR Incentive Programs: Achieving Meaningful Use*, available at https://www.medscape.org/viewarticle/770841#content=0_0 (last visited January 14, 2020).

²⁸ Id.

²⁹ Centers for Medicare and Medicaid Services, *Stage 2 Overview Tipsheet*, (Aug. 2012), available at https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/stage2overview_tipsheet.pdf (last visited January 14, 2020). For the initial year of stage 2, CMS required providers to demonstrate meaningful use for 90 days, but in subsequent year the requirement is for a full year.

³⁰ Centers for Medicare and Medicaid Services, *An Introduction to the Medicare EHR Incentive Program for Eligible Professionals*, available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Medicare_Stg1_BegGuide.pdf (last visited January 14, 2020).

³¹ Centers for Medicare and Medicaid Services, *Medicare and Medicaid Promoting Interoperability Program Basics*, (last rev. Aug. 2019), available at <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/basics.html> (last visited January 14, 2020). Participants must have enrolled to participate in the Medicaid program before 2016 to be eligible for incentive payments.

³² Id.

³³ Id.

³⁴ Centers for Medicare and Medicaid Services, *Quality Payment Program*, available at <https://qpp.cms.gov/participation-lookup/about?py=2019> (last visited January 14, 2020), Centers for Medicare and Medicaid Services, *Merit-based Incentive Payment System: Promoting Interoperability Requirements*, available at <https://qpp.cms.gov/mips/promoting-interoperability?py=2019> (last visited January 14, 2020), and Centers for Medicare and Medicaid Services, *Quality Payment Program: Explore Measures*, available at <https://qpp.cms.gov/mips/explore-measures/promoting-interoperability?py=2019#measures> (last visited January 14, 2020).

³⁵ U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Florida Health IT Summary*, available at <https://dashboard.healthit.gov/apps/health-information-technology-data-summaries.php?state=Florida&cat9=all+data> (last visited January 14, 2020).

³⁶ Id.

³⁷ *Supra* note 16.

³⁸ *Supra* note 7.

³⁹ Id.

over the course of a specified duration and then send all entered prescriptions at a designated time or interval.⁴⁰

Requirements for Electronic Prescriptions

Federal Requirements

The federal Drug Enforcement Administration (DEA) implements the Comprehensive Drug Abuse Prevention and Control Act of 1970, often referred to as the Controlled Substances Act (CSA).⁴¹ In 2010, the DEA adopted a rule authorizing prescribers to issue electronic prescriptions for controlled substances and permitted pharmacies to receive, dispense, and archive these electronic prescriptions.⁴² To e-prescribe controlled substances, a prescriber must:⁴³

- Purchase or use DEA-compliant software that supports e-prescribing;
- Complete the identity-proofing process to acquire a two-factor authentication credential or digital certificate;
- Attach the authentication credential to his or her identity;
- Set access controls so that only individuals who may legally prescribe a controlled substance are allowed to do so; and
- Access the e-prescribing or electronic health record platform.

Florida Requirements

Current law requires prescriptions that are electronically generated and transmitted to contain the following:⁴⁴

- The name of the prescriber;
- The name and strength of the drug prescribed;
- The quantity of the drug prescribed in numerical format;
- Directions for use;
- Date and electronic signature of the prescriber.

E-prescribing software may not interfere with a patient's choice of pharmacy or use any means, such as pop-up ads, advertising, or instant messaging to influence or attempt to influence the prescribing decision of the prescriber at the point of care.⁴⁵ E-prescribing software may provide formulary information, as long as nothing makes it more difficult or precludes a prescriber from selecting a specific pharmacy or drug.⁴⁶

Florida Prescribers

The Agency for Health Care Administration (AHCA) houses a clearinghouse of information on electronic prescribing, including trends on the adoption and use of e-prescribing in the state.⁴⁷ In creating the clearinghouse, AHCA worked in collaboration with the private sector and relevant stakeholders, including representatives of health care practitioners, pharmacies, health care facilities,

⁴⁰ Id.

⁴¹ 21 U.S.C. 801–971.

⁴² U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, *Electronic Prescriptions for Controlled Substance (EPCS)*, available at https://www.deadiversion.usdoj.gov/e-comm/e_rx/ (last visited January 14, 2020). See also 21 C.F.R. s. 1306.08 and 21 C.F.R. Part 1311.

