Sections 23A and 23B of the Federal Reserve Act.

Prohibition on credit extensions to nonfinancial affiliates.

Change in Control Act restrictions.

Insider lending restrictions.

A ''well-capitalized'' requirement for subsidiary banks.

Civil money penalties, cease-and-desist authority, and similar banking law enforcement provisions applicable to violations of the new statute.

New criminal law penalty provisions for knowing violations of the new statute.

Divestiture requirement applicable to banks within any financial services holding company that fails to satisfy certain safety and soundness standards.

Anti-Tying and Cross-Marketing Provisions. As with the D'Amato-Baker bills, (1) anti-tying restrictions would apply to a financial services holding company as if it were a bank holding company, but (2) the bill would preempt cross-marketing restrictions imposed on financial services holding companies by state law or any other federal law.

Securities Activities. The draft bill includes principal elements of the most recently introduced version of the Leach bill, H.R. 2520, as it relates to Glass-Steagall issues. These include statutory firewall, ''push-out,'' and ''functional regulation'' provisions, with some modifications. These new restrictions would apply only to financial services holding companies; they would not apply to the securities or investment company activities of banks that remained part of bank holding companies.

Wholesale Financial Institutions. Financial services holding companies (but not bank holding companies) could also form uninsured bank subsidiaries called wholesale financial institutions or ''WFIs.'' Unlike the Leach bill, such WFIs could be either state or nationally chartered, and there would be no restrictions on the ability of a WFI to affiliate with an insured bank. A WFI would not be subject to the statutory securities firewalls applicable to insured banks and their securities affiliates, but the WFI could not be used to evade such statutory firewalls.

2. ELIMINATION OF THRIFT CHARTER

With the new financial services holding company structure in place, the thrift charter would be eliminated; thrifts would generally be required to convert to banks, with grandfathering/transition provisions; and unitary thrift holding companies would be required to convert to either bank holding companies or financial services holding companies, also with grandfathering/transition provisions. The statutory language for the charter conversion is the same as the language included in the last version of the Roukema bill, which is the one that was used in the House's offer in the Budget Reconciliation conference in late 1995.

3. NATIONAL MARKET FUNDED LENDING INSTITUTIONS

Unlike the D'Amato-Baker bills, the draft bill generally precludes a commercial firm from owning an insured depository institution. However, the bill recognizes the important role that nonfinancial companies play in other aspects of the financial services industry by allowing such companies to own ''national market funded lending institutions.'' This new kind of OCC-regulated institution would have national bank lending powers, but would have no access to the federal safety net: it could not take deposits or receive federal deposit insurance, and it would have no bank-like access to the payments system or the Federal Reserve's discount window. In addition, the institution could not use the term ''bank'' in its name. By owning a national market funded lending institution, a nonfinancial company could provide all types of credit throughout the country using uniform lending rates and terms.

4. EFFECTIVE DATE

The bill's provisions would generally become effective on January 1, 1997.

STRUCTURE OF DRAFT BILL

Title I. This title creates a new freestanding banking law called the ''Financial Services Holding Company Act.''

Subtitle A is the modified D'Amato/Baker bill (H.R. 814), which provides companies the option of becoming ''financial services holding companies.'' Only ''predominantly financial companies'' may be financial services holding companies. The holding company oversight provisions reflect the unitary thrift holding company model and consistent aspects of ''Fed lite'' from H.R. 2520, the most recent Glass Steagall bill introduced by Chairman Leach. Companies that choose not to become financial services holding companies remain subject to existing law, subject to Title II's limits on affiliations between banks and securities companies.

Subtitle B includes H.R. 2520's statutory firewall and baking law ''push-out'' provisions, with some modifications. These apply to companies that choose to become financial services holding companies.

Subtitle C includes H.R. 814's requirement that any company that enters the insurance agency business must do so by acquiring an existing insurance agency that has been in business for at least two years.

