HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #:   CS/HB 831   Electronic Prescribing
SPONSOR(S): Health & Human Services Committee, Mariano
TIED BILLS: **IDEN./SIM. BILLS:**   SB 1192

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 1 N	Siples	McElroy
2) Health Care Appropriations Subcommittee	9 Y, 0 N	Mielke	Clark
3) Health & Human Services Committee	12 Y, 2 N, As CS	Siples	Calamas

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 15 states enacted mandatory e-prescribing laws.

Beginning January 1, 2021, HB 831 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 January 1, 2021, to improve readability by combining several provisions related to e-prescribing in a single section of law.

The bill makes conforming changes throughout Florida statutes.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

<u>Present Situation</u>

<u>Electronic Prescribing</u>

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 nearly 700,000 emergency room visits and 100,000 hospitalizations.[4] Some ADEs occur without accessing hospital care, such as overdoses to opioid medications.[5] It is estimated that 50 percent 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 prescriptions for controlled substances be written on counterfeit-proof prescription pads purchased from an authorized supplier.[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;

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[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 Dec. 7, 2018).
[2] Agency for Health Care Administration, *Florida's Annual Electronic Prescribing Reports*, available at http://www.fhin.net/eprescribing/fleprescribingRpts.shtml (last visited Dec. 7, 2018).
[3] U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, *Medication Errors and Adverse Drug Events*, (Aug. 2018), available at https://psnet.ahrq.gov/primers/primer/23/Medication-Errors-and-Adverse-Drug-Events (last visited January 3, 2019).
[4] Id.
[5] Id.
[6] Id.
[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 3, 2019).
[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 3, 2019).
[9] *Supra* note 7.
[10] Id.
[11] Section 456.42, F.S.
[12] Rule 64B-3.005, F.A.C.

- Resists erasures and alterations; and
- The word "void" or "illegal" must appear on any photocopy or reproduction;

Unused counterfeit-proof prescription pads must be destroyed by the health care practitioner or health care facility that purchased them and returned to the vendor.[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

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[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 3, 2019).

[15] National Association of Chain Drug Stores, *Opioid Abuse Epidemic: Solutions from the Front Lines of Care*, (last rev. Oct. 19, 2018), available at https://www.nacds.org/pdfs/government/2017/Opioid-Policy-Oct-2017.pdf (last visited December 13, 2018).

[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 December 14, 2018).

[17] Academy of Managed Care Pharmacy, *Concept Series Paper on Electronic Prescribing*, available at http://amcp.org/WorkArea/DownloadAsset.aspx?id=9297 (last visited December 14, 2018).

[18] *Supra* note 16.

[19] Id.

[20] *Supra* note 7.

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

[22] *Supra* note 3.

health system in Michigan estimated that it saved $3 million after mandatory e-prescribing was implemented in that state.[23]

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

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[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 December 15, 2018).

[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*, 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://www.cda.org/news-events/how-to-start-prescribing-controlled-substances-electronically (last visited March 31, 2019).

[26] Point of Care Partners, *HIT Perspectives: The Impact of Cost on EPCS Adoption*, (Apr. 2018), available at https://www.pocp.com/hit-perspectives-cost-EPCS-Adoption (last visited March 31, 2019).

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 when they meaningfully used 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, were included as a part of the merit-based incentive payment program and accounts for 25 percent of the final score.[34]

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.[35] 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 or prescriptions.[36] Additionally, these systems may be configured to bundle prescriptions or to transmit at a time other than the time of entry.[37] For example, the system may allow users to input prescriptions over the course of a specified duration and then send all entered prescriptions at a designated time or interval.[38]

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[27] Medscape, *EHR Incentive Programs: Achieving Meaningful Use*, available at https://www.medscape.org/viewarticle/770841#content=0_0 (last visited December 15, 2018).

[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 March 31, 2019). 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/beginners_guide.pdf (last visited March 31, 2019).

[31] Centers for Medicare and Medicaid Services, *Medicare and Medicaid Promoting Interoperability Program Basics*, available at https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/basics.html (last visited March 31, 2019). 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 March 31, 2019), 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 March 31, 2019), and Centers for Medicare and Medicaid Services, *Quality Payment Program: Explore Measures*, available at https://qpp.cms.gov/mips/explore-measures/promoting-interoperability?py=2018#measures (last visited March 31, 2019).

[35] *Supra* note 16.

[36] *Supra* note 7.

[37] Id.

[38] Id.

