Kevin M. Esterling

When is Policy Analysis Used in Congress? The Case of Medicare Policy

Executive Summary

This report examines the extent to which members of the US Congress pay attention to policy analysis as they hold hearings on the Medicare program. Why are some hearings on the Medicare program better informed than others, in terms of expert research and policy analysis? Are members of committees sometimes receptive to analytical arguments and evidence-based debate, and other times not? Are there ways to improve the conditions that foster informed discussion and debate in congressional committee hearings?

An examination of Congressional hearings on Medicare between January 2000 and December 2003 indicates that congressional committees tend to have a high demand for policy analysis when they are considering ways to finance benefits, including prescription drug coverage, and expanding services for preventative medicine. Committee members have a lower demand for information when considering mechanisms for regulating health care providers. One salient difference between issues with a high information demand and those with a low demand is whether legislators already know their positions prior to a hearing. Many of the financing issues for Medicare are non-partisan, non-ideological and pragmatic, where members simply wish to learn how to “get it right.” On the other hand, members have a low demand for information on ideological issues, and often use hearings to express opposition to regulation and to the regulatory state itself. Having the ability to identify issues where committee members care about analysis has practical implications for policy analysis, issue advocates, political scientists, and citizens in general.

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Introduction

While recent declarations of a program “crisis” are perhaps premature, runaway costs and coverage limitations are creating a degree of urgency for Medicare reform in the United States (see Oberlander 2003, Patashnik and Zelizer 2000). In 2005, Medicare spent $330 billion providing coverage to 42.5 million beneficiaries. A number of factors are straining the financing of this government-run health insurance program, including the retirement and aging of the “baby boom” generation and the rapid advance of costly medical technology (CMS 2006). The Medicare Trustees, in their 2006 report on the program’s finances, project that the Hospital Insurance Trust Fund (Part A of the program) will become insolvent by the 2018. In addition, coverage for physician services and outpatient care (Part B) and prescription drugs (Part D) have grown significantly faster than the U.S. gross domestic product (for more on the Medicare program, see Figure 1). Currently, Medicare expenditures equal 3.2% of GDP, and the trustees estimate that this figure will rise to 11% by 2080 (CMS 2006).

Congress often considers revisions to the Medicare program to contain costs while maintaining the quality of and access to services. One would hope that as Congress undertakes these revisions, the relevant committee members inform themselves with policy research. The conventional wisdom in the health politics literature holds a rather dim view—that political considerations crowd out reasoned analysis in congressional committees. A recent example is the prescription drug provisions originally proposed by the Bush Administration and incorporated into the Medicare Modernization Act of 2003. However, one can find clear examples of congressional committees making extensive use of analytical research in decision-making, perhaps most famously with the adoption of the Medicare payment system. The current system reimburses hospitals based on a patient’s diagnosis rather than the cost of treating a patient. This payment system creates incentives for hospitals to minimize the costs to patient care (Smith 1992, Quadagno and Street 2005).

This policy brief demonstrates strong variation in the attentiveness of legislators in US congressional committee hearings to systematic policy research on the financing issues that surround the Medicare program (for background on the Medicare program, see Iglehart 2001, Moon 1993 and 2006, Jennings 2004). Two hearings before a Ways and Means subcommittee provide a useful contrast. In a hearing on medical savings accounts, participants simply offer and discuss ideological platitudes on the benefits of privatization and market forces, but make little use of evidence to support their positions. By contrast, in a hearing on risk adjustment methods for Medicare HMO reimbursement, participants make extensive use of research-based, technical and analytical arguments to examine how a given reimbursement formula would have the perverse

Figure 1: Overview of the Medicare Program

Medicare is a health insurance program for:
• people age 65 or older,
• people under age 65 with certain disabilities, and
• people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has three components:

Part A - Hospital Insurance - Most people don’t pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B - Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors’ services and outpatient care. It also covers some other medical services that Part A doesn’t cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Part D - Prescription Drug Coverage - Most people will pay a monthly premium for this coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. Everyone with Medicare can get this coverage that may help lower prescription drug costs and help protect against higher costs in the future. Medicare Prescription Drug Coverage is insurance. Private companies provide the coverage. Beneficiaries choose the drug plan and pay a monthly premium. Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later.

effect of rewarding HMOs that excessively hospitalize and penalize plans that emphasize low-cost outpatient and preventative care.3

Why do lobbyists in some committee hearings use extensive research to support their testimony, while in others rely on opinion and personal anecdote? Why are members of committees sometimes receptive to analytical arguments and evidence-based debate, and other times not? Or more generally, why are some hearings on the Medicare program better informed than others? Are there ways to improve the conditions that foster informed discussion and debate in congressional committee hearings?

