does it lie in exploiting foreign labor to disadvantage American workers. And the answer does not lie in raiding workplace after workplace, tearing apart families, or building walls along our borders.

THE MATTHEW SHEPARD ACT OF 2007

Mr. SMITH. Mr. President, I wish to speak about the need for hate crimes legislation. Each Congress, Senator KENNEDY and I introduce hate crimes legislation that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society. Likewise, each Congress I have come to the floor on many occasions to highlight a separate violent, hate-motivated crime that has occurred in our country.

On the evening of August 9, 2008, 24-year-old Michael Roike was leaving the Playbill Cafe a Washington, DC, area bar with three of his friends when they noticed an SUV parked next door nearby. The SUV carried several men who reportedly spoke with Roike and his friends. The conversation allegedly began casually but escalated when the men from the SUV repeatedly used the word ''faggot.'' One of Roike's friends, Stevon-Christophe Burrell, 29, allegedly became upset and asked the men to leave them alone. In response, a male from the SUV reportedly approached Burrell aggressively. Roike said he stepped between them and tried to diffuse the situation, but Roike recounts that he suddenly felt pain in the left side of his head and hit the ground. Burrell was also struck before the attackers fled back to the vehicle and drove away. While no suspects have been apprehended, the Metropolitan Police Department report lists the attack as a ''simple assault,'' filing it as a hate crime based on sexual orientation.

I believe that the Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Matthew Shepard Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

NATO MEMBERSHIP FOR ALBANIA AND CROATIA

Mr. CARDIN. Mr. President, the NATO Alliance is now considering its third round of post-Cold War enlargement. This will be the smallest of the rounds, with only two countries to consider compared to three in 1999 and seven in 2004. It should also be easiest, since the development of Membership Actions Plans allow NATO significantly more preinvitation interaction with aspirants today than took place in earlier rounds. Albania and Croatia were formally invited at the April NATO Summit in Bucharest, Romania. Macedonia did not receive an invitation because of its lingering name dispute with Greece, and several European allies were unwilling to go forward with Membership Action Plans for Georgia and Ukraine.

In March of this year, the Helsinki Commission, which I cochair, held a hearing on the prospects for NATO enlargement which included testimony from expert analysts and contributions from the embassies of these five countries. We have also had hearings on the matter in the Senate Foreign Relations Committee which included administration views. It is important for the Senate to act on these protocols quickly so that ratification by all NATO countries can be completed in a timely matter.

Turning to the records of the two aspirants, Albania has made tremendous strides since 1991, and the country is solidly committed to Euro-Atlantic integration. This is demonstrated by its contribution to numerous peace operations around the world. There are concerns about organized crime and official corruption in Albania, but I believe the country is well aware of these concerns and is continuing to undertake efforts to address them. The country is also aware of the need for further electoral reform before parliamentary elections next June.

Assistant Secretary of State for European Affairs Dan Fried credibly asserted before the Senate Foreign Relations Committee that ''countries continue reforms rather than abandon them, when they join the alliance,'' and this particularly applies to Albania given its ongoing EU aspirations. In that spirit, I want to express my support for Albania's NATO membership, which will strengthen the alliance as well as the prospects for further reform in Albania.

Croatia is clearly ready for NATO membership. Its democratic credentials are very strong. Recovering from the violent breakup of Yugoslavia, the country essentially shed its extreme nationalist leanings in 2000 and has been in rapid transition ever since. Croatia is also preparing for EU membership, boosting reform efforts, and it has become an increasingly active and helpful player in world affairs. I therefore want to express my strong support for Croatia's NATO membership as well.

CMS CERTIFICATIONS OF HRSA RURAL HEALTH CLINIC DESIGNATIONS

Mr. BAUCUS. Mr. President, yesterday we passed the Health Care Safety Net Act, which reauthorizes multiple programs within the jurisdiction of the Committee on Health, Education, Labor and Pensions, HELP. This bill does include one section that changes the timeframe for the Centers for Medicare and Medicaid Services, CMS, to certify rural health clinic, RHC, shortage area designations from 3 years to 4 years. We have worked closely with the chairman and ranking member of the HELP Committee to have language included in H.R. 3343 to align the timeframe for CMS certifications of rural health clinic designations with the timeframe for HRSA designations. This provision is crucial to maintaining access to primary care and other necessary medical services in rural areas. I know that several rural health clinics in Montana would be forced to close their doors if the CMS rule were permitted to go forth. I am proud to stand with my colleagues on both sides of the aisle to ensure that these important parts of our health care delivery system are protected.

