State, or the specific Economic Development District in the State; and

''(II) the allocation of additional H–2B nonimmigrant visas pursuant to this paragraph—

''(aa) will not displace domestic workers; and

''(bb) will not negatively affect average wages in such State; and

''(iv) employers who hire H–2B nonimmigrant workers pursuant to this paragraph comply with any additional requirements imposed by the Secretary of Labor, by regulation.

''(B) The Secretary of Homeland Security, acting through the Director of U.S. Citizenship and Immigration Services, shall issue the supplemental H–2B nonimmigrant visas requested by the Governor of a State pursuant to subparagraph (A) to the extent that the applications for such visas submitted by employers based in such State meet all applicable requirements of the H–2B nonimmigrant visa program.

''(C) If the number of employer applications from a State exceed the number of H–2B nonimmigrant visas requested pursuant to subparagraph (A), the Office of Foreign Labor Certification shall randomly assign for processing all of the remaining H–2B nonimmigrant visa applications and issue supplemental visas to all qualified applicants until the number of supplemental visas allocated to such State pursuant to subparagraph (B) have been issued.

''(D) This paragraph shall cease to have force or effect on the date that is 4 years after the date of the enactment of the SEASONAL Act.

''(E) Nothing in this paragraph may be construed to prohibit the legislature of any State from setting limits with respect to supplemental H–2B nonimmigrant visas that the Governor of such State may request, including—

''(i) limiting the number of such visas that may be requested in a fiscal year; and

''(ii) limiting the allocation of such visas to H–2B nonimmigrant workers who are employed—

''(I) within such State;

''(II) within specified Standard Occupational Classification Groups; or

''(III) within specified Economic Development Districts.''.

**SEC. 3. ANNUAL REPORT.**

Not later than 15 months after the date of the enactment of this Act, and annually thereafter until the date that is 4 years after such date of enactment, the Secretary of Homeland Security and the Secretary of Labor shall submit a joint report to Congress that includes, with respect to the preceding year—

(1) the number of supplemental H–2B nonimmigrant visas issued pursuant to section 214(g)(12) of the Immigration and Nationality Act (8 U.S.C. 1184(g)(12)), disaggregated by the State in which the recipients of such visas are working;

(2) a breakdown of Standard Occupational Classification Groups or Economic Development Districts for which supplemental H–2B nonimmigrant visas were issued, disaggregated by the State in which the recipients of such visas are working;

(3) an analysis of any effect caused by the issuance of supplemental H–2B nonimmigrant visas that led to the displacement of domestic workers or a reduction in the average wages, disaggregated by State; and

(4) an assessment of whether the issuance of supplemental H–2B nonimmigrant visas led to increased economic opportunities and productivity in the States in which the recipients of such visas are working.

## SUBMITTED RESOLUTIONS

### SENATE RESOLUTION 319—DECLARING RACISM A PUBLIC HEALTH CRISIS

Mr. BROWN (for himself, Mr. BOOKER, Mr. PADILLA, Ms. WARREN, Mr. MERKLEY, Mr. MARKEY, Ms. SMITH, Mr. WHITEHOUSE, Mr. CARPER, Mr. CARDIN, Ms. HIRONO, Mr. BLUMENTHAL, Mr. MENENDEZ, Ms. BALDWIN, Mr. WYDEN, Mr. REED, Ms. STABENOW, and Ms. DUCKWORTH) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 319

Whereas a public health crisis is an issue—

(1) that affects many people, is a threat to the public, and is ongoing;

(2) that is unfairly distributed among different populations and disproportionately impacts health outcomes, access to health care, and life expectancy;

(3) the effects of which could be reduced by preventive measures; and

(4) for which those preventive measures are not yet in place;

Whereas public health experts agree that significant racial inequities exist in the prevalence, severity, and mortality rates of various health conditions in the United States;

Whereas examples of those inequities include—

(1) life expectancies for Black and Native American people in the United States are significantly lower than those of White people in the United States;

(2) Black and Native American women are 2 to 4 times more likely than White women to suffer severe maternal morbidity or die of pregnancy-related complications;

