again in 2000. The measure passed the House by overwhelming votes.

On June 28, 2000, almost 3 months after the House last voted on the partial-birth abortion ban, the Supreme Court struck down a Nebraska ban on partial-birth abortions in the Stenberg case. And so once again we are here to stand and to fight against this violent and crude procedure.

The Congress' last attempt to ban partial-birth abortions failed, but we must continue to do everything we can to save innocent lives. So many of us here in the House and the Senate and all across America want to see this legislation passed into law, not to trample on the rights of any individual as some would say. We want this legislation to pass to become law simply to protect the lives of the innocent.

This afternoon I would urge my colleagues to join with me in cosponsoring this important piece of legislation that will save the lives of many, many and let our common goal be to protect the lives of mothers and infants.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. QUINN). Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote is objected to under clause 6 of rule XX.

Record votes may be taken in two groups, the first occurring after debate has concluded on H.R. 4679, and the second after debate has concluded on the remaining motions to suspend the rules.

IMPROVING ACCESS TO PHYSICIANS IN MEDICALLY UNDERSERVED AREAS

Mr. SENSENBRENNER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4858) to improve access to physicians in medically underserved areas.

The Clerk read as follows:

H.R. 4858

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

SECTION 1. WAIVER OF FOREIGN COUNTRY RESIDENCE REQUIREMENT WITH RESPECT TO INTERNATIONAL MEDICAL GRADUATES.

(a) INCREASE IN NUMERICAL LIMITATION ON WAIVERS REQUESTED BY STATES.—Section 214(l)(1)(B) of the Immigration and Nationality Act (8 U.S.C. 1184(l)(1)(B)) is amended by striking ''20;'' and inserting ''30;''.

(b) EXTENSION OF DEADLINE.—Section 220(c) of the Immigration and Nationality Technical Corrections Act of 1994 (8 U.S.C. 1182 note) is amended by striking ''2002.'' and inserting ''2004.''.

(c) TECHNICAL CORRECTION.—Section 212(e) of the Immigration and Nationality Act (8 U.S.C. 1182(e)) is amended by striking ''214(k):'' and inserting ''214(l):''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect as if this Act were enacted on May 31, 2002.

□ 1215

The SPEAKER pro tempore (Mr. QUINN). Pursuant to the rule, the gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentlewoman from Texas (Ms. JACKSON-LEE) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. SENSENBRENNER).

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 4858, the bill currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, H.R. 4858 extends authority for a visa-requirement waiver that permits certain foreign medical doctors to practice medicine in underserved areas without first leaving the United States. The bill also increases the number of foreign residence waivers from 20 per State to 30 per State.

Aliens who attend medical school in the United States on ''J'' visas are required to leave the United States after graduating to reside abroad for 2 years before they may practice medicine in the United States. The intent behind this policy is to encourage American-trained foreign doctors to return home to improve health conditions and advance the medical profession in their native countries.

In 1994, the Congress created a waiver of the 2-year foreign residence requirement for foreign doctors who commit to practicing medicine for no less than 3 years in the geographic area or areas, either rural or urban, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals. The waiver limited the number of foreign doctors to 20 per State so that underserved areas in all States receive doctors. The original waiver was set to expire on June 1, 1996. The Congress extended the waiver to June 1, 2002.

States with underserved medical areas worry that health facilities in such areas will have to close down if the authority for these medical waivers is not extended. The States have also requested additional waivers so that they have more doctors to help keep their clinics open.

Mr. Speaker, H.R. 4858 increases the numerical limitation on waivers requested by States from 20 per State per year to 30 per State per year. It also extends the deadline for the authorization of the waiver to June 1, 2004. The bill retroactively takes effect May 31, 2002, prior to the waiver's expiration.

I urge my colleagues to support this bill so that urgently needed doctors may continue to practice medicine in areas that are in critical need of medical care.

Mr. Speaker, I reserve the balance of my time.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

I thank the distinguished chairman of the Committee on the Judiciary. I would like to offer my support for this legislation.