Title II. This title includes conforming amendments to other laws for financial services holding companies (taken from H.R. 814 and H.R. 2520). It also includes a modified version of H.R. 2520's FDI Act provision limiting affiliations between banks and securities companies.

Title III. This title includes H.R. 2520's ''functional regulation/push-out'' amendments to the securities laws, with some modifications. It applies only to financial services holding companies.

Title IV. This title includes H.R. 2520's ''wholesale financial institution'' provisions for state member banks. It adds a parallel provision for national banks. Only financial services holding companies may own WFIs. Unlike H.R. 2520, WFIs may affiliate with insured banks. The principal benefit of the WFI is that it is not subject to statutory securities firewalls.

Title V. This title is the most recent version of Rep. Roukema's Thrift Charter Conversion Act (taken from the House offer in the 1995 reconciliation conference).

Title VI. This title authorizes formation of ''national market funded lending institutions.'' These OCC-regulated institutions may not call themselves ''banks.'' take deposits, or receive federal deposit insurance. They also may not have access to the discount window or the payments system. They do have national bank lending powers, which allows them to lend at uniform rates throughout the country. Because they have no access to the federal safety net, any commercial firm may own a national market funded lending institution without being treated as a bank holding company or the new financial services holding company.

Title VII. The bill's general effective date is January 1, 1997.

MEDICARE AND OUTPATIENT INFECTIOUS DISEASES THERAPY: LEGISLATION TO PROVIDE A COST-SAVING BENEFIT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. STARK. Mr. Speaker, Medicare could save money and benefit patients by facilitating certain cost-effective outpatient treatments in place of inpatient treatment. As the body of medical knowledge grows about what diseases can be safely and effectively treated at home, Medicare's policies need to be updated to capture the cost savings. A crucial area where Medicare policy lags relates to infections and treatment. After years of study by health experts, it is well-established that outpatient intravenous antibiotic therapy for certain infectious can be a cost-effective alternative to prolonged hospitalization. Although only a subset of patients are medically appropriate candidates for outpatient therapy, significant cost savings may accrue. The bill I am introducing today provides a benefit for outpatient parenteral antimicrobial therapy while ensuring that Medicare capture the savings from use of this outpatient rather than inpatient rather than inpatient treatment.

Certain infections require prolonged antimicrobial therapy. These include endocarditis, an infection of the heart valves, osteomyelitis, an infection of bones, infections involving certain prosthetic devices such as prosthetic joints, and certain abscesses such as those of liver, lung, or brain. Patients with these diseases often require intravenous antibiotic therapy for 4 to 6 weeks and sometimes longer. Intravenous therapy can produce much higher and more constant blood levels of an antibiotic than oral therapy and is used for serious infections. Certain viral and fungal infections also require prolonged antimicrobial therapy.

After initial hospitalization and stabilization of their condition, many patients would be well enough to be discharged from the hospital except for the need for continued intravenous therapy. For these patients, outpatient antibiotic therapy would be beneficial and cost-effective. Unfortunately, many patients must currently remain in the hospital because Medicare does not cover the outpatient treatment. Medicare loses because it may have to pay the hospital an outlier payment in addition to the usual diagnosis-related group [DRG] payment; the outlier payment is an extra amount to help cover the patient's longer than average stay. Alternatively, the hospital may try to save costs by transferring the patient to an extended care facility to complete treatment. Again Medicare loses, because it pays for the treatment at the receiving facility in addition to the DRG payment it makes to the hospital. If Medicare covered the outpatient treatment, it could avoid these extra inpatient payments. In addition, Medicare's DRG payments for these diseases could potentially be reduced as the average inpatient cost for the conditions decreases.

