ability to write a post-dated check. Since they are borrowing against their next paychecks, and the debt is due all at once in a lump sum, a large percentage of borrowers can't repay the debt and end up having to roll over the debt again and again, paying exorbitant fees and interest costs for the same borrowed funds.

The cost of a typical payday loan is $15 to $17.50 for each $100 advanced over a two-week period. This translates into comparable annual percentage rates (APR) of 390% to 465% for a two-week loan. If the loan is extended over multiple two-week periods, the finance costs rapidly escalate, often exceeded 2000%. The Illinois Department of Financial Institutions reported last year that the typical payday customer ''remains a customer for at least 6 months,'' averaging over 11 loan extensions. Indiana financial regulators found that only 9% of payday loans are not rolled over and that the average customer typically had ten loan renewals.

U.S. PIRG recently calculated the cost of borrowing $200 from three widely available credit sources: a cash advance on a high-rate credit card, a loan under a typical state small loan interest cap of 35% and a typical payday loan. Over the period of a single month, the total charges for a payday loan, at $70, were 8 times higher than the nearest alternative, $8.41 for the credit card advance. Over three months, charges for the payday loan, at $210, were nearly 18 times higher than the closest alternative, the $12.10 paid for the high rate small loan.

Unfortunately, an accurate assessment of these costs is rarely provided to payday loan customers. The Truth in Lending Act (TILA) requires creditors to provide customers with complete and accurate estimates of credit costs, including comparable APR figures that permit comparison with other credit alternatives. Congress intended that TILA disclosure requirements apply very broadly to all forms of credit, including short-term payday loans. The fact that payday lenders continue to resist making accurate cost disclosures, with repeated unsuccessful challenges of TILA's application in court, indicates to me that their intent of deceiving people into borrowing at rates far higher than necessary and far higher than most can afford.

The fact that payday lenders can threaten to cash a borrower's check, or even threaten criminal prosecution for intentional writing of a bad check, leaves borrowers with few options but to roll over the debt or default on other debts to pay off the payday loan. Because payday loans by definition leave the borrower unable to repay all their debts, the use of postdated checks becomes an effective tool in forcing borrowers to pay the payday lender first. Industry sources openly acknowledge that ''the potential for future (bad check) charges and/or loss of check-writing privileges'' clearly motivates borrowers to pay off payday loans first, while defaulting on other obligations.

Unfortunately, most payday lenders are not federally regulated entities, and regulation of small loan interest rates has traditionally fallen within State jurisdiction. A large number of states, including my home state of New York, have in place small loan rate caps, usury ceiling or other restrictions to prohibit payday loans or limit their worst abuses. But these states are now under significant pressure from the rapidly expanding payday lending industry. In 19 states, the payday loan industry has carved out special exemptions from state interest caps or enacted specific payday loan ''regulatory'' statutes that are written to benefit the industry, not consumers.

In states where the industry's lobbying tactics have failed, payday lenders either try to disguise these transactions, calling them service fees or sale-leaseback transactions, or they have set up special arrangements to conduct payday lending as affiliates or agents of nationally chartered banks and thrifts. This permits a payday lender to, essentially, ''lease'' the federal preemption authority accorded national banks by the Supreme Court's 1978 Marquette decision in order to circumvent otherwise applicable state interest rate restrictions.

The recent entry of insured national banks into payday lending is extremely troubling to me. I do not think institutions that benefit from a public charter, access to the federal payment system and federal deposit insurance should engage in lending that does not properly assess borrowers' ability to repay, that encourages writing of bad checks on accounts with other institutions, that seeks to trap borrowers in perpetual debt, that encourages default on obligations with other lenders, or that facilitates violations of state lending law. These are unacceptable activities for insured federal institutions that threaten the safety and soundness not only of the institution, but the entire banking system. Moreover, federal institutions have an obligation under the Community Reinvestment Act to serve all consumers in their surrounding community, not seek to exploit the most disadvantaged.

I believe Congress has a two-fold responsibility in this area. First, we must continue to address the inadequacies of the financial marketplace that fuel the growth of payday lending and other abusive practices. We have helped to make credit union services available to more people in financially underserved communities in the 1998 Credit Union Membership Access Act. The Treasury Department has recently implemented a Congressional mandate to make low-cost electronic transfer accounts available to all unbanked federal beneficiaries. And President Clinton has requested funding to implement new initiatives to make affordable ''first account'' banking services available to low-income households.