I offer my support for this legislation with a qualification, recognizing that this legislation did not come before the Subcommittee on Immigration and Claims and was marked up in full committee. I believe the importance of this legislation was such that deviation from regular order and committee procedures was to be understood. So I rise in support of this legislation, a bill that will help provide underserved areas with needed health care providers.

As my colleagues know, there are many inner city and rural areas in dire need of doctors, and this program will allow a limited number of foreign doctors the opportunity to practice in America. In working on this legislation, I worked with Members and colleagues from both rural and urban areas, and their advocation for this showed the dire need for those who are in underserved areas.

The bill was introduced by the gentleman from Kansas (Mr. MORAN); and many of our colleagues from the rural areas and, as I said, inner city areas, have asked for this legislation to be in place.

Mr. Speaker, H.R. 4858 reauthorizes the Conrad 20 program until May 31, 2004. The reauthorization is retroactively effective to May 31, 2002, as that was the date of the expiration of the program and also noting the ending of the involvement of the USDA. The bill also includes a modest increase in the number of eligible foreign physicians. That number goes from 20 to 30 based upon a survey showing the need.

Might I note that the Texas Primary Care Office, certainly a State of which I come from that recognizes the importance of serving in rural areas and inner city areas, surveyed all 50 States on the use of the J–1 visa. Upon the USDA announcement that they were ending their participation, the PCO again surveyed the States and, as a result, the most recent survey by the PCO, every State but two, indicated that they are or are intending to put in place a Conrad 20 program, which would utilize the J–1 visas.

Under current immigration law, a ''J'' visa is available to foreign physicians as an exchange visitor if the person meets certain requirements, including the intention to return to his or her home country, participation in an exchange visitor program designated by the U.S. Information Agency, and participation in a program that is intended to train foreign nationals in a field that can be utilized in the person's home country, and sufficient funds and fluency in English. They are limited in the number of visas of a 2-

year residency requirement available to foreign physicians.

In particular, a foreign physician may obtain a waiver through a recommendation issued by an interested State or Federal agency interested in facilitating the physician's employment in a designated medically underserved area.

Until recently, the USDA, as I indicated, participated in this program. However, back in late February, citing security concerns, the USDA announced that they were no longer going to act as an interested government agency in processing J–1 visas. Now the role of recommending J–1V visas rests primarily with the State agencies.

I want to ensure, however, that as we work with the INS, that the INS certainly will be involved in providing assistance as it may be needed. This is an important aspect of the question of homeland security, and I would hope this legislation does not in any way suggest to the American people that we attempt to jeopardize security and/or would not be concerned in light of the Federal oversight agency, the USDA, no longer being involved in those programs. Rural communities still need health care, urban centers still need health care; in fact, Americans need health care.

It is interesting to note, Mr. Speaker, the fast pace at which this legislation has come. Again, I would like to thank the proponents of the legislation, and they have my support, but certainly I would be remiss if I did not mention the fact that we are about to address the question dealing with Medicare and the particular provisions to provide senior citizens with efforts to give them a Medicare drug benefit.

I am hoping that as we came together in a bipartisan manner to support this legislation, as I indicated that I support, that we can look seriously at the Democratic proposal. That is a serious proposal that provides a deductible and a $25-a-month premium and provides for an 80 percent coverage for Medicare benefits for our seniors. This is the kind of work we should be doing in the House of Representatives. This is the kind of serious legislation that we should be doing and not attending to special interests and harming the particular senior citizens that we are trying to protect.

So, with that, Mr. Speaker, let me support this legislation and hope that my colleagues in a bipartisan manner will likewise support this legislation so that we can have good health care, protected health care in this country.

Mr. Speaker, I reserve the balance of my time.

Mr. SENSENBRENNER. Mr. Speaker, I yield 5 minutes to the gentleman from Kansas (Mr. MORAN), the author of the bill.