<u>Florida Law on Electronic Prescriptions in Florida</u>

Current law requires prescriptions that are electronically generated and transmitted to contain the following: [39]

- 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;
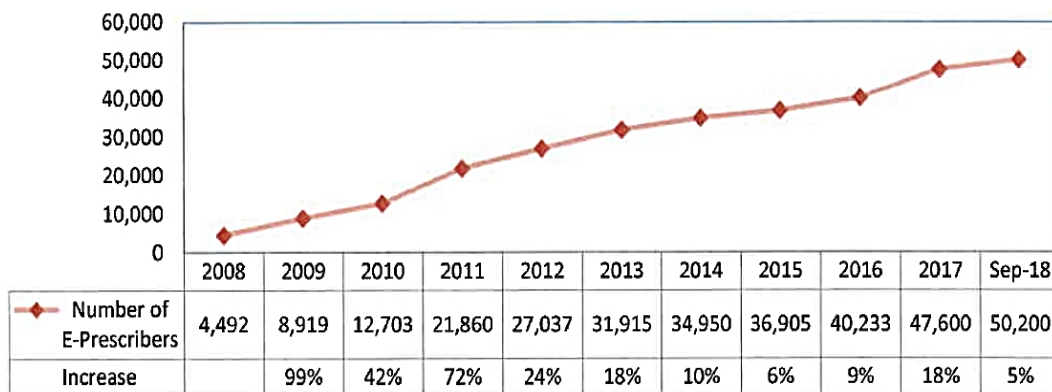- Date and electronic signature of the prescriber.

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.[40] 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.[41]

<u>Florida Prescribers</u>

The Agency for Health Care Administration (AHCA) houses a clearinghouse of information on electronic prescribing, including information on trends in e-prescribing in the state and electronic health records systems.[42] AHCA annually reports to the Governor and Legislature on the implementation of electronic prescribing by health care practitioners, facilities, and pharmacies.[43]

AHCA reports that as of the end of September 2018, the average number of e-prescribers is 50,200, and that almost 10 million e-prescriptions are transmitted each month.[44]

Figure 2. Average Number of Electronic Prescribers per Month in 2008 - 2018 and Annual Increase

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Sep-18
Number of E-Prescribers	4,492	8,919	12,703	21,860	27,037	31,915	34,950	36,905	40,233	47,600	50,200
Increase		99%	42%	72%	24%	18%	10%	6%	9%	18%	5%

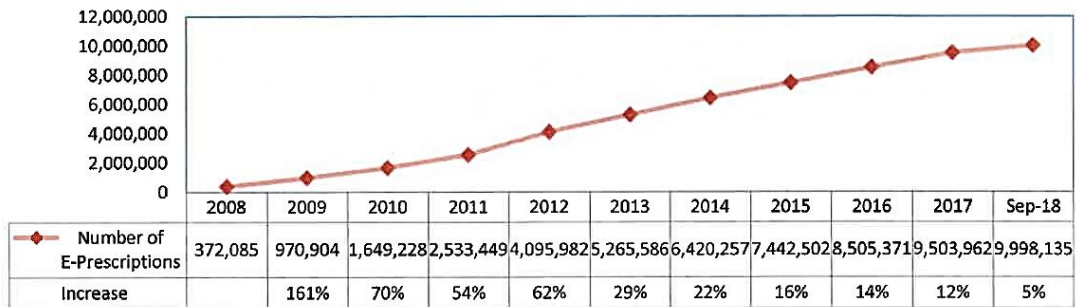
[39] Section 456.42, F.S.
[40] Section 456.43, F.S.
[41] Id.
[42] Section 408.0611, F.S.
[43] Agency for Health Care Administration, Florida Center for Health Information and Transparency, "Florida Electronic Prescribing Annual Report for 2018," (Jan. 2019), available at http://www.fhin.net/eprescribing/docs/reports/Florida2018ePrescribeReport.pdf (last visited March 3, 2019).
[44] *Supra* note 43.