(3) Black and Native American infants are 2 to 3 times more likely to die than White infants;

(4) the Black infant mortality rate in the United States is higher than the infant mortality rates recorded in 27 of the 36 democratic countries with market-based economies that are members of the Organization for Economic Co-operation and Development;

(5) Hispanic women are 40 percent more likely to be diagnosed with and 30 percent more likely to die from cervical cancer compared to non-Hispanic White women;

(6) Asian Americans face health disparities in cancer and chronic diseases, and are the only population in the United States for which cancer is the leading cause of death;

(7) Native Hawaiians and Pacific Islanders suffer from a number of poor health outcomes such as high rates of overweight status, obesity, hypertension, and asthma and cancer mortality;

(8) Native Hawaiians suffer from coronary heart disease, stroke, heart failure, cancer, and diabetes at a rate 3 times greater than in other ethnic populations in Hawaii and become afflicted with those diseases a decade earlier in their lives compared with other ethnic populations; and

(9) during the COVID–19 pandemic, Black, Hispanic or Latino, Asian American, Native Hawaiian or Pacific Islander, and Native American communities experienced disproportionately high rates of COVID–19 infection, hospitalization, and mortality compared to the White population of the United States;

Whereas inequities in health outcomes are exacerbated for people of color who are LGBTQIA+;

Whereas inequities in health outcomes are exacerbated for people of color who have disabilities;

Whereas, historically, explanations for health inequities have focused on false genetic science such as eugenics;

Whereas, historically, explanations for health inequities have focused on incomplete social scientific analyses that narrowly focus on individual behavior to highlight ostensible deficiencies within racial and ethnic minority groups;

Whereas modern public health officials recognize the broader social context in which health inequities emerge and acknowledge the impact of historical and contemporary racism on health;

Whereas racism is recognized in modern public health discourse as one of many social determinants of health, which—

(1) are a broad range of nonmedical factors that can enhance or hinder quality of life and influence health outcomes;

(2) are the conditions in which people are born, grow, work, live, and age, and include the wider set of forces and systems shaping the conditions of daily life;

(3) include such factors as housing, employment, education, health care, food, transportation, social support, poverty, crime, violence, segregation, and environmental toxins;

(4) are linked to a lack of opportunity and resources to protect, improve, and maintain health; and

(5) taken together, create health inequities that stem from unfair and unjust systems, policies, and practices, and limit access to the opportunities and resources needed to live the healthiest life possible;

Whereas, since its founding, the United States has had a longstanding history and legacy of racism, mistreatment, and discrimination that has perpetuated health inequities for members of racial and ethnic minority groups;

Whereas that history and legacy of racism, mistreatment, and discrimination includes—

(1) the immoral paradox of freedom and slavery, which is an atrocity that can be traced throughout the history of the United States, as African Americans lived under the oppressive institution of slavery from 1619 through 1865, endured the practices and laws of segregation during the Jim Crow era, and continue to face the ramifications of systemic racism through unjust and discriminatory structures and policies;

(2) the failure of the United States to carry out the responsibilities and promises made in more than 350 treaties ratified with sovereign indigenous communities, including American Indians, Alaska Natives, and Native Hawaiians or Pacific Islanders, as made evident by the chronic and pervasive underfunding of the Indian Health Service and Tribal, Urban Indian, and Native Hawaiian health care, the vast health and socioeconomic inequities faced by Native American people, and the inaccessibility of many Federal public health and social programs in Native American communities;

(3) the enactment of immigration laws in the United States that scapegoated Asians, separated families, and branded Asians as perpetual outsiders, such as—

(A) the enactment of the Act entitled ''An Act supplementary to the Acts in relation to immigration'', approved March 3, 1875 (commonly known as the ''Page Act of 1875'') (18 Stat. 477, chapter 141), which effectively prohibited the entry of East Asian women into the United States;