Second, we need to act decisively to restrict the abusive practices of payday lenders. At a minimum, we must keep federally regulated and insured institutions out of the business of payday lending, both to promote safe and sound banking practices and to eliminate the national bank ''loophole'' that permits payday lenders to circumvent state lending laws. But we need to much more—we must end the ''indirect'' involvement of insured institutions in payday lending by the fact that checks and other withdrawal on their accounts are being used by others as the basis for making and enforcing payday loan transaction. We also must make explicitly clear the fact that Truth in Lending Act disclosures and protections apply, and have always applied, to all payday loans.

The legislation I am introducing today will make four important changes in current law with regard to payday loans. First, it prohibits all federally insured banks and thrifts from engaging directly, or indirectly through other lenders, in any form of payday lending. Second, it makes explicit Congress' intent that Truth in Lending Act protections apply to payday loan transactions, by specifically listing payday loans within TILA's definition of credit and providing a uniform federal definition of what constitutes a payday loan to eliminate future ambiguity.

Third, it amends current law to prohibit uninsured lenders from making any payday loan using a personal check or other written or electronic debit authorization on an account with an insured institution. Finally, the bill increases civil penalties under the Truth in Lending Act to provide a stronger deterrent to discourage abusive practices.

Mr. Speaker, Congress has spent a great deal of time in recent years creating a new, more flexible financial services structure that permits financial institutions to take full advantage of evolving technologies and changing market opportunities. Our challenge in future years will be to assure the benefits of these new structure will be equally available in all communities and to all consumers. I consider the ''Federal Payday Loan Consumer Protection Amendments of 2000'' a first step toward meeting this challenge. I urge its prompt consideration and adoption.

INTRODUCTION OF THE GLOBAL HEALTH ACT OF 2000

HON. JOSEPH CROWLEY

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Thursday, March 2, 2000

Mr. CROWLEY. Mr. Speaker, today I am introducing legislation to address an issue that is receiving much needed attention by the international community and the U.S. government. That issue is global health.

In August of 1999, my constituents were shocked to learn that an outbreak of West Nile-Like Encephalitis had surfaced for the first time in the Western hemisphere in the heart of my district in Queens and the Bronx.

This outbreak was a wake up call for every American. It illustrates that the global community has truly become the local community. As demonstrated by West Nile-Like Encephalitis, HIV/AIDS and tuberculosis, a disease respects no borders. An outbreak in Africa, Europe, Asia or South America can travel to U.S. shores within days.

No longer can diseases occurring in far off lands be ignored. They pose a direct threat to the national security of our great country and must be addressed by the U.S. government, this Congress and the international community as a whole. Diseases can not be seized by Customs and they do not apply at the U.S. Embassy for a visa. The only way to stop them is to target them at the source.

To address this growing danger, I have been joined by 22 of my colleagues in introducing bipartisan legislation to increase the U.S. commitment to global health by one billion dollars over Fiscal Year 2000 appropriated levels. With these additional funds, our commitment to global health will be authorized at 2.19 billion dollars.

Mr. Speaker, I would like to thank the cosponsors of the Global Health Act of 2000, Representatives CONNIE MORELLA, NANCY PELOSI, AMO HOUGHTON, NITA LOWEY, JIM

GREENWOOD, BERNIE SANDERS, CHARLIE RANGEL, CARRIE MEEK, LOUISE MCINTOSH SLAUGHTER, BOBBY RUSH, MAURICE HINCHEY, WILLIAM DELAHUNT, TONY HALL, CAROLYN MALONEY, ROSA DELAURO, SHERROD BROWN, LYNN WOOLSEY, BARNEY FRANK, ROBERT WEXLER, SHEILA JACKSON-LEE, JIM MCGOVERN, and JIM MCDERMOTT. These cosponsors represent a broad cross section of the House; Democrats and Republicans, members of the Women's Caucus, the Progressive Caucus, the Black Caucus, Appropriators and Authorizers, who have recognized the need and importance of an increased commitment to global health. I ask that a copy of the Global Health Act be printed in RECORD following my remarks.

The cosponsors of the Global Health Act have realized that an investment in global health today will benefit the health of our own citizens and be highly cost effective. They realize, Mr. Speaker, that its pay now, or pay dearly later.

We are joined in this effort by over 100 national organizations committed to global health, such as the Global Health Council, Save the Children, the Salvation Army World Services and the Global AIDS Action Network, and the list is growing every day.

Mr. Speaker, I have included a broad list of health organizations, faith based groups and development NGO's that support this legislation and ask that it be entered into the record.

Mr. Speaker, you may ask, what does the Global Health Act do?

The Global Health Act provides an additional $475 million to prevent, control and combat infectious diseases such as HIV/AIDS and malaria. It authorizes an additional $325 million in critical funding to help child and family survival through nutrition and health advice for pregnant women and mothers, along with programs for child survival and infant care, such as immunizations.