Background Literature

A common refrain in the literature on health politics is that policy analysts often make for very bad political analysts. Health policy analysis tends to proceed entirely in the abstract, focusing on problems of efficacy and efficiency in public programs and corresponding solutions, without regard to the political process in which policies are actually decided on and implemented. As Ted Marmor and Gary McKissick (2000, 3) write, “Because many policy analysts pay only cursory attention to the political analysis of Medicare..., the fundamental issues at stake in the debate over Medicare’s future are regularly obscured.” Examples of policy analysis conducted in a political vacuum abound. For example, there is considerable research on inefficiencies in the allocation of program resources and coverage provisions (Fuchs 2000, Cutler 2000, McClellan 2000, Antos and Bilheimer 1999), and coverage provisions affecting access to and the quality of care (e.g., Neumann et al. 1999, Iezzoni 2005, Foote and Blewett 2003). This literature offers policy solutions with scant reference to the political processes that are the root cause for these inefficiencies. When health policy analysts do discuss politics, the claims they offer are often either purely speculative or based on unfounded assertions regarding public opinion or political history (Oberlander 2001).

However, policy analysts may turn the mirror on health oriented political scientists, who to date have failed to systematically analyze when political debates and decisions are informed by policy analysis, and when they are not. Since legislatures produce the policies that govern us, surely policy analysts will be interested to know when the political process is receptive to expert arguments and reasoned analysis, and perhaps more importantly, when not. In the health policy literature, political scientists have reached conclusions that are largely dismissive of the receptiveness of Congress to policy analysis. The common refrain is that politics overwhelms analysis, with the assumption that the two on balance are mutually exclusive (e.g., Peterson 1995).

On some major issues, however, Congress clearly makes extensive use of analytical policy research to reform Medicare. For example, Smith (1992) carefully documents the role of state-level evaluation research as Congress developed diagnosis related groups for the Part A hospital prospective payment system (see also Mayes 2004). Esterling (2004) documents how Congress made careful use of evaluation research on HMOs when considering the Medicare reforms in the Nixon Health Strategy legislation of 1972. In addition, health advocacy organizations involved in day-to-day policymaking, which have direct observation of and involvement in the process, believe that analysis plays an important role in the political process. Some representative quotations:

Alliance for Health Reform: “In the heat of debate, opinion leaders need an unbiased source of information so they can understand the roots of the nation’s health care problems and the trade-offs posed by competing proposals for change. The Alliance for Health Reform exists to provide that information.”

Kaiser Family Foundation: “Through our policy research and communications programs, we work to provide reliable information in a health system in which the issues are increasingly complex and the nation faces difficult challenges and choices.”

Center for Health Affairs, now a part of NORC at the University of Chicago: “NORC is leading a series of analyses to inform policy making related to the Medicare program. Often these projects involve gathering information on trends in the private sector health care market and identifying potential lessons learned for the Medicare program or looking into the implications of program changes for health care providers and Medicare beneficiaries.”

If research did not matter to Medicare politics, these sophisticated organizations would not engage in costly efforts to gather and disseminate research to political actors. Clearly, there are times when evidence does matter to con-
gressional committees as they engage in Medicare reform and times when evidence does not matter. This article tackles the question of when analysis matters and when it does not. Are there systematic conditions that foster the use of evidence in health policy discussions within Congress?

**Measuring Legislators’ Demand For Information**

To understand the conditions that foster the use of policy analysis and evidence, one must be able to distinguish a “well informed” hearing from a “poorly informed” one. The approach I take in this paper is to construct a measure of committee members’ demand for information. Committees have full control over the schedule of witnesses who testify at hearings. To get a sense of how much a committee cares about policy analysis, we can look at the extent to which witnesses at a hearing make use of research and analysis to support their testimony. Panels where witnesses make extensive use of research indicate the committee is very interested in gaining policy-analytic information, and panels where witnesses make little or no use of analysis indicate the opposite.