We are most appreciative of the efforts of the HELP Committee to include this language at our request. As chairman of the Finance Committee, I am obligated to point out for the record that Medicare is exclusively governed by title XVIII of the Social Security Act, which is under the exclusive jurisdiction of the Finance Committee. Inclusion of these Medicare provisions in H.R. 3343 does not represent any waiver of the Finance Committee's jurisdiction on this subject. In the absence of the Chairman of the HELP Committee, Senator KENNEDY, I would ask the distinguished ranking member, Senator ENZI, to acknowledge that Medicare is governed by title XVIII of the Social Security Act and is under the exclusive jurisdiction of the Finance Committee. Again, I would like to extend our thanks to the chairman and ranking member of the HELP Committee for graciously agreeing to our request to include this language in H.R. 3343.

Mr. ENZI. It is a great pleasure to work with my distinguished colleagues on H.R. 3343, the Health Care Safety Net Act. The Committee on Health, Education, Labor and Pensions has a long and distinguished history of championing legislation improving our health care system. Reauthorization of the health center program, the National Health Service Corps, rural health care programs, and dental workforce programs are a handful of examples of the successful programs the HELP Committee governs. I have had the pleasure of working with Senators KENNEDY and HATCH on this bill, and I very much appreciate the work of Senators SMITH, BARRASSO, ROBERTS, and the other sponsors of S. 3367, which was the genesis of the rural health clinic provision included in this bill. I also sincerely appreciate the contributions of Senators BAUCUS and GRASSLEY, as the rural health provision is under the jurisdiction of the Finance Committee. I look forward to strengthening our relationship next year as our two great

committees work together on health care reform, and I am pleased the passage of this bill puts us one step closer to a higher quality health care system.

Mr. GRASSLEY. I agree with my colleague, Chairman BAUCUS, and would also like to extend my thanks to the chairman and ranking member of the HELP Committee, Senator KENNEDY and Senator ENZI, for working with us on this issue. In my 7 years as chairman and ranking member of the Finance Committee, I have worked to preserve the committee's jurisdiction over legislation amending the Social Security Act, as Senator BAUCUS is doing now. In this case, the CMS certification requirement for rural health clinic designations is governed by title XVIII of the Social Security Act, which, as the Chairman has noted, is within the exclusive jurisdiction of the Finance Committee. The Balanced Budget Act of 1997 required that rural health clinics be located in an underserved or shortage area that were designated or updated within the previous 3 years but the 3-year requirement has only been applied to new facilities seeking to be designated as rural health clinics. The Centers for Medicare and Medicaid Services, CMS, recently issued a rule proposing changes in the requirements for rural health clinics. One of the proposed changes would apply the 3-year designation requirement to all rural health clinics and decertify RHCs located in communities where the shortage area designation is more than 3 years old.

The Health Resources and Services Administration, HRSA, and most States update their shortage area designations every 4 years. We need to align the timeframes for HRSA and CMS shortage area designations so that CMS certifications of rural health clinic designations would be valid for a 4-year period, consistent with the 4-year period used for HRSA designations. Otherwise, many rural health clinics in Iowa and other States throughout the country could lose their RHC designation simply because their State is not able to comply with the new CMS 3-year timeframe for certification.

Under the CMS proposal, if an RHC loses its designation or the State has not renewed its shortage area designation within 3 years, the RHC must request an exception within 90 days or it will be decertified 180 days after the 3-year period ends. Unless the statutory 3-year CMS certification period is changed to 4 years, many RHCs could be subject to being decertified in the near future unless they are deemed ''essential.'' Rural health clinics should not be jeopardized with closure because a shortage area designation has not been updated in a timely fashion by the State or Federal Government.