Finally, the GHA includes key funding provisions to increase the U.S. commitment to international family planning by authorizing an additional $200 million for programs such as contraceptive use, spacing of children and proper care and nutrition during pregnancy.

According to a 1993 World Bank report, a basic health care package can be delivered to developing nations at a low cost of $13–$15 per person annually. This figure includes all immunizations, curative health care for children and adults, particularly cures for infectious diseases, reproductive health needs, education and treatment of sexually transmitted diseases. In other words, basic health services can be provided to the 2 billion people currently living in poverty at a cost $30 billion each year.

In this context, an investment of an additional $1 billion of global health by the United States—the world's richest nation—is a sound investment. The United States can serve as a catalyst to increase the commitment of other donor nations, foundations, and corporations to increase their contributions to further global health.

Mr. Speaker, make no mistake, this funding is urgently needed.

Over 10 million children under the age of five die each year in developing nations from preventable causes.

More than 150 million married women in developing nations still want to space or limit childbearing, but do not have access to modern contraceptives.

Nearly 600,000 women die each year from complications of pregnancy and childbirth, and another 18 million women suffer pregnancy-related health programs that can be permanently disabling.

Thirteen million people die annually from infectious diseases, most of which are preventable or curable.

HIV/AIDS has become the world's leading infectious disease threat with over 16,000 new infections daily of which 7,000 of these are young people between the ages 10–24.

The 21st century faces an estimated 33.5 million people around the world who are infected with HIV/AIDS. The spread of HIV/AIDS can be prevented with an urgent and necessary investment. We must stand at the forefront of tackling this disease, in order to secure the health and prosperity of our future generations.

Currently, India is the epicenter for HIV/AIDS as it leads the world in newly infected people. Last year, the continent of Africa experienced the death of over 2 million people, which is equivalent of four funerals per minute.

We can and must do better.

Mr. Speaker, I am pleased to say that the President, in his Fiscal Year 2001 budget request, has asked for additional funding for family planning and HIV/AIDS. Unfortunately, child survival's funding remained level, and maternal health had no request at all.

I am encouraged, however, by the Administration's statements on the U.S., commitment to global health. In his State of the Union address, the President called for a concerted international action to combat infectious diseases in developing countries. Vice President Gore recently told the UN Security Council that the Administration's FY 2001 budget will include a proposed $50 million contribution to the vaccine purchase fund of the Global Alliance for Vaccines and Immunization. This week, appearing before the UN Economic and Social Council, Ambassador Holbrooke, along with other members of the Security Council, reported on the increased security concerns of HIV/AIDS and other infectious diseases.

Mr. Speaker, the time to turn these words into actions is now and I believe the Global Health Act provides the means.

Although other legislative proposals target specific diseases and seek to create new programs to help promote global health, the Global Health Act of 2000 represents a comprehensive, balanced approach that builds upon proven, existing programs.

For example, the Global Health Act of 2000 would provide a total of $500 million for the prevention, care, and treatment of HIV/AIDS in FY 2001 through existing programs. This legislation uniquely addresses the issue of health infrastructure—allowing for vaccines, drugs, and medical devices to be delivered to those who need them most.

Additionally, the legislation emphasizes the interconnectedness of global health by calling for increased funding for child survival, woman's health and nutrition, reducing unintended pregnancies, and combating the spread of other infectious diseases. It also calls for increased coordination between the different government agencies administering health programs.

With the resources provided under the Global Health Act and the assistance of other nations, we can make a profound difference in the health and well-being of millions of the world's poorest citizens and protect our own national security as well.

Mr. Speaker, I urge my colleagues to support this important legislation.

H.R. —

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Global Health Act of 2000''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) More than 10,000,000 children under 5 years of age die each year in developing nations from preventable causes, and more than ½ of these deaths are due to 5 conditions; pneumonia, diarrhea, malaria, malnutrition, and measles.

(2) Despite progress in making family planning services available, more than 150,000,000 married women in developing nations will still want to space or limit child bearing, but do not have access to modern contraceptives.

(3) According to the World Health Organization, nearly 600,000 women die each year from complications of pregnancy and childbirth, and another 18,000,000 women suffer pregnancy-related health problems that can be permanently disabling.

(4) According to the World Health Organization, 13,000,000 people die annually from infectious diseases, most of which are preventable or curable, and 6 diseases account for 90 percent of these deaths; pneumonia, diarrhea diseases, measles, tuberculosis, malaria, and HIV/AIDS.