(B) the Act entitled ''An Act to execute certain treaty stipulations relating to Chinese'', approved May 6, 1882 (commonly known as the ''Chinese Exclusion Act''; 22 Stat. 58, chapter 126), which banned thousands of Chinese-born laborers, who were

essential in the completion of the transcontinental railroad and development of the West Coast of the United States; and

(C) the Act entitled ''An Act to regulate the immigration of aliens to, and the residence of aliens in, the United States'', approved February 5, 1917 (commonly known as the ''Immigration Act of 1917'') (39 Stat. 874, chapter 29), which barred all immigrants from the ''Asiatic zone'' and prevented the migration of individuals from South Asia, Southeast Asia, and East Asia; and

(4) during the Great Depression Era, the deportation of approximately 1,800,000 individuals based on their Mexican ethnic identity, although approximately 60 percent of the deported individuals were citizens of the United States, and the targeting of individuals of Mexican descent for ''repatriation'' due to scapegoating efforts, which blamed those individuals for ''stealing'' jobs from ''real'' Americans;

Whereas, in 1967, President Lyndon B. Johnson established the National Advisory Commission on Civil Disorders, which concluded that White racism is responsible for the pervasive discrimination and segregation in employment, education, and housing, causing deepened racial division and the continued exclusion of Black communities from the benefits of economic progress;

Whereas overt racism was embedded in the development of medical science and medical training during the 18th, 19th, and 20th centuries, causing disproportionate physical and psychological harm to members of racial and ethnic minority groups, including—

(1) the unethical practices and abuses experienced by Black patients and research participants, such as the Tuskegee Study of Untreated Syphilis in the Negro Male, which serve as the foundation for the mistrust the Black community has for the medical system; and

(2) the egregiously unethical and cruel treatment of enslaved Black women who were forced to be the subject of insidious medical experiments to advance modern gynecology, including those perpetuated by the so-called ''father of gynecology'', J. Marion Sims;

Whereas structural racism cemented historical racial and ethnic inequities in access to resources and opportunities, contributing to worse health outcomes;

Whereas examples of that structural racism include—

(1) before the enactment of the Medicare program, the United States health care system was highly segregated, and, as late as the mid-1960s, hospitals, clinics, and doctors' offices throughout the northern and southern United States complied with Jim Crow laws and were completely segregated by race, leaving Black communities with little to no access to health care services;

(2) the landmark case Simkins v. Moses H. Cone Memorial Hospital, 323 F.2d 959 (4th Cir. 1963), which challenged the use of public funds by the Federal Government to expand, support, and sustain segregated hospital care and provided justification for title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and the Medicare hospital certification program by establishing Medicare hospital racial integration guidelines that applied to every hospital that participated in the Federal program;

(3) Pacific Islanders from the Freely Associated States experience unique health inequities resulting from United States nuclear weapons tests on their home islands while they have been categorically denied access to Medicaid and other Federal health benefits;

(4) language minorities, including Chinese-, Korean-, Vietnamese-, and Spanish-speaking Americans, were not assured nondiscriminatory access to federally funded services, including health services, until the signing of Executive Order 13166 (42 U.S.C. 2000d–1 note; relating to improving access to services for persons with limited English proficiency) in 2000;

(5) the COVID–19 pandemic exacerbated economic, health, housing, and food security barriers for Black, Hispanic or Latino, Asian American, Native Hawaiian or Pacific Islander, and Native American households, which already suffer from disproportionately higher rates of food insecurity; and

(6) members of the Black, Native American, Alaska Native, Asian American, Native Hawaiian or Pacific Islander, and Hispanic or Latino communities are disproportionately impacted by the criminal justice and immigration enforcement systems and face a higher risk of contracting COVID–19 within prison populations and detention centers due to the over-incarceration of members of those communities;

Whereas subtle or implicit racism in all sectors of the medical service profession continues to cause disproportionate physical and psychological harm to members of racial and ethnic minority groups;

Whereas examples of subtle or implicit racism in the medical service profession include—

(1) the history and persistence of racist and nonscientific medical beliefs, which are associated with ongoing racial inequities in treatment and health outcomes;