Mr. MORAN of Kansas. Mr. Speaker, I thank the gentleman from Wisconsin and the gentlewoman from Texas for their remarks earlier today; and I would like to thank them, as well as the gentleman from Pennsylvania (Mr. GEKAS), the subcommittee chairman, that dealt with this issue for their prompt attention to an issue that is terribly important to rural America and urban America as well. It is good to see us come together, Republicans and Democrats, urban and rural, on behalf of health care for our citizens.

Much of our time, in fact, this week much of our time will be spent on the affordability of health care. How do we help our citizens pay for it? How do we make health care more affordable? Many of us who live in regions of the country that are underserved struggle to have access to health care. How do we keep physicians in our communities? How do we keep our hospital doors open? How do we have our other health care providers available for the citizens who happen to live in the urban core of the city or in a rural community of our country?

One of the ways that we can help address the issue of physicians in underserved areas is the J–1 visa program. Clearly, it has been an opportunity for physicians to remain in the United States and serve in those underserved areas during the history of the program beginning in 1994. There are 98 physicians in Kansas who were waived under this program. Of those, 50 are still practicing in our State.

Mr. Speaker, this is often the only opportunity that a community, a clinic, or a hospital in a rural or underserved urban area has to access a physician. I would guess in the 6 years that I have been a Member of Congress, probably not more than 4 weeks goes by that I do not have a call or letter or e-mail from a clinic, a community, or a hospital saying, can you help us locate a physician and can you help us with the paperwork associated with the J–1 visa.

These are ways in which our communities are served. Lacrosse, Kansas, population 1,800 has had a J–1 visa physician in place who is now retiring. He and his wife are the only physicians in the community. They are both here on a J–1 visa. For 2 years they have been telling the community they are retiring. The community has been looking for a physician and, gratefully, they found a J–1 visa physician.

They may have been the last J–1 visa granted in the United States. Back in February of this year, the Department of Agriculture concluded that it would no longer be an interested government agency for processing J–1 visas.

The Rural Health Care Coalition, which I chair with the gentleman from North Carolina (Mr. MCINTYRE) and I tried to quickly respond to this issue. In fact, 56 Members of Congress, including the gentleman from Nebraska (Mr. OSBORNE) and the gentleman from Texas (Mr. STENHOLM), who are here today, asked the Bush administration to come together and to solve the problem. Because there are two ways a J–1 visa can be issued, one through the Federal Government and one through the State program. Forty-six States in our country has a State program. Kansas is one that does not, although we are certainly encouraging them under the current circumstances to create a State program.

Today, we reauthorized both programs. The Bush administration and the Department of Agriculture, I am very grateful to them, they responded. They processed the J–1 applications that were in the works; and they decided to have an inter-government agency meeting, a set of meetings, between INS, the State Department, the Department of Agriculture, the Department of Health and Human Services to figure out how do we continue the J–1 visa program.

So this actually is an experience in the 6 years I have been in Congress in which I thought government responded in a way that it should to meet the needs of citizens of our Nation.

So today I am here to support strongly the reauthorization of the J–1 visa program, to continue to encourage the Federal Government to be engaged in the process of helping us sponsor J–1 visa physicians and to particularly reauthorize the program for States and to expand the number of individual physicians that can be admitted under the State program from 20 a year to 30 a year to meet the needs in the absence of a Federal interested government agency of rural communities across our country.

The program is important. It is the way that health care is delivered in rural and urban settings across our country. Access to a physician is so important, and it ought not matter where you live. This program has worked. Security and other concerns with the program are being addressed, and we have general support from the Bush administration and from the INS and from the State Department as we reauthorize this program, both at the Federal level and at the State level.

I appreciate the Rural Health Care Coalition and my colleagues in Congress who care about these issues; and I appreciate the fact that Republicans, Democrats, and urban and rural Members of Congress came together on behalf of citizens and the delivery of health care to those citizens here on the floor this afternoon. I urge my colleagues to support this legislation. I thank again the chairman and the ranking members for their continued consideration of this issue and their promptness in moving it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself such time as I may consume.