(5) HIV/AIDS has become the world's leading infectious disease threat, with 34,000,000 people infected worldwide, and more than 16,000 new infectious daily, of which 7,000 cases occur in people between the ages of 10 and 24.

SEC. 3. ASSISTANCE TO IMPROVE GLOBAL HEALTH.

(a) EMPHASIS ON DISEASE SURVEILLANCE AND PREVENTION AND RESPONSE TO DISEASE OUTBREAKS.— Section 104(c) of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b(c)) is amended by adding at the end the following:

''(4) Congress recognizes the growing threat that infectious diseases and other global health problems pose to Americans and people everywhere. Accordingly, activities supported under this subsection shall include activities to improve the capacity of developing nations to conduct disease surveillance and prevention programs and to respond promptly and effectively to disease outbreaks.''.

(b) INCREASE IN FY 2001 USAID ASSISTANCE.—

(1) AUTHORIZATION OF APPROPRIATIONS.— To carry out the purposes of section 104 of the Foreign Assistance Act of 1961 (22 U.S.C. 2151b) for fiscal year 2001, there is authorized to be appropriated, in addition to funds otherwise available for such purposes, the following amounts for the following purposes:

(A) The amount equal to the aggregate of amounts made available for fiscal year 2000 to carry out that section with respect to the health and survival of children, the health and nutrition of pregnant women and mothers, voluntary family planning, combating HIV/AIDS, and the prevention and control of infectious diseases other than HIV/AIDS, to be used for such purposes of fiscal year 2001.

(B) $1,000,000,000, to be available in accordance with paragraph (2).

(2) ALLOCATION OF FUNDS.— Of the amount authorized to be appropriated in paragraph (1)(B)—

(A) $225,000,000 should be available for the health and survival of children;

(B) $100,000,00 should be available for the health and nutrition of pregnant women and mothers;

(C) $200,000,000 should be available for voluntary family planning;

(D) $275,000,000 should be available for combating HIV/AIDS; and

(E) $200,000,000 should be available for the prevention and control of infectious diseases other than HIV/AIDS.

(3) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to paragraph (1) are authorized to remain available until expended.

(c) COORDINATION AMONG FEDERAL DEPARTMENTS AND AGENCIES.— It is the sense of Congress that the President, acting through the Administrator of the United States Agency for International Development, should coordinate with the Centers for Disease Control and Prevention, the National Institutes of Health, the Department of State, the Department of Health and Human Services, the Department of Defense, and other appropriate Federal departments and agencies to ensure that United States funds made available for the purposes described in paragraph (1) are utilized effectively.