In this paper, I use data that I gathered from a random sample of U.S. congressional hearings on the Medicare program that were held between January of 2000 and December of 2003. The sample includes 34 hearings with strong variation in the substantive topics considered at the hearings, each of which focused on specific aspects of the program’s financing and health care delivery. I grouped the hearings under the following topics:

1. **Payments rates to long term care providers such as hospices, skilled nursing facilities and home health agencies.** While Medicare does not reimburse for the cost of nursing home care, it does cover these other services that are provided by an industry with high labor costs. According to the General Accounting Office, Medicare spent about $19 billion dollars on long term care services in 2000, a figure that will only rise with the aging of the population over the next few decades.

2. **Payments to managed care plans (HMOs) that participate in the Medicare program.** Managed care plans can enroll Medicare beneficiaries in a plan called “Medicare Advantage” and in return receive a lump sum payment for enrollee. Beneficiaries sometimes prefer managed care plans because they offer comprehensive prescription drug coverage and integrated health care services. Setting the rates for managed care plans is a difficult balancing act, where Congress wishes to set the rates high enough to be attractive to the plans but at the same time realize some cost savings over the traditional Medicare fee-for-service plan. In addition, Congress requires the payments to managed care plans be adjusted for the risk of the population covered, to minimize the tendency of these plans to cherry pick the healthiest – and least expensive – beneficiaries.

3. **Prospective payment rates for physicians under Medicare’s Part B.** Medicare uses a scale to reimburse physicians for services, where the scale values the cost of services across the different specialties. One concern is that under this system, physicians have an incentive to increase either the volume or intensity of services to increase their incomes.

4. **Extending coverage for prescription drugs for outpatient services.** The original Medicare Act of 1965 did not provide for coverage of outpatient prescription drugs. In the meantime, prescription drugs have come to take a more central place in the practice of medicine. Throughout the 1990s, Congress debated how to include coverage of prescription drugs in a manner that was financially sustainable. The result was the new Medicare Part D prescription drug coverage enacted in the Medicare Modernization Act of 2003.

5. **Extending coverage for prevention and preventative medicine services.** Like with prescription drugs, the practice of medicine in 1965 strongly emphasized acute care, or the treatment of disease once it occurs, over preventative medicine, which aims to prevent disease in the first place. It is significantly less expensive to keep a beneficiary healthy than to treat her once she becomes ill. But the original Medicare Act only provided coverage for acute care and currently provides limited incentives for physicians to practice preventative medicine.

6. **Legal strategies to limit fraudulent billing and wasteful practices among providers.** Congress frequently holds hearings where witnesses recount horror stories of how dishonest physicians and health plans.game the Medicare payment systems through fraudulent practices, costing taxpayers millions. At the same time, physicians, hospitals, and health plans complain that they are often investigated and fined for honest bookkeeping errors, criminalizing otherwise honest administrators.
7) Centers for Medicare and Medicaid Services (CMS) regulation and oversight of health care administration and billing practices. Many of the providers who participate in the Medicare program are small businesses, which are often overwhelmed by the quantity of paperwork and documentation they are required to file with CMS for reimbursement.

8) Solvency of the Medicare Trust Fund (Part A) and costs for outpatient coverage (Parts B and D). Medicare consumes approximately 12% of the Federal budget, and the Congressional Budget Office projects the program to incur up to a $1.1 trillion dollar debt by 2012 that would need to be covered from other portions of the budget. This creates pressures as the program is projected to cut into other spending priorities.

I also include hearings on Medicaid financing (a means-tested insurance program jointly financed by the federal government and the states) for comparison. Table 1 summarizes the number of hearings in my dataset that fall under each of these topics, as well as the number of witnesses who participated in these hearings. This list of topics covers the major issues surrounding the Medicare program (see Iglehart 2001).

Table 1. Issues Covered in Medicare Reform Hearings

<table>
<thead>
<tr>
<th>Issues Covered in Medicare Reform Hearings</th>
<th>Number of Hearings</th>
<th>Number of Witnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Managed Care</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Physician Payments</td>
<td>9</td>
<td>35</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>7</td>
<td>33</td>
</tr>
<tr>
<td>Prevention and Preventative Medicine</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Provider Fraud and Waste</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Regulation of Health Care Administration</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Solvency of the Medicare Trust Fund</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Medicaid Financing (included for comparison)</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>138</strong></td>
</tr>
</tbody>
</table>

Source: Author’s dataset; see appendix.