Figure 1. Average Number of Electronic Prescriptions Per Month in 2008 - 2018 and Annual Increase

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Sep-18
Number of E-Prescriptions	372,085	970,904	1,649,228	2,533,449	4,095,982	5,265,586	6,420,257	7,442,502	8,505,371	9,503,962	9,998,135
Increase		161%	70%	54%	62%	29%	22%	16%	14%	12%	5%

Florida's e-prescribing rate has steadily increased since 2007 with an estimated 75.7 percent of all prescriptions being e-prescribed.[45]

Figure 3. Estimated Average Annual Electronic Prescribing Rate, 2007 - 2018
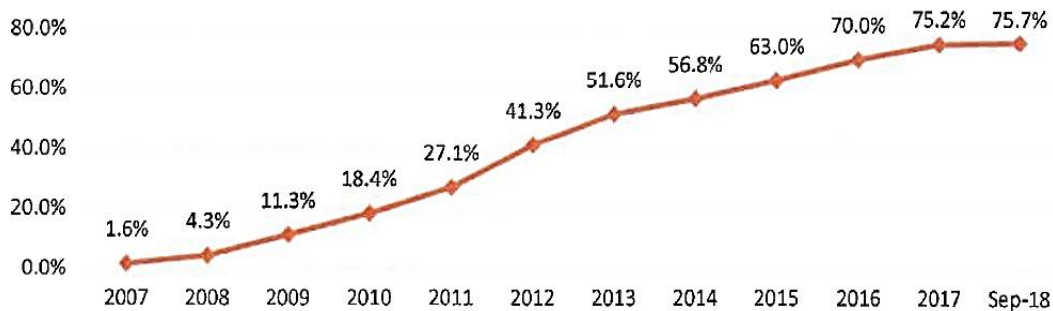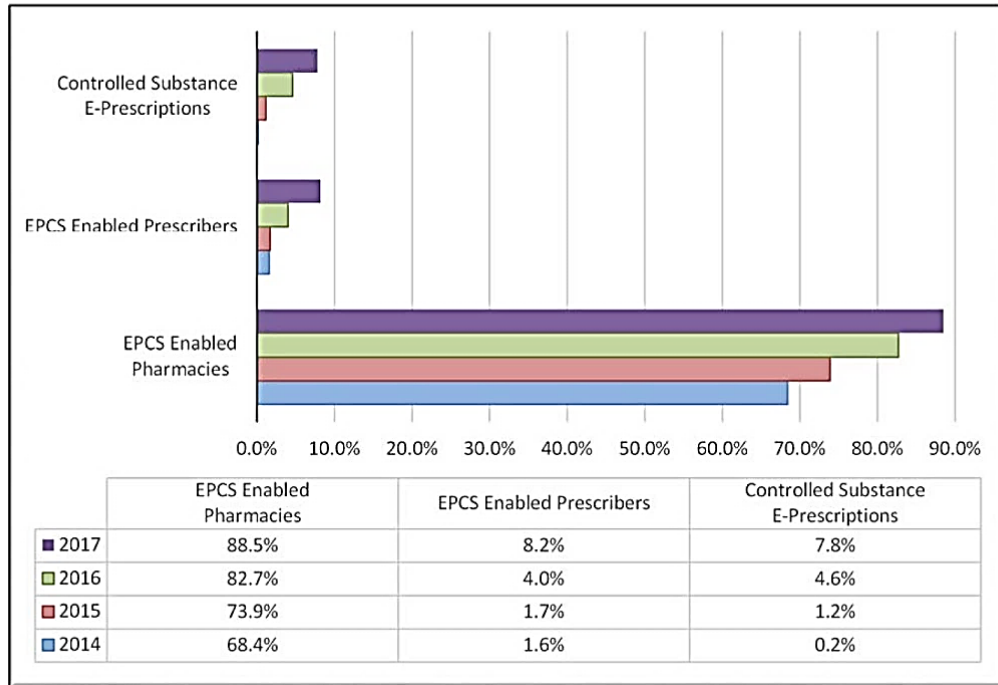

However, Florida prescribers have been slower to adopt e-prescribing for controlled substances.[46] In 2017, only 7.8 percent of controlled substance prescriptions were e-prescribed.

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[45] Id. Electronic prescribing rate is defined as the amount of e-prescribing relative to all prescriptions that could have been e-prescribed.
[46] Agency for Health Care Administration, Florida Center for Health Information and Transparency, "2018 Florida Electronic Prescribing Quarterly Summary," available at http://www.fhin.net/eprescribing/dashboard/docs/2018eprescribemetrics.pdf (last visited March 3, 2019).