GLOBAL HEALTH ACT SUPPORTERS AS OF 2–29–00

1. Abt Associates, Inc., Bethesda, MD
2. Advocates for Youth, Washington, DC
3. AIDS Treatment News, San Francisco, CA
4. AIDS Vaccine Advocacy Coalition, Washington, DC
5. Alan Guttmacher Institute, Washington, DC
6. Alliance Lanka, Sri Lanka
7. American Association for World Health, Washington, DC
8. American Association of Dental Schools, Washington, DC
9. American Association of University Women, Washington, DC
10. American International Health Alliance, Washington, DC
11. American Medical Women's Association, Washington, DC
12. American Public Health Association, Washington, DC
13. American Public Health Laboratories, Washington, DC
14. American Society of Tropical Medicine and Hygiene, Washington, DC
15. Asia Pacific Network of People Living with HIV/AIDS, Singapore
16. Asian & Pacific Islander Wellness Center, San Francisco, CA
17. Association for Professionals in Infection Control and Epidemiology, Washington, DC
18. Association of Academic Health Centers, Washington, DC
19. Association of Reproductive Health Professionals, Washington, DC
20. Association of Schools of Public Health, Washington, DC
21. AVSC International, New York, NY
22. Catholics for Free Choice, Washington, DC
23. Center for Health and Gender Equity (CHANGE), Takoma Park, MD
24. Center for Reproductive Law and Policy, New York, NY
25. Centre for Development and Population Activities, Washington, DC
26. Child Health and Development Centre, Uganda
27. Childreach, US Member of PLAN International, Warwick, RI
28. CIDA–AIDS Project, Ghana
29. Community Working Group on Health—Training and Research Support Centre, Zimbabwe
30. Concern America, Santa Ana, CA
31. CONRAD Program, Arlington, VA
32. Department of Pediatrics & Child Health, Faculty of Medicine, University of Natal, South Africa
33. Dutch AIDS Coordination Bureau, The Netherlands
34. Eighteenth International AIDS Conference, Durban, South Africa
35. Esperanca, Phoenix, AZ
36. Family Health International, Research Triangle Park, NC
37. Female Health Company, Chicago, IL
38. Female Health Foundation, Chicago, IL
39. Fighting Drug Abuse in Kenya
40. Foundation for Compassionate America Samaritans, Cincinnati, OH
41. Francois-Xavier Bagnoud US Foundation, New York, NY
42. Freedom from Hunger, Davis, CA
43. Global AIDS Action Network, Washington, DC
44. Global Alliance for Africa, Chicago, IL
45. Global Health Connection, Columbus, OH
46. Global Health Council Washington, DC
47. Global Network of People Living with HIV/AIDS, The Netherlands
48. Heartland Alliance for Human Needs & Human Rights, Chicago, IL
49. Helen Keller Worldwide, New York, NY
50. Human Rights Campaign, Washington, DC
51. Humanitas Foundation, Chicago, IL
52. Institucion Internacional Para la Salud y el Desarrollo (ISDAE), Spain
53. Instituto Nacional de Salud Publica, Cuernavaca, Mexico
54. International Association of Physicians in AIDS Care, Chicago, IL
55. International Center for Research on Women, Washington, DC
56. International Community of Women Living with HIV/AIDS (ICW), United Kingdom
57. International Council of AIDS Service Organizations (ICASO)
58. International Eye Foundation, Bethesda, MD
59. International Women's Health Coalition, New York, NY
60. John Snow, Inc., Boston, MA
61. Just Like Me Program, Orlando, FL
62. Loma Linda University, School of Public Health, Loma Linda, CA
63. Management Sciences for Health, Boston, MA
64. Medical Service Corporation International, Arlington, VA
65. Migrant Clinicians Network, Austin, TX
66. Minnesota International Health Volunteers, Minneapolis, MN
67. Multidisciplinary African Women's Health Network (MAWHN), Ghana
68. National Abortion and Reproductive Rights League, Washington, DC
69. National AIDS Fund, Washington, DC
70. National Center for Health Education, New York, NY
71. National Family Planning and Reproductive Health Association, Washington, DC
72. National Latina/o Lesbian, Gay, Bisexual & Transgender Organization, Washington, DC
73. National Minority AIDS Council, Washington, DC
74. Pacific Institute for Women's Health, Los Angeles, CA
75. Pathfinder International, Watertown, MA
76. Pearl S. Buck International, Perkasie, PA
77. Physicians for Social responsibility, Washington, DC
78. Planned Parenthood Federation of America, Washington, DC
79. Population Action International, Washington, DC
80. Population Institute, Washington, DC
81. Positive Life in Delhi, India
82. Program for Appropriate Technology in Health, Seattle, WA
83. Project Concern International, San Diego, CA
84. Project HOPE, Millwood, VA
85. Project Inform, San Francisco, CA
86. Project Troubador, Salisbury, CT
87. Salvation Army World Services, Arlington, VA
88. SatelLife, Watertown, MA
89. Save the Children Federation, Westport, CT
90. Shrada Dhanvantari Charitable Hospital, India
91. Southern Colorado AIDS Project, Colorado Springs, CO
92. Strategies for Hope, United Kingdom
93. Sub-Saharan Relief Fund, Washington, DC
94. Swiss Red Cross, Ghana
95. Thailand Business Coalition on AIDS
96. The Microbicides Alliance, Arlington, VA
97. The Seraphim foundation, Arlington, VA
98. Uganda Youth Anti-AIDS Association
99. The United Methodist Church—General Board of Church and Society, Washington, DC
100. University of Michigan Population Fellows Program, Ann Arbor, MI
101. U.S. Committee for UNFPA, New York, NY
102. U.S. Fund for UNICEF, New York, NY
103. VISIONS Worldwide, Boston, MA
104. Women's Health Institute, Boston, MA
105. World Neighbors, Oklahoma City, OK
106. Zero Population Growth, Washington, DC

HOUSE OF REPRESENTATIVES

March 1, 2000.

Pursuant to Clause 4 of the rule XXII of the rules of the House of Representatives, the following sponsors are hereby added to the Global Health Act of 2000.

Constance A. Morella, Nancy Pelosi, Amo Houghton, Nita M. Lowey, James C. Greenwood, Bernard Sanders, Charles B. Rangel, Carrie P. Meek, Louise McIntosh Slaughter, Bobby L. Rush, Maurice D. Hinchey, William D. Delahunt, Tony P. Hall, Carolyn B. Maloney, Rosa L. DeLauro, Sherrod Brown, Lynn C. Woolsey, Borney Frank, Robert Wexler, Sheila Jackson Lee, Jim McDermott, and James P. McGovern