I thank the gentleman from Kansas for his leadership on this issue, and I thank him for the very important statement of having Americans have access to good health care. That is why I remind my colleagues of the importance of ensuring that we have an effective Medicare prescription drug benefit that clearly is fundable and clearly

is supportable by the seniors who need it very much.

Mr. Speaker, I am delighted to yield 5 minutes to the distinguished gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I rise in strong support of H.R. 4858, which I have been pleased to work on and cosponsor with the gentleman from Kansas (Mr. MORAN). I thank the gentleman from Wisconsin (Mr. SENSENBRENNER) for bringing the bill to the floor today.

Mr. Speaker, H.R. 4858 reauthorizes and expands the State Conrad 20 program. The 2-year reauthorization allows States to continue to act as an interested government agency in order to sponsor foreign-born doctors to practice in medically underserved areas. The number of doctors that can be sponsored per State is expanded from 20 to 30.

Since the mid-1990s, 42 States and the District of Columbia have been using the Conrad 20 program, processing an estimated 595 physicians per year.

□ 1230

However, the demand for doctors continues to grow. Despite a continuing population migration to urban and suburban communities throughout the State, the vast majority of Texas remains rural, posing unique challenges to the delivery and accessibility of high-quality health care. Not only are health care services likely to be unevenly distributed, but many rural residents do not even have access to a local doctor, primary care provider, or hospital.

Regrettably, a doctor would diagnose the health care problems in rural communities as chronic and persistent. The issues are not new, and we have tried a variety of medicines to remedy these problems, but we still have a long way to go before we achieve a healthy rural America.

Consider the following state-wide facts: 77 percent of Texas counties are considered rural, and 88 percent of these are considered medically underserved; 2.9 million people, or 15 percent of the State's 19.6 million residents, reside in nonmetropolitan counties; 25 rural Texas counties have no primary care physician; an additional 29 counties have only one; only 11 percent of licensed primary care physicians practice in rural areas.

For other health professionals, the figures are similar: pharmacists, 11.9 percent; physician assistants, 18 percent.

Access to primary care promotes appropriate entry into the health system and is vital to ensure the long-term viability of rural health care delivery. Without access to local health care professionals, rural residents are frequently forced to leave their communities to receive necessary treatments. Not only is this a burden to rural residents, who are often older or lack reliable transportation, but it drains vital health care dollars from the local community, further straining the financial well-being of rural communities.

It is imperative that we identify and expand those programs that provide physicians, pharmacists, nurses, dentists, and physician assistants incentives to practice in rural areas. The J–1 visa waiver program was expanded in 1995, allowing medical exchange graduates in U.S. residency training to extend their stay for 3 years, provided they practice in an underserved community.

For certain rural, as well as urban, areas in the United States, the J–1 docs have been key providers. Since 1995, Texas alone has received the services of over 350 J–1 physicians. This represents service to a population of over 1 million people. One million people have received health care that they would not otherwise have received, or at least it would have been more difficult to receive, as a result of this program that we reauthorize today.

However, on March 1, 2002, USDA made a unilateral decision to stop acting as a sponsor for international medical graduates in rural health services. Everyone involved in this program, starting with the Department of Public Health of every State, to the health care facilities who are desperately waiting for their recruited physicians to start work in their rural communities, to the doctor who needed the waiver to start work and have legal status, were shocked to learn of the elimination of this vital program.

Through the quick efforts of the Rural Health Care Coalition, we were able to convince USDA at a minimum to process those doctors who already had an application pending. While I am pleased with USDA's decision to take a second look at the program, the affected health care facilities have lost several critical months during which they could have had a physician filling that void in their community.

However, I would like to take this opportunity to encourage USDA, the State Department, and the INS to expedite those pending applications to the best extent possible, as our rural communities are in dire need and deserve every opportunity to access medical care. The J–1 waiver program is considered a lifeline for rural communities all over the United States.