I collected data from the testimony of all 138 witnesses who gave testimony at these hearings. In particular, I coded their testimony for indicators of the presence of policy analysis to support the arguments made, such as the proportion of arguments within their written testimony that cite research, the number of footnotes and references, the number of data tables, and whether the testimony summarizes original research. These data are summarized in the appendix. As I show next, I use these coded indicators to construct a measure of the informativeness of each witnesses’ testimony, and indirectly, the demand for analysis on each of the major Medicare topics among committee members.

### Measuring informativeness

One major difficulty in the study of the informativeness of committee hearings is that “informativeness” itself is very difficult to measure. There is no single reliable measure of the extent to which a witness informs her testimony with analysis. The measurement approach I use makes use of several measures of informativeness, along with a statistical procedure called confirmatory factor analysis, which taken together help to construct a valid and reliable measure of the informativeness of a witness’s testimony. Factor analysis is a statistical procedure for identifying a single measure of an unobserved concept of interest, such as informativeness, based on many observed measures (Skandal and Rabe-Hesketh 2004). I construct a scale of informativeness using four indicators:

1) A count of the number of sentences in the witness’s testimony that cite research (given the total number of sentences in the testimony);
2) The presence of either footnotes or a reference list that cites research;
3) A count of the number of data tables in the witness’s testimony and
4) Whether or not the testimony summarizes original research conducted by the witness.

To test the validity of the informativeness scale as a measure of committee members’ demand for information at a hearing, I include one additional indicator: The number of analytical questions that committee members ask at the hearing (given the total number of questions committee members ask at hearings).

To get a sense of how much a committee cares about policy analysis, we can look at the extent to which witnesses at a hearing make use of research and analysis to support their testimony.
An illustration of a testimony that ranks low in its informativeness is when the president of a company spent most of her time urging the committee to pass legislation that would make the company’s product eligible for Medicare reimbursement. On the other hand, a highly informative testimony was one in which the director of public policy research in a large lobbying organization provided detailed, expert testimony based on original research.

The appendix describes the measurement model and its results in more detail. While the model itself is mathematically complicated, its output is very easy to understand. The model takes all five indicators and creates a composite scale, ranging from 1 to 10, where the higher the witness scores on this scale, the more informative is his/her testimony. Figure 2 shows the output of this model. In this graph, witnesses are sorted on the horizontal axis, where those on the left hand side of the graph have the least informative testimony, and those on the right hand side have the most informative testimony. The vertical axis shows the level of informativeness from 1 to 10, and each dot indicates the score of each witness on this scale. The bars surrounding each dot indicate the level of statistical uncertainty for each witness’s score. From this graph, one can see that statistically, there are three distinct groups of witnesses, about one-third have low degrees of informativeness, about one-third have high degrees of informativeness, and the rest fall in between.

Validity of the Informativeness Scale

Since it is the committee who schedules witnesses to testify, I take the informativeness scale as a measure of the committee’s demand for information. The measurement model itself contains a validity test of the claim that committees that schedule informative witnesses have a greater demand for information. As I detail in the appendix, the model results demonstrate that in hearings where informed witnesses testify, the committee members tend to ask analytical questions that are subject to verification and falsification. This shows that the committee tends to schedule more informed witnesses as the demand for analysis increases among committee members. In addition, in a separate analysis (not reported here), I demonstrate that witnesses tend to give more informative testimony when an employee from a support agency (such as the General Accounting Office or Congressional Budget office) also testifies. Congress relies on the support agencies for independent and accurate policy information. This analysis shows that when the committee wishes to learn about policy analysis through support agency testimony, they also tend to schedule other witnesses who also give informed testimony.

Figure 2: Witness Testimony Ranked by Informativeness

<table>
<thead>
<tr>
<th>Informativeness Rank</th>
<th>0</th>
<th>50</th>
<th>100</th>
<th>150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informativeness</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>(Expected Value)</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>

Note: Some witnesses have a low informative score, some medium, and some high. The blue dots indicate the estimated score for each witness, and the bars indicate the 95% confidence interval for each witness.

Variation Across Topics

The informativeness scale stands as a useful measure of committee members’ demand for information. Given this measure, it is possible to test whether the committees with jurisdiction over the Medicare program have a higher demand for policy analysis on some issues than on others. And given a pattern of findings across issues, it may be possible to detect a pattern for the types of issues on which committees attend to analytical information.