Percent of Electronic Prescribing of Controlled Substances (EPCS), EPCS Enabled Pharmacies and EPCS Enabled Providers in Florida[1], 2014 to 2017

	EPCS Enabled Pharmacies	EPCS Enabled Prescribers	Controlled Substance E-Prescriptions
2017	88.5%	8.2%	7.8%
2016	82.7%	4.0%	4.6%
2015	73.9%	1.7%	1.2%
2014	68.4%	1.6%	0.2%

Mandatory 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.[47] 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.[48]

Over the last few years, 15 states have enacted mandatory e-prescribing laws.[49]

State	Effective Date	Applicable Prescriptions
Arizona	January 1, 2019 in large counties; July 1, 2019 in small counties	Schedule II opioids
California	January 1, 2022	All
Connecticut	Currently required	Controlled substances
Iowa	January 1, 2020	All
Maine	Currently required	All controlled substances containing opiates
Massachusetts	January 1, 2020	Schedules II-VI controlled substances
Minnesota	Currently required	All
New Jersey	May 1, 2020	Schedule II controlled substances
New York	Currently required	All
North Carolina	January 1, 2020	Schedule II and III opioids
Oklahoma	January 1, 2020	Controlled substances
Pennsylvania	October 24, 2019	Controlled substances
Rhode Island	January 1, 2020	Controlled substances

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[47] Substance Use-Disorder Prevention that Promotes Opioid Recovery Treatment (SUPPORT) for Patients and Communities Act, Pub. L. No. 115-271 s. 2003 (2018). *See also* U.S. House of Representatives, Energy and Commerce Committee, *HR 6: SUPPORT for Patients and Communities Act*, available at https://energycommerce.house.gov/wp-content/uploads/2018/06/HR6_Summary-of-Provisions_06192018_FINAL.pdf (last visited January 3, 2019).
[48] *Supra* note 27.
[49] DrFirst, *E-Prescribing Mandate Map*, available at https://www.drfirst.com/resources/e-prescribing-mandate-map/ (last visited January 3, 2019), and SureScripts, *Electronic Prescribing for Controlled Substances*, available at https://surescripts.com/enhance-prescribing/e-prescribing/e-prescribing-for-controlled-substances/ (last visited January 3, 2019).

State	Effective Date	Applicable Prescriptions
Tennessee	July 1, 2020	Schedule II controlled substances
Virginia	July 1, 2020	All prescriptions containing opiates

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.[50]

Previously, a major obstacle to e-prescribing was a prohibition by the U.S. Drug Enforcement Administration (DEA) on electronic prescribing of controlled substances. However, in 2010, the DEA adopted a rule that allowed providers to write electronic prescriptions for controlled substances and permitted pharmacies to receive, dispense, and archive these electronic prescriptions.[51] To e-prescribe controlled substances, a health care practitioner must:[52]

- 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.

Effect of Proposed Changes

The bill 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. 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 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 regulates the use of e-prescribing software. The bill does not amend these provisions but simply relocates them.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 456.42, F.S., relating to written prescriptions for medicinal drugs.
Section 2: Amends s. 409.91196, F.S., relating to supplemental rebate agreements; public records, and public meetings exemption.
Section 3: Amends s. 409.912, F.S., relating to cost-effective purchasing of health care.
Section 4: Amends s. 456.0392, F.S., relating to prescription labeling.
Section 5: Amends s. 458.3265, F.S., relating to pain management clinics.
Section 6: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 7: Amends s. 458.347, F.S., relating to physician assistants.
Section 8: Amends s. 459.0137, F.S., relating to pain management clinics.
Section 9: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.

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[50] 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 3, 2019).
[51] Department of Justice, Drug Enforcement Administration, *Electronic Prescriptions for Controlled Substance (EPCS)*, available at https://www.deadiversion.usdoj.gov/ecomm/e_rx/ (last visited December 13, 2018).
[52] *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 December 13, 2018).

Section 10: Amends s. 459.022, F.S., relating to physician assistants.
Section 11: Repeals: s. 456.43, F.S., relating to electronic prescribing for medicinal drugs; s. 831.311, F.S., relating to unlawful sale, manufacture, alteration, delivery, uttering, or possession of counterfeit-resistant prescription blanks for controlled substances; and s. 893.065, F.S., relating to counterfeit-resistant prescription blanks for controlled substances.
Section 3: Provides an effective date of January 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:

Rulemaking authority is not necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 3, 2019, the Health and Human Services committee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Authorized a prescriber to issue a written prescription if electronic prescribing is unavailable due to a technological or electrical failure, and requires that written prescriptions meet the requirements of current law;
- Changed the effective date from January 1, 2020 to January 1, 2021; and
- Made conforming changes.

The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.