Not all patients are medically appropriate candidates for outpatient antimicrobial therapy. However, for those that are, outpatient therapy avoids the restrictive environment of a hospital and decreases the patient's risk for hospital-

acquired infections. Studies have documented that the longer a patient remains in the hospital the greater the chance of developing a new infection due to an organism acquired in the hospital; this results in increased morbidity and mortality, longer hospital stays, and additional costs. Another benefit of outpatient therapy is that patients who are ambulatory and active can often resume work or other regular activities during the period of their treatment.

Several models are used for the administration of outpatient parenteral antimicrobial therapy. These include, first, the therapy can be administered in a physician's office or hospital treatment room to a patient who commutes to the site daily. This type of outpatient treatment is already covered by Medicare because the drugs are administered incident to a physician's services. Second, the therapy can be administered in a patient's home by a health professional who visits daily. Third, the therapy can be self-administered by the patient after appropriate training and with appropriate backup and support services. Fourth, the therapy can be administered via a programmable infusion pump in a patient's home or other location since some pumps are small and portable. Pumps can be set up to run for a few days by a health professional and require little manipulation by patients. They can be used with a variety of antimicrobials, including ones with frequent dosing schedules which otherwise could not be feasibly administered in the outpatient setting.

Some infectious disease specialists treat a variety of infections with outpatient intravenous antimicrobial therapy in addition to the ones I mentioned earlier. These include certain skin and soft tissue infections, kidney infections, and pneumonia. I invite medical experts to help us define the optimal list of diseases for which outpatient parenteral therapy is a safe, effective, and cost-effective alternative to inpatient treatment. Because Medicare savings may be more readily identified with some disease categories than others, I encourage development of a list for which the savings are clear.

The bill I am introducing today establishes a benefit for outpatient parenteral antimicrobial drugs, when the outpatient treatment is used in place of continued inpatient treatment. Reimbursement for drugs will be on the basis of actual costs plus an appropriate administration fee. The bill recognizes that certain supplies, equipment, and professional services are a necessary part of appropriate outpatient treatment. It directs the Secretary of Health and Human Services to determine the savings that can be obtained by providing this outpatient benefit which facilitates reduced inpatient payments. The diseases for which inpatient payments can be reduced if outpatient benefits are provided will be determined by reviewing all infectious disease DRG's.

The bill also calls for repeal of coverage for antimicrobial drugs under the durable medical equipment [DME] clause, and provision of the coverage under the new outpatient parenteral therapy benefit. The DME benefit currently covers three antiviral drugs, one antifungal drug, and one anti-bacterial drug called vancomycin. As I have described previously in introducing another bill addressing vancomycin policy, Medicare's coverage of this single antibacterial drug among more than 50 available antibacterials is causing inappropriate overuse of this drug. This is contributing to a public health problem of vancomycin resistant bacteria. Incorporating these five antimicrobials into the new outpatient parenteral therapy benefit will provide a more rational policy that can avoid the pitfalls of the current system. Coverage for infusion pumps used to administer these and other antimicrobials covered by the outpatient parenteral therapy benefit will be provided under the DME benefit.

This bill focuses on disease categories rather than specific antimicrobials. As evident from the vancomycin issue, the naming of specific antimicrobials can cause changes in physicians' prescribing practices resulting in overuse of the named drugs. The naming of antimicrobials poses a different risk than for other classes of drugs and should be avoided; if we guess wrong about which antimicrobials should be named in a law, the result is not merely lack of coverage for the unnamed drugs, but also a potential public health problem of increased drug resistance. The legislative process cannot respond fast enough to change the list of drugs each time a problem occurs. Focusing on disease categories, rather than naming specific drugs, avoids this special risk. Also, this strategy helps to ensure Medicare savings by clearly identifying the DRG's, outliers, and extended care categories for which reduced inpatient payments may be feasible. This bill provides the mechanism to update Medicare's policies and capture cost-savings as healthcare shifts from the inpatient to the outpatient arena.