In the 17th district of Texas that I have the privilege of representing, I have three hospitals awaiting approval for a J–1 doctor: Fisher County Hospital in Rotan, North Runnels Hospital in Winters, and the San Angelo State School in San Angelo. These are doctors whose applications were pending at the time of the decision to stop the program.

Coordination among agencies involved to expeditiously process these applicants has reached a critical stage in my district, as I am sure it has in many rural areas across the country. I am hopeful through the efforts of the Rural Health Care Coalition and the White House task force formed to look into reinstating the J–1 program, we can develop a workable plan to meet the ever-growing needs of access to quality health care in rural America.

However, until we have an alternative solution at the Federal level, there is no other sponsorship program that can fill the void for our rural communities other than the Conrad 20 program. I urge my colleagues to support H.R. 4858 in an effort to fill that void.

Mr. SENSENBRENNER. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. OSBORNE).

Mr. OSBORNE. Mr. Speaker, I would like to express my support of H.R. 4858, introduced by my good friend, the gentleman from Kansas (Mr. MORAN).

I am very pleased to be a cosponsor of this legislation, along with the gentleman from Kansas and the gentleman from Texas (Mr. STENHOLM), who recently spoke. All of us serve sparsely populated rural areas. There are a lot of small towns with great distances between these towns.

It is very, very difficult in these areas to recruit doctors. Usually in these types of communities there is only one doctor, and usually that doctor is the only doctor for many, 30, 40, or 50, miles. So the problem is that the doctor knows when he goes to that community that there is not going to be any rotation, and that doctor is always on call at 2 o'clock in the morning, 6 o'clock in the morning, late at night, whatever.

So, number one, it is difficult to find somebody that will answer that call. Then once you get somebody who will agree, oftentimes it is even more difficult to recruit that doctor's spouse, because in those communities there is no shopping center, there is no symphony, there is no major league sports team in any close proximity. So to get that combination of a doctor and the spouse that will come to that type of community is very difficult.

When a small town loses a doctor, then it loses its hospital and then begins to lose young people, because young people with children usually do not want to be in a community where there is no hospital or no doctor. The community very rapidly begins to unravel.

By April 15 of this year, 36 physicians were placed in rural Nebraska communities under the J–1 program. An example of this would be Oshkosh, Nebraska, which is a county of roughly 1,700 square miles with one doctor serving 2,500 people. We were able to secure an internist from Poland on a J–1 visa waiver. This has been critical to the survival of the hospital and the community.

So this has been a tremendously important program to rural areas as well as to urban areas. We like the flexibility of the program. It has been able to provide some key specialists in certain communities.

Mr. Speaker, we urge support of H.R. 4858. I would like to thank the gentleman from Kansas (Mr. MORAN) for his leadership, and I would like to especially thank the gentleman from Wisconsin (Chairman SENSENBRENNER) for bringing this legislation to the floor.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, in conclusion, let me acknowledge two points that I thought the previous speakers made very well, but I think it is very important.

It is very important that the pending applications be processed between the INS, the State Department, and the USDA. I think it is also important to recognize that not having a physician in any community, whether it be urban or rural, is like not having a school. It is a vital part of the components of a community, such as access to health care.

This particular legislation had the concerns, of course, because it represented foreign physicians, that there was a question of homeland security, or a question of security in light of the incidences of September 11.

One of the things that we are trying to do as the President moves his legislation forward is to ensure that, as much as we can, the lifestyles of Americans and the values of Americans continue. We recognize that as these individuals come in to share their talents that this particular visa will give them the authority to work and to give service, but it also gives the ability for this country to be safe. We should balance those responsibilities.

Let me also say, Mr. Speaker, that our previous speakers have mentioned the fact that access to health care is important, and I believe that the quality of health care is important. So that is why I emphasize in my support of this legislation the importance, as well, for this Congress to support a viable Medicare drug benefit through the Medicare process, one that will provide the 80 percent coverage, a premium of $25, and a deductible of $100.