(2) implicit racial and ethnic biases within the health care system, which have an explicit impact on the quality of care experienced by members of racial and ethnic minority groups, such as the undertreatment of pain in Black patients;

(3) nearly ⅕ of Hispanic or Latino Americans avoid medical care due to concern about being discriminated against or treated poorly;

(4) the United States health care system and other economic and social structures remain fraught with biases based on race, ethnicity, sex (including sexual orientation and gender identity), and class that lead to health inequities;

(5) women of color, including Black, Native American, Hispanic or Latina, Asian American, and Native Hawaiian or Pacific Islander women, have faced and continue to face attacks on their prenatal, maternal, and reproductive health and rights; and

(6) physicians routinely, through the early 1980s, sterilized members of racial and ethnic minority groups, specifically American Indian and Alaska Native women (with ¼ of childbearing-age women sterilized by the Indian Health Service) and African American and Latina women, performing excessive and medically unnecessary procedures without their informed consent;

Whereas structural racism perpetuates racial and ethnic inequities in the social determinants of health, which produces unintended negative health outcomes for members of racial and ethnic minority groups;

Whereas examples of that structural racism include—

(1) there are fewer pharmacies, medical practices, and hospitals in predominantly Black and Hispanic or Latino neighborhoods, compared to White or more diverse neighborhoods;

(2) environmental hazards such as toxic waste facilities, garbage dumps, and other sources of airborne pollutants, are disproportionately located in predominantly Black, Hispanic or Latino, Asian American, Native Hawaiian or Pacific Islander, and low-income communities, resulting in poor air quality conditions, which can increase the likelihood of chronic respiratory illness and premature death from particle pollution;

(3) employed Black adults are 10 percent less likely to have employer-sponsored health insurance than employed White adults because of racial segregation in occupation sectors and the types of organizations in which they work, nearly ¼ of American Indians and Alaska Natives lack health insurance, and nonelderly Native Hawaiian or Pacific Islander adults and certain groups of nonelderly Asian American adults, including Korean, Vietnamese, and Cambodian adults, also have lower levels of insurance than White adults;

(4) several States with higher percentages of Black, Hispanic or Latino, and Native American populations have not expanded their Medicaid programs, continuing to disenfranchise minority communities from access to health care as of the date of adoption of this resolution;

(5) discriminatory housing practices, such as redlining, which have, for decades, systemically excluded members of racial and ethnic minority groups from housing by robbing them of capital in the form of low-cost, stable mortgages and opportunities to build wealth, and the use by the Federal Government of its financial power to segregate renters in public housing;

(6) social inequities such as differing access to quality health care, healthy food and safe drinking water, safe neighborhoods, education, job security, and reliable transportation, which affect health risks and outcomes;

(7) exclusionary disciplinary practices (such as detention and suspension) in primary education and even early education settings, which disproportionately affect children from racial and ethnic minority backgrounds, particularly Black children; and

(8) that, as much as 60 percent of the health of a person in the United States can be determined by their zip code;

Whereas structural racism perpetuates ongoing knowledge gaps in data, research, and development, which produces unintended negative health outcomes for members of racial and ethnic minority groups;

Whereas examples of that structural racism include—

(1) most participants in clinical trials are White, so there is insufficient data to develop evidence-based recommendations for people from racial and ethnic minority groups;

(2) medical research equipment and medical devices are typically developed by majority-White teams and thus can have racial blind spots unintentionally built into their design, rendering them less effective for people from racial and ethnic minority groups, such as—

(A) electroencephalogram (EEG) electrodes used in neuroimaging research do not collect reliable data when used on scalps with thick, curly hair; and

(B) pulse oximeters produce less accurate oxygen saturation readings when used on fingertips with darker skin;

(3) a lack of images depicting darker skin in medical textbooks, literature, and journals contributes to higher rates of underdiagnosis or misdiagnosis in patients with darker skin; and

(4) many health-related studies fail to include data on Native Americans, Asian Americans, and Native Hawaiians or Pacific Islanders, or do not disaggregate data among those groups, leading to their invisibility in health data and unjust resource allocation and policies;