⁴³ Id. See also, DrFirst, *EPCS: Getting Started with Electronic Prescribing of Controlled Substances*, available at http://www.drfirst.com/wp-content/uploads/EPCS_Infographic_from_DrFirst-1.png (last visited January 14, 2020).

⁴⁴ Section 456.42, F.S.

⁴⁵ Section 456.43, F.S.

⁴⁶ Id.

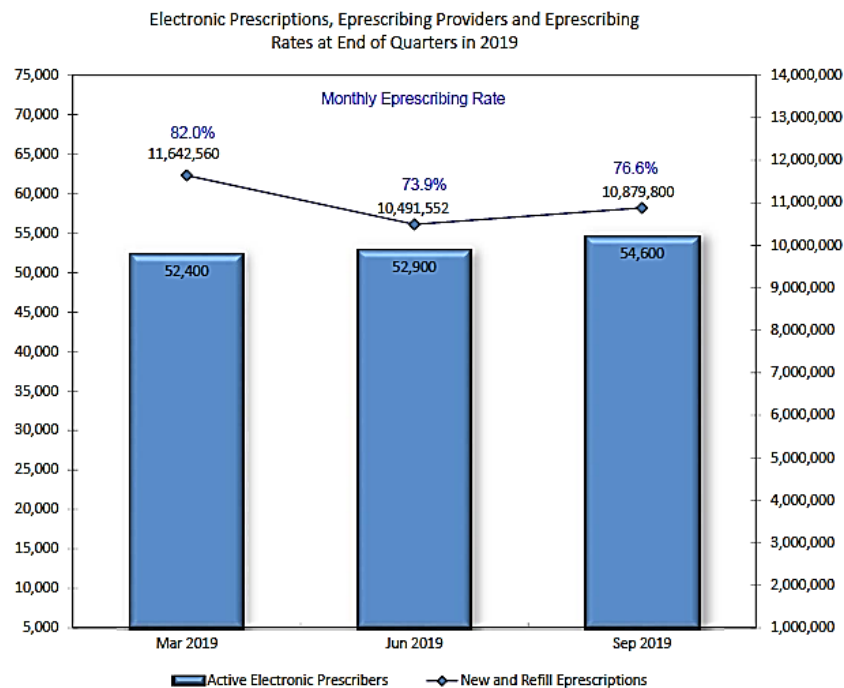
⁴⁷ Section 408.0611, F.S.

organizations that operate e-prescribing networks, organizations that create e-prescribing products, and regional health information organizations.⁴⁸ On its website, AHCA provides:⁴⁹

- Information on the e-prescribing process and the availability of e-prescribing products;
- Information on the advantages of e-prescribing;
- Links to federal and private sector websites that provide guidance on selecting an appropriate e-prescribing product; and
- Links to state, federal, and private sector incentive programs for the implementation of e-prescribing.

AHCA annually reports to the Governor and Legislature on the implementation of electronic prescribing by health care practitioners, facilities, and pharmacies.⁵⁰

AHCA reports that as of the end of September 2019, the average number of e-prescribers in the state is 54,600, and that almost 10 million e-prescriptions are transmitted each month.⁵¹



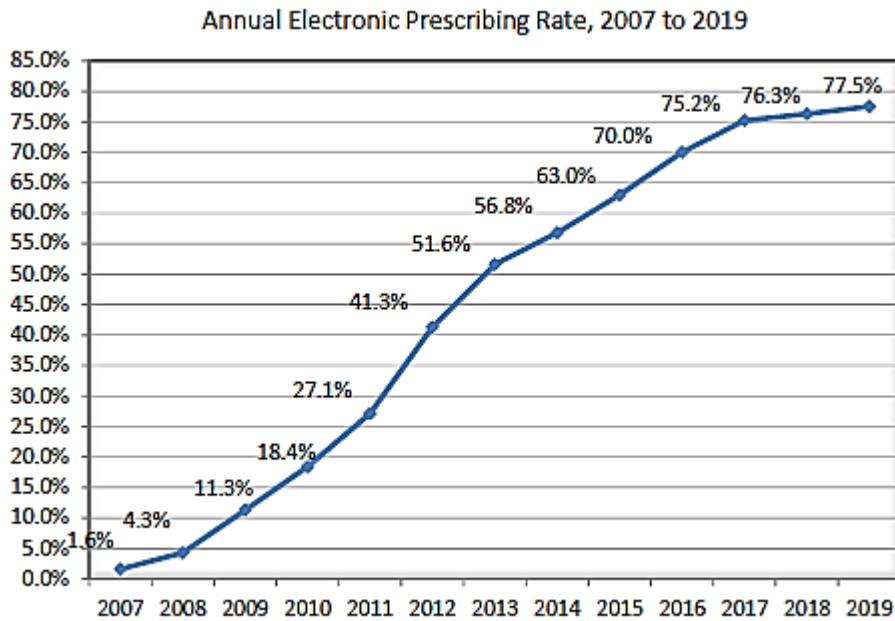
⁴⁸ Id.