We must realize that when we do this for our seniors and those that need access to health care, we provide preventive medicine. What we do in doing that is to ensure that the usage of Medicare part A and B hospitalization, emergency surgeries, et cetera, are diminished because we have the kind of care that our seniors need with respect to a good Medicare drug benefit for prescription drugs.

Mr. Speaker, the fight still continues for good health care in America. When we pass this legislation, we will help our rural and inner city areas which are underserved, and we will fix some of those problems; but we will not fix them in totality if we do not pass a Medicare drug benefit, prescription drug benefit, tied to the Medicare plan that provides 80 percent coverage and is not one that plays to the special interests, paying money to pharmaceuticals when that is not needed.

We really need to be seriously considering providing good health care.

Mr. COSTELLO. Mr. Speaker, I rise today in support of H.R. 4858. The number of doctors practicing in rural America continues to decline. Congress needs to find ways to meet the medical needs of all rural Americans. This important legislation brings us one step closer to improving access to medical care in rural America by expanding a state program to recruit physicians.

The need for this legislation became crucial after the Federal program used to bring doctors to rural areas was brought to a halt in February 2002. The U.S. Department of Agriculture announced it would no longer process J–1 Visa applications for foreign doctors wishing to practice in underserved areas. This left the state operated program as the only option for recruiting much-needed doctors to work in medically underserved areas. However, this program expired on May 31, 2002.

H.R. 4558 reauthorizes the state program for two years and expands the program from 20 to 30 doctors per state, in order to accommodate the increased demands. This year alone, three psychiatrists applying for the J-1 visa program in Illinois left my state to apply in other states because Illinois could not provide any additional J-1 Visa waivers. This legislation would have allowed these psychiatrists to remain in Illinois where their service is greatly needed. Since 1994, the J-1 Visa waiver program has brought 338 physicians to Illinois, many of which currently serve in my district.

I am committed to ensuring that, to the maximum extent possible, physicians are available to provide service to medically underserved areas. J-1 Visa participants can and will help meet these needs once the program is reauthorized. Mr. Speaker, for these reasons I support this legislation and urge my colleagues to do the same.

Mr. TOWNS. Mr. Speaker, I rise today in support of H.R. 4858, introduced by my colleague Congressman MORAN of Kansas. As a co-sponsor of this legislation, let me stress that it is vital to maintaining access to health care for the medically underserved, both in urban and rural areas. This legislation is needed to reauthorize the J1 Visa waiver program, whose authorization expired on June 1, 2002. The J1 Visa waiver program has been successful in recruiting physicians in both primary care and specialty areas in both rural and urban medically underserved communities. Without this critical program many rural communities would be without access to basic primary care if not for a physician with a J1 Visa waiver.

Since its inception in 1994, the J1 Visa program has been successful as both a Federal and State program, but in late February, the U.S. Department of Agriculture announced that it was no longer going to act as the Federal Interested Government Agency (IGA) in processing J1 Visa applications for physicians wishing to practice 8in rural underserved areas. The USDA cited security concerns as the issue. However, USDA's decision caused a major shortage of filling the needs of the medically underserved. Although, the Administration has formed a task force to address the Federal J1 program in selecting another IGA to sponsor candidates, we still need to reauthorize the state program to limit the disruption in health care services in these communities. Today, I am pleased that we here in Congress have an opportunity to take a proactive stand to ensure that the states' J1 Visa program is continued. I urge my colleagues to support this bill.

Mr. SIMPSON. Mr. Speaker, I rise to support H.R. 4858, introduced by my good friend Representative JERRY MORAN of Kansas. This legislation will extend for two years the J–1 visa waiver program for states and increase each state's allotment from 20 to 30.

The J–1 visa waiver program allows foreign medical students to remain practicing in the U.S. without having to return to their home countries for two years, as the J–1 visa requires. International Medical Graduates are a thriving part of the physician population in the U.S. It is estimated that close to 24% of practicing physicians are foreign nationals. In addition, in 1999 over 2,000 foreign medical graduates were practicing in health professional shortage areas or medically underserved areas, where waiver recipients are required to work.