Whereas racism produces unjust outcomes and treatment for members of racial and ethnic minority groups, with such negative experiences serving as stressors that over time have a negative impact on physical health (leading, for example, to high blood pressure or hypertension) and mental health (leading, for example, to anxiety or depression);

Whereas there is evidence that racial and ethnic minority groups continue to face discrimination in the United States, examples of which include that—

(1) social scientists have documented racial microaggressions in contemporary United States society, including—

(A) assumptions that members of racial and ethnic minority groups are not true Americans;

(B) assumptions of lesser intelligence;

(C) statements that convey color-blindness or denial of the importance of race;

(D) assumptions of criminality or dangerousness;

(E) denial of individual racism;

(F) promotion of the myth of meritocracy;

(G) assumptions that the cultural background and communication styles of an individual are pathological;

(H) treatment as a second-class citizen; and

(I) environmental messages of being unwelcome or devalued;

(2) compared to White Americans, Black Americans are 5 times more likely to report experiencing discrimination when interacting with the police, Hispanic or Latino Americans and Native Americans are nearly 3 times as likely, and Asian Americans and Native Hawaiians or Pacific Islanders are nearly twice as likely;

(3) 42 percent of employees in the United States have experienced or witnessed racism in the workplace;

(4) Muslims, South Asians, and Sikhs were unjustly targeted for profiling, surveillance, arrest, discrimination, harassment, assault, and murder after 9/11;

(5) xenophobic rhetoric, including anti-immigrant rhetoric and the scapegoating of people of East Asian and Southeast Asian descent for the COVID–19 pandemic, resulted in a surge of hate against Asian Americans and Native Hawaiians or Pacific Islanders, including increased harassment, discrimination, bullying, vandalism, and assault;

(6) nearly ½ of Asian Americans and Native Hawaiians or Pacific Islanders throughout the United States have experienced discrimination or unfair treatment that may be illegal and the majority of victims of discrimination name race or related characteristics as the reason for the discrimination; and

(7) more than 50 percent of Hispanic or Latino adults experience at least one form of discrimination due to their racial or ethnic heritage, such as being treated as if they were not smart, criticized for speaking Spanish, told to return to their country, called offensive names, or unfairly stopped by the police;

Whereas Black people in the United States experience overt and direct forms of violence that, when not fatal, can cause severe physical or psychological harm;

Whereas examples of such forms of violence include—

(1) that Black people are confronted and threatened by armed citizens while performing everyday tasks, such as jogging in neighborhoods, driving, or playing in a park;

(2) that Black people are 3 times more likely to be killed by police than White people, and police violence is the sixth leading cause of death for young Black men;

(3) the killings of Tamir Rice, Ahmaud Arbery, Breonna Taylor, George Floyd, Elijah McClain, Jayland Walker, Jeenan Anderson, Timothy McCree Johnson, Jordan Neely, and countless other Black Americans by law enforcement;

(4) that it took the United States 66 years after the senseless and brutal murder of 14-year-old Emmett Till to make lynching a Federal crime;

(5) that, since 2015, mass shootings around the country, such as in Buffalo, New York, and Charleston, South Carolina, serve as reminders of the unresolved history of racism in the United States and highlight the threats Black people must take into consideration when going about their daily lives, both when outside their communities and within those communities; and

(6) that the real threat of brutality and violence adversely impacts mental health among Black communities;

Whereas American Indians and Alaska Natives experience historical trauma, systemic oppression, and cultural genocide that, even when not fatal, can cause severe physical or psychological harm;

Whereas examples of such forms of violence include—

(1) forced relocation, termination, and assimilation policies such as boarding schools that contributed to health disparities and legacies of trauma inflicted on indigenous people;

(2) the United States Army attempting cultural genocide by instigating numerous massacres, including the mass execution of 38 Dakota men in Minnesota and the murder of 300 Lakota people at the Battle of Wounded Knee, to eradicate American Indians and Alaska Natives;