⁴⁹ Id. The clearinghouse website established and maintained by AHCA is www.fhin.net (last visited January 14, 2020).

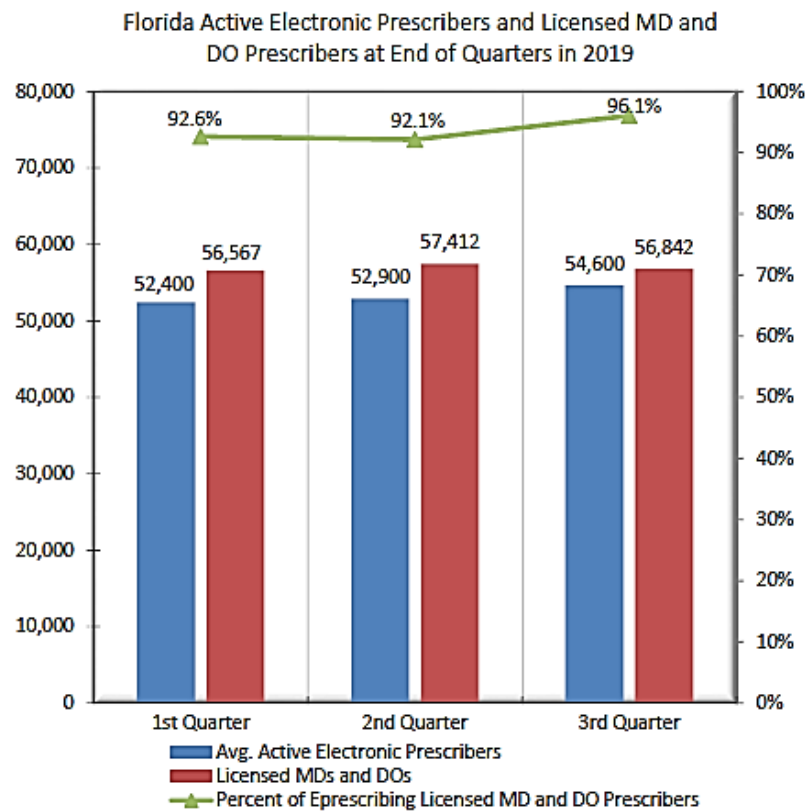
⁵⁰ Id., and Agency for Health Care Administration, Florida Center for Health Information and Transparency, *Florida Electronic Prescribing Annual Report for 2018*, (Jan. 2019), available at <https://ahca.myflorida.com/SCHS/ePrescribing/docs/Florida2018ePrescribeReport.pdf> (last visited January 14, 2020).

⁵¹ Agency for Health Care Administration, Florida Center for Health Information and Transparency, *2019 Florida Electronic Prescribing Quarterly Summary*, available at <https://ahca.myflorida.com/SCHS/ePrescribing/docs/2019eprescribmetrics3Q.pdf> (last visited January 14, 2020).