I am a strong supporter of the J–1 visa waiver program and disagree with USDA's decision to withdraw as an Interested Government Agency. Since 1994, California has received 229 J–1 visa waiver physicians to practice in underserved areas. Five states—Texas, Louisiana, Michigan, California and Florida account for 45% of USDA J–1 recommendations. USDA's withdrawal has left states with nowhere else to turn but to the state waiver programs, often referred to as Conrad-20 programs.

Since the USDA began its program in 1994, the agency has recommended over 3,000 physicians for J–1 visa waiver status. As USDA will not longer make these recommendations, the states now will have to fill this vital role. Hospitals and clinics needing a foreign doctor that would have turned to USDA, which did not have a waiver recommendation limit, will now relay on the states to fulfill their needs.

However, the states have been limited to only twenty recommendations per year. Without USDA involvement the 20 slots are simply not enough to fill the void for most states. I am in support of increasing the number of slots to 30, as this will help the problem, but I am worried that this number is insufficient for many states. A recent survey by the Texas Primary Care office found that 23 states could recommend more than 20. Although increasing the limit to 30 will help, it will not address all of the states' needs, especially in California. In this same survey, 15 states indicated that they could use over 31 waivers. Seven of those states said they could use more than 51 waivers.

This J–1 visa waiver program is essential to ensuring that our rural health clinics and medical practices can remain in business serving our rural constituencies. These areas cannot attract American doctors despite aggressive recruitment procedures. Foreign doctors fill this significant role. I strongly support continuing this important state program and endorse increasing the number of slots to thirty as a first step to providing much needed medical personnel in underserved areas across the country.

Mr. PALLONE. Mr. Speaker, I rise in support of H.R. 4858, a bill to improve access to physicians in medically underserved areas. In many rural areas of the country, we are experiencing an enormous shortage of qualified

doctors. For this reason, the J–1 visa waiver program was established on the State and Federal level.

This program allowed foreign medical graduates to come to the United States on a J–1 visa for up to 3 years to train in accredited residency programs in rural, underserved parts of the country. Mr. Speaker, the impetus behind accepting physicians from other countries and training them in American residency positions is to attract physicians to provide care to the medically underserved who live in rural areas where doctors trained in the United States do not want to practice.

The law states that once the residency program is complete, the doctors are required to return to their country of origin for two years. However, the Federal government and states have the authority to waive the requirements if it is in the United States' interest to keep the physician here. The US Department of Agriculture (USDA) Rural Development Branch was thrilled by the waiver because it provided the opportunity to retain medical trainees who would continue to serve in typically medically underserved communities in rural America. In addition, individual state agencies could act as an Interested Government Agency (IGA) and under the Conrad 20 program, could process up to 20 J–1 doctors on their own.

Unfortunately, the USDA has indicated an intention to stop granting permission under the J–1 visa waiver program. National security concerns have taken hold and new, extensive background checks have put the USDA in the position of not being able to afford to continue this program to keep foreign medical graduates. At the same time, the Conrad 20 program which allowed states to process J–1 visa waivers expired on May 31, 2002.

I support passage of H.R. 4858, because this legislation would reauthorize the Conrad 20 program for 2 years and expand the number of J–1 visa waivers to 30 per state in order to make up for increasing demands brought on by the termination of the Federal government program under the USDA.

I will work to see that this bill is taken up by the other body and signed into law by the President to ensure that medical care is available throughout all rural, underserved communities in the United States.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield back the balance of my time.

Mr. SENSENBRENNER. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. QUINN). The question is on the motion offered by the gentleman from Wisconsin (Mr. SENSENBRENNER) that the House suspend the rules and pass the bill, H.R. 4858.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds of those present have voted in the affirmative.