CMS has estimated that approximately 500 of the 3,700 rural health clinics operating today no longer meet the existing location requirements for RHCs, either because they are not in an area designated by the U.S. Census Bureau as ''nonurban'' or they are not designated by HRSA as being located in an eligible shortage area. Others believe that this estimate is too low. The National Rural Health Association has estimated that the proposed changes to the location requirements could result in up to 45 percent of RHCs being ineligible to continue in the program unless they are granted an exception. If this estimate holds true for RHCs throughout the country, over 1,600 RHCs could be decertified. This would severely impact access to health care for those in rural and medically underserved areas where rural health clinics provide the only access to critical medical services.

We are most appreciative of the efforts of our colleagues, Senator KENNEDY and Senator ENZI, to amend H.R. 3343 to change the CMS certification period for shortage area designations from 3 to 4 years in order to align the CMS certification period for shortage area designations with HRSA's designation review period.

HEALTH INSURANCE

Mr. GRASSLEY. Mr. President, I am here today to talk about health insurance. A year ago, in the spirit of bipartisanship, I joined Senator WYDEN and Senator BENNETT in cosponsoring the Healthy Americans Act. The Wyden-Bennett bipartisan legislation offers elements that are consistent with a ''patient-driven'' approach to improving our health care system. A ''patient-driven'' approach means people can shop for their own health insurance in a competitive marketplace, which will allow them to choose the type of health care coverage that meets their needs. Many in the Democratic Party, including the Democratic Presidential candidate, want a Government-controlled system that is not ''patient-driven.'' This is a non-starter and is bad policy. And the majority of Americans do not want the Government making their health care decisions for them.

I continue to be interested in exploring ways to reform the health care system through the Tax Code. I am interested in examining whether Congress should offer Americans a choice between a tax credit and a deduction for health insurance. The Wyden-Bennett bill raises some tough questions that we need to explore as we look at health care reform. We need to determine the future role of Medicaid and SCHIP in our system over the long haul. We need to explore better ways to make the market work to hold down the rising costs of health care. And we need to find better ways to make health coverage more affordable and secure. This ''patient-driven'' approach—with insurance reforms and changes in the tax treatment of health insurance—should make health insurance more affordable for everyone. The goal should also be, if people are happy with their current health care coverage, they can keep it.

During my tenure in the Senate, I have sought to build bridges between Republicans and Democrats. I believe that there are times where Republicans and Democrats need to come together to produce results. Health care reform cannot be successful if it is not bipartisan. I commend Senators WYDEN and BENNETT for forging the only bipartisan effort in Congress to date.

As I did last year, I want to make clear that my cosponsorship of the Wyden-Bennett bill is not an endorsement of all that the bill proposes. Instead, I am cosponsoring this bill to add my voice to those who are calling for people to work across party lines to find innovative solutions that can work. While I support the ''patient-driven'' approaches in the bill, I have serious concerns about a number of the provisions of the Healthy Americans Act. For example, this bill would require all individuals to buy health insurance. I support accessibility to private insurance and differ with my colleagues on this point. Also, Senator WYDEN's approach envisions a bigger role for Government than I would prefer. In addition, I certainly am not endorsing the repeal of the non-interference clause in Medicare Part D. That is not going to be on the table for me.

I also need to address a concern about the Wyden-Bennett bill I have seen pop up lately. These accusations are particularly troubling because I don't think they are accurate. It is true that the Joint Committee on Taxation has estimated the gross cost of the bill to be about $1.4 trillion annually by the year 2014. It is also true that the Joint Committee on Taxation estimated that the bill is fully paid for so the net cost to the Federal Government is zero. I have also read a concern that the Wyden-Bennett bill does not do enough regarding mandated benefits. The Wyden-Bennett bill reduces the impact of the myriad State mandates so that there will only be a much more limited set of requirements of a health plan much more consistent with what is already provided to Federal employees today.

Finally, I want to refute one particular charge regarding coverage of abortion services. The Wyden bill does not mandate that every American buy a health insurance plan that covers abortion services. This Senator supports legislation that protects life, and one only needs to point to my record in this area for evidence of that fact. I would not support a bill that requires individuals to purchase health insurance that covers abortion, or legislation that encourages women to seek