(3) murder being the third leading cause of death for Native women and ⅘ of Indigenous women experiencing violence in their lifetime;

(4) since 2016, there have been 5,712 cases of missing and murdered indigenous women and people across the United States, including 506 cases in 71 urban cities and 153 cases missing from law enforcement databases, with those missing cases likely undercounting the actual number of cases due to the underreporting of cases within American Indian and Alaska Native communities;

(5) the overall death rate from suicide among American Indians and Alaska Natives is 20 percent higher compared to non-Hispanic White populations; and

(6) cycles of violence have overburdened indigenous communities to respond to levels of violence such as gender-based violence, human trafficking, suicide, and homicide with minimal resources;

Whereas Hispanics or Latinos, Asian Americans, and Native Hawaiians or Pacific Islanders experience racially motivated kidnapping, murders, and mass violence, such as shootings in Oak Creek, Wisconsin, El Paso and Allen, Texas, Atlanta, Georgia, and Indianapolis, Indiana, that, even when not fatal, can cause severe physical or psychological harm;

Whereas, throughout the history of the United States, members of racial and ethnic minority groups have been at the forefront of civil rights movements for essential freedoms, human rights, and equal protection for marginalized groups and continue to fight for racial and economic justice today;

Whereas racial inequities in health continue to persist because of historical and contemporary racism;

Whereas public health experts agree that racism meets the criteria of a public health crisis because—

(1) the condition affects many people, is seen as a threat to the public, and is continuing to increase;

(2) the condition is distributed unfairly;

(3) preventive measures could reduce the effects of the condition; and

(4) those preventive measures are not yet in place;

Whereas the Centers for Disease Control and Prevention—

(1) declared racism a serious threat to public health; and

(2) acknowledged the need for additional research and investments to address that serious threat;

Whereas a Federal public health crisis declaration proclaims racism as a pervasive health issue and alerts the people of the United States to the need to enact immediate and effective cross-governmental efforts to address the root causes of structural racism and the downstream impacts of that racism; and

Whereas such a declaration requires the response of governments to engage significant resources to empower the communities that are impacted: Now, therefore, be it

*Resolved,* That the Senate—

(1) supports the resolutions drafted, introduced, and adopted by cities and localities across the United States declaring racism a public health crisis;

(2) declares racism a public health crisis in the United States;

(3) commits to—

(A) establishing a nationwide strategy to address health disparities and inequities across all sectors in society;

(B) dismantling systemic practices and policies that perpetuate racism;

(C) advancing reforms to address years of neglectful and apathetic policies that have led to poor health outcomes for members of racial and ethnic minority groups; and

(D) promoting efforts to address the social determinants of health for all racial and ethnic minority groups in the United States, and especially for Black and Native American communities; and

(4) places a charge on the people of the United States to move forward with urgency to ensure that the United States stands firmly in honoring its moral purpose of advancing the self-evident truths that all people are created equal, that they are endowed with certain unalienable rights, and that among these are life, liberty, and the pursuit of happiness.

## SENATE RESOLUTION 320—CALLING FOR THE IMMEDIATE RELEASE OF EYVIN HERNANDEZ, A UNITED STATES CITIZEN AND LOS ANGELES COUNTY PUBLIC DEFENDER, WHO WAS WRONGFULLY DETAINED BY THE VENEZUELAN REGIME IN MARCH 2022

Mr. PADILLA (for himself and Mrs. FEINSTEIN) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 320

Whereas, since 2006, Eyvin Hernandez has been a public defender for Los Angeles County, dedicating his career to representing the most vulnerable people in the county;

Whereas Eyvin Hernandez is a man of impeccable character and a beloved member of his community, admired by many who know him for his deep devotion to justice, respect for humanity, willingness to help others, patience, kindness, and intellect;

Whereas Eyvin Hernandez has volunteered his time to advocate for children in the juvenile justice system, to mentor aspiring young lawyers through the Latina Lawyer Bar Association and the University of California, Los Angeles (UCLA) Law Fellows Program, and to participate in the Los Angeles County Public Defender's Union, Local