Florida's e-prescribing rate has steadily increased since 2007 with an estimated 77.5 percent of all prescriptions being e-prescribed.⁵²



The vast majority of physicians who are actively licensed to practice in Florida have adopted e-prescribing.⁵³



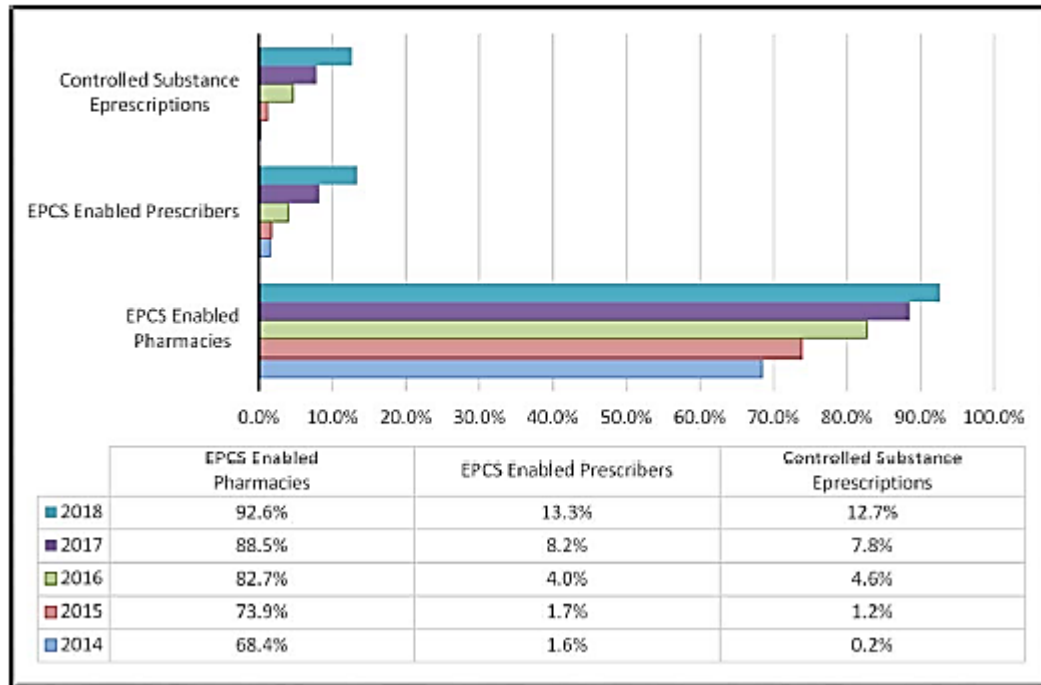
However, Florida prescribers have been slower to adopt e-prescribing for controlled substances.⁵⁴ In 2018, only 12.7 percent of controlled substance prescriptions were e-prescribed.

⁵² Id. Electronic prescribing rate is defined as the amount of e-prescribing relative to all prescriptions that could have been e-prescribed.

⁵³ Id.

⁵⁴ Id.

Percent of Electronic Prescribing of Controlled Substances (EPCS), EPCS Enabled Pharmacies and EPCS Enabled Providers in Florida¹, 2014 to 2018



Mandatory E-Prescribing

Medicare E-Prescribing

In 2018, Congress mandated e-prescribing for controlled substances under the Medicare Part D program by January 1, 2021, as a part of a comprehensive bill to address the opioid crisis.⁵⁵ Under the HITECH Act of 2009, the federal government provides incentive payments to those who adopt and meaningfully use electronic health record technology, including the use of e-prescribing.⁵⁶

Florida

In 2019, the Legislature enacted legislation requiring a prescriber who maintains electronic health care records (EHR) systems, or who is an owner, employee, or contractor of a licensed health care facility or practice that maintains an EHR system, to generate and transmit all prescriptions electronically, unless the prescriber qualifies for an exemption.⁵⁷ The requirement takes effect upon the renewal of the prescriber’s license or by July 1, 2021, whichever is earlier.⁵⁸

Laws in Other States

Over the last few years, at least 27 states have enacted mandatory e-prescribing laws.⁵⁹

⁵⁵ Substance Use-Disorder Prevention that Promotes Opioid Recovery Treatment (SUPPORT) for Patients and Communities Act, Pub. L. No. 115-271 s. 2003 (2018).

⁵⁶ *Supra* note 27.

⁵⁷ Chapter 2019-112, L.O.F. The effective date of the law is January 1, 2020.

⁵⁸ Id. Health practitioner licenses are biennially renewed.

⁵⁹ DrFirst, *Mandates Driving EPCS and PDMP Utilization*, available at <https://www.drfirst.com/resources/e-prescribing-mandate-map/> (last visited January 14, 2020), SureScripts, *Electronic Prescribing for Controlled Substances*, available at <https://surescripts.com/enhance-prescribing/e-prescribing/e-prescribing-for-controlled-substances/> (last visited January 14, 2020), and independent research by committee staff.