Mr.SENSENBRENNER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8, rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

LIFETIME CONSEQUENCES FOR SEX OFFENDERS ACT OF 2002

Mr. SENSENBRENNER. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4679) to amend title 18, United States Code, to provide a maximum term of supervised release of life for child sex offenders, as amended.

The Clerk read as follows:

H.R. 4679

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 ''Lifetime Consequences for Sex Offenders Act of 2002''.

SEC. 2. SUPERVISED RELEASE TERM FOR SEX OFFENDERS.

Section 3583 of title 18, United States Code, is amended by adding at the end the following:

''(k) SUPERVISED RELEASE TERMS FOR SEX OFFENDERS.—Notwithstanding subsection (b), the authorized term of supervised release for any offense under chapter 109A, 110, 117, or section 1591 is any term of years or life.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Wisconsin (Mr. SENSENBRENNER) and the gentleman from Virginia (Mr. SCOTT) each will control 20 minutes.

The Chair recognizes the gentleman from Wisconsin (Mr. SENSENBRENNER).

GENERAL LEAVE

Mr. SENSENBRENNER. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the bill, H.R. 4679, as amended, currently under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. SENSENBRENNER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, H.R. 4679, the Lifetime Consequences for Sex Offenders Act of 2002, amends the current law, which grants Federal courts the authority to include in any sentence a term of supervised release after imprisonment.

Under this legislation, a court would be authorized to impose a term of supervised release for any term of years or life for a number of serious sex offenses. These offenses include crimes of sexual abuse, sexual exploitation of children, transportation for illegal sexual activity, sex trafficking of children by force, fraud, or coercion. Under current law, a term of supervised release for any of these crimes is limited to a maximum term of between 1 and 5 years.

This legislation will provide judges with greater discretion in dealing with sex offenders. The court imposing the sentence is in the best possible position to determine if an extended period of supervision is necessary, based on that court's knowledge of the facts of the case and the defendant's criminal history.

The court is also in the best position to determine what conditions of release are necessary to ensure the defendant will not reoffend and the public will be safe.

There is no requirement in this bill that a judge impose any term of supervised release if the court feels that it is not necessary. The court may also revoke such supervision at any time after 1 year if the court decides that supervision is no longer warranted.

Lifetime supervised release is not a novel idea. A court may currently impose a life term of supervised release for certain Federal drug and terrorism offenses. It does not make any sense to tie the hands of the court in the case of a sex offender if that court knows that there is a greater possibility that a defendant will victimize another person if they are not subject to the conditions of supervised release.

Study after study has shown extremely high recidivism rates for sex offenders. The lifelong harm that they cause to their victims far outweighs any inconvenience they may suffer as a result of lifetime supervision. This legislation will give the courts the ability to permanently monitor those individuals who have demonstrated a higher risk to society.

Mr. Speaker, I urge my colleagues to support this legislation, and I reserve the balance of my time.

Mr. SCOTT. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in opposition to H.R. 4679. Mr. Speaker, this bill lacks any standard for application of lifetime supervision and would make subject to lifetime supervision those who may be involved only in misdemeanors and in cases involving consensual acts, including consensual touching between teenagers still in high school. There may be cases for which consideration of such treatment is warranted, but certainly not in misdemeanors and consensual sex acts.

During the committee consideration of the bill, I offered amendments aimed at focusing the bill on the types of cases that might warrant consideration of lifetime supervision by eliminating misdemeanors and consensual acts for first-time offenders, but these amendments were rejected and were on a procedure that does not allow amendments on the floor.

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Although judges have the discretion to impose lifetime supervision or not, a judge must consider that if Congress authorizes lifetime supervision for first-time misdemeanors or consensual acts between adults or between high school students, with no indication of how it should be applied in these cases, it must be that Congress intends for it to apply in such cases. In this overzealous context of indiscriminately ferreting out sex offenders for harsher treatment, there are likely to be judges who, like the lawmakers promoting such policies, who will prefer to err on the side of harsh treatments to avoid the possible criticism that they were not as tough as they could have been should an offender actually recidivate.