CONFERENCE REPORT ON H.R. 3666, DEPARTMENTS OF VETERANS AFFAIRS AND HOUSING AND URBAN DEVELOPMENT, AND INDEPENDENT AGENCIES APPROPRIATIONS ACT, 1997

SPEECH OF

HON. BILL ORTON

OF UTAH

IN THE HOUSE OF REPRESENTATIVES

Tuesday, September 24, 1996

Mr. ORTON. Mr. Speaker, with the passage of the VA/HUD appropriations bill in the House and Senate and expected approval by the President, I am very pleased to note the enactment into law of important FHA reforms, which will improve and enhance the program.

The first reform is the elimination of the current prohibition against parental loans in conjunction with FHA mortgages. In spite of the fact that parental financial assistance plays an important role in meeting down payment requirements and promoting homeownership, current FHA rules do not permit parents to lend money to their children for this purpose. This prohibition is antihomeownership and antifamily. I am pleased to see Congress adopt my proposal and allow parental loans, on either a secured or unsecured basis, for this purpose.

The second reform would allow direct endorsement lenders to issue their own mortgage certificates. This will lower costs for lenders and for FHA which can be passed along to borrowers in the form of lower premiums and lower loan costs. Since direct endorsement lenders are already given underwriting authority, this change will not negatively affect the quality of loans approved. This proposal was adopted 2 years ago in the House, and was included in my FHA reform bill introduced at the beginning of this Congress.

The third reform is the establishment of an FHA down payment simplification proposal on a demonstration basis in Alaska and Hawaii. This proposal is based on my down payment proposal which was adopted in the Banking Committee in 1994. Virtually everyone who uses FHA acknowledges that the current down payment calculation is unnessarily complex. This proposal would greatly simplify the process for borrowers, lenders, and realtors.

I am disappointed that the Senate prevailed over the House on this issue, scaling back nationwide application to a demonstration project. However, I am pleased that Congress has finally acknowledged that we ought to take action on this issue. My hope is that next year, we can expand this demonstration status to the entire Nation and make it permanent.

And, I would like to acknowledge the efforts and leadership of Representative WELLER's amendment to codify the lowering of the FHA premium from 2.25 percent to 2 percent for first-time home buyers who receive homeownership counseling. This continues a trend over the last 4 years of lowering FHA premiums, as a result of lowered FHA loss rates and reductions in administrative costs.

These legislative changes represent a great achievement, in light of the fact that it now appears that no comprehensive housing legislation will be enacted this Congress.

The passage of these provisions is especially noteworthy, in light of the great number of House Members who are opposed to FHA. Early last year, legislation was introduced which would have effectively eliminated FHA. This legislation was supported by 60 House Members including many in leadership positions, such as Majority Leader DICK ARMEY and Majority Whip TOM DELAY. A companion bill was introduced in the Senate.

Not only were FHA proponents able to repel this effort to destroy FHA, but we were able to improve the program through much-needed reforms. These reforms are critically important in my home State of Utah and throughout the country. A recent Fannie Mae study cited the required downpayment as the No. 1 impediment to home ownership in this country. FHA, with its low downpayment provisions, is the most effective and widely available mortgage tool used to help young families and individuals overcome that downpayment hurdle. And, it does so at no cost to the taxpayer.

In fact, a recent GAO study showed that 77 percent of first-time home buyers who used FHA loans in 1995 would not have qualified for a loan without FHA. In my home State of Utah, 68 percent of first-time home buyers use FHA. Thus, in Utah, over half of first-time home buyers would not be able to enter the housing market without FHA.

These statistics clearly show the folly of proposals to end or privatize FHA. They also show how critical it is to continue to improve and modernize the program.

Therefore, it is my hope that next year, we can finish the job we started back in the 103d Congress. Specifically, we should extend the demonstration downpayment simplification proposal to nationwide status, raise the national FHA loan floor to 50 percent of the Fannie Mae/Freddie Mac limit, allow the use of two-step mortgages, and eliminate the outdated 90 percent loan-to-value limitation on new construction.