State	Effective Date	Applicable Prescriptions
Arizona	January 1, 2020	Schedule II opioids
Arkansas	January 1, 2021	Controlled substances
California	January 1, 2022	All
Colorado	July 1, 2021 for podiatrists, physicians, physician assistants, advance practice nurses, and optometrists July 1, 2023 for dentists, rural practitioners, and solo practitioners	Schedules II-IV controlled substances
Connecticut	Currently required	Controlled substances
Delaware	January 1, 2021	All
Indiana	January 1, 2021	Controlled substances
Iowa	January 1, 2020	All
Kansas	July 1, 2021	All controlled substances containing an opioid
Kentucky	January 1, 2021	Controlled substances
Maine	Currently required	All controlled substances containing opiates
Massachusetts	January 1, 2020	Controlled substances
Minnesota	Currently required	All
Missouri	January 1, 2021	Controlled substances
New York	Currently required	All
Nevada	January 1, 2021	Controlled substances
North Carolina	January 1, 2020	Schedule II and III opioids and narcotics
Oklahoma	January 1, 2020	Controlled substances
Pennsylvania	October 24, 2019	Controlled substances
Rhode Island	January 1, 2020	Controlled substances
South Carolina	January 1, 2021	Controlled substances
Tennessee	July 1, 2021	Controlled substances
Texas	January 1, 2021	Controlled substances
Virginia	July 1, 2020	All prescriptions containing opiates
Washington	January 1, 2021	Controlled substances
Wyoming	January 1, 2021	Controlled substances

The industry anticipates that additional states will introduce and pass legislation mandating e-prescribing in some fashion, whether it includes all prescriptions or is limited to controlled substances.⁶⁰

Effect of Proposed Changes

HB 1103 requires all prescribers to generate and transmit all prescriptions electronically, and effectively prohibits written prescriptions, except when electronic prescribing is unavailable due to a temporary electrical or technological failure. The bill also eliminates all other exceptions to the mandatory electronic prescribing requirement that exist under the current law. Written prescriptions for controlled substances must meet the requirements of current law, which includes the use of counterfeit-proof prescription pads and have the quantity of the drug prescribed written in both textual and numerical formats.

The bill relocates language regarding electronic prescribing from existing s. 456.43, F.S., to s. 456.42, F.S., and repeals current s. 456.43, F.S. These provisions regulate the use of e-prescribing software. The bill does not amend these provisions but simply relocates them.

The bill makes conforming changes.

The bill provides an effective date of July 1, 2021.

⁶⁰ Surescripts, *EPCS Legislation Shows Power and Promise*, (May 3, 2018), available at <https://surescripts.com/news-center/intelligence-in-action/opioids/epcs-legislation-shows-power-and-promise/> (last visited January 14, 2020).

B. SECTION DIRECTORY:

- Section 1:** Amends s. 456.42, F.S., relating to written prescriptions for medicinal drugs.
- Section 2:** Repeals: s. 456.43, F.S., relating to electronic prescribing for medicinal drugs.
- Section 3:** Amends s. 458.347, F.S., relating to physician assistants.
- Section 4:** Amends s. 459.022, F.S., relating to physician assistants.
- Section 5:** Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

- 1. Revenues:
None.
- 2. Expenditures:
None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

- 1. Revenues:
None.
- 2. Expenditures:
None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Prescribers may achieve savings in operating costs based on the efficiencies offered by using e-prescribing software. However, prescribers who do not have such software will incur costs associated with the initial installation and ongoing maintenance. Pharmacies may also achieve cost savings related to the efficiencies provided by e-prescribing.

Vendors currently authorized to sell the counterfeit-proof prescription pads will experience a decrease in demand, which may result in a financial loss.

Vendors of e-prescribing software will experience an increase in demand.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

- 1. Applicability of Municipality/County Mandates Provision:
Not applicable. This bill does not appear to affect county or municipal governments.
- 2. Other:
None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On January 15, 2020, the Health Quality Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment replaced the term “subsection” with “section” to clarify the authority of the health care regulatory boards to adopt rules for electronic prescribing.