The results summarized in Figure 3 shows the relative degree of committee members’ demand for policy information across the major topics relevant to the Medicare program. For the analysis presented in this figure, I have classified each witness (out of 138 witnesses in the sample) by the topic of the hearing in which they gave testimony. The height of each bar indicates committees’ average demand for information on that topic, where this measure can range from zero to ten. I have placed a line corresponding to the topic with the median level of information demand, which was “Managed Care.” Bars that are below the line indicate
Legislators tend to have a high demand for policy analysis in hearings on prescription drug coverage, solvency of the Medicare trust fund, and expanding coverage of preventative medicine practices. One common thread for these topics is that Congress is very interested in reforming these aspects of Medicare so as to preserve the fiscal integrity of the program.

First, consider prescription drug coverage. Throughout the 1990s, Congress struggled mightily with the issue of how to cover prescription drugs within reasonable fiscal constraints. Compared to when Medicare was first enacted in the mid-1960s, prescription drugs have become very important to the practice of medicine and also have become far more expensive. Up until Congress enacted the prescription drug proposal in the Medicare Modernization Act (MMA) of 2003, the program did not provide nearly any coverage for prescription drugs. Seniors were demanding prescription drug coverage, but committee members were very concerned about the costs of such a program spiraling out of control. While one can debate the merits of the terms of coverage embodied in the MMA (see e.g., Moon 2006), the Ways and Means committee and the Energy and Commerce Subcommittee on Health spent a considerable amount of time and effort throughout the 1990s and early 2000s struggling with alternative means to establish a prescription drug benefit for seniors in a manner that was fiscally responsible. And even in the MMA, the much vilified “donut hole” (or gap in coverage for those with moderate prescription drug expenses) was an attempt to keep the otherwise popular program within budgetary constraints.

Second, consider solvency of the Medicare trust fund. Here the concerns often center on the analysis prepared by the trustees of the Medicare program, with both short and long term projections of the long-term financial health of the program (see Oberlander 2003). In addition, these hearings consider the ever growing impact of the program on the overall federal budget. Here, members of the House and Senate Budget committees wish to know how to preserve the program that is so popular among seniors, but with an eye on minimizing the impact of the program on the overall federal budget.

Finally, consider expanding coverage of preventative medicine. When Medicare was enacted, its structure emulated the traditional, fee-for-service private health insurance that at the time dominated the health insurance market. At the time, medical practice was focused almost exclusively on treating diseases, rather than preventing disease and promoting health. As a result, Medicare has very generous coverage for in-patient treatment, but limited coverage of ambulatory care. In addition, the program contains almost no incentives for physicians to focus on the overall health and well-being of patients, and to regularly practice preventative medicine (see Gusmano and Schlesinger 2001). Treating disease is very expensive, while it is relatively cheap to keep patients healthy. As a consequence, Medicare spending is very inefficient, for example treating the symptoms of diabetes rather than providing a means for
patients to keep their diabetes under control (Abraham 1993).

Conversely, the results presented in Figure 3 indicate legislators tend to have a low demand for information when considering how the Centers for Medicare and Medicaid Services (CMS) regulates the administration of health care providers. In these hearings, committee members focus on the paperwork burden of small health care providers and the complexity of contracting with CMS for processing payments. One salient contrast between this set of poorly informed hearings and those that tend to be well informed is that committee members tend to already know the answers to the legislative inquiry: committee members already know they wish to reduce paperwork burdens. Reading between the lines, these hearings have a strong ideological tone that taps into anti-regulatory and anti-government sentiment—that CMS is too heavy handed in its administrative practices. In contrast to preserving and expanding benefits for seniors (which committee members wish to do well) committee members in these regulatory hearings seem to shift into an ideological mode and wish to express their frustration with, and opposition to, the regulatory state itself, an ideological-driven preference that was especially predominant beginning with the conservative Republican takeover of the House in 1994.

When Do Committees Care About Information?

To date, political science has been mostly dismissive of the prospects for policy expertise and the use of analysis in the legislative process. The discipline has devoted very little research to the topic. Even casual observation of the day-to-day politics of Medicare, however, shows that on some issues, such as those that touch on financing of politically popular benefits, Congress cares very much about policy analysis. At the same time, on other issues it equally apparently does not. This was most apparent in the hearings that had an ideologically-driven, anti-regulatory purpose. Taking a step back from the analysis, it appears that what distinguishes issues where legislators seek information from those where they do not is that in the former, committee members have not already made up their minds on how they will write legislation. On many issues, legislators have strong ideological or personal beliefs about what makes for good public policy. For example, committee members with a strong preference for free markets might favor health savings accounts as a way to create competition among providers, independently of evidence in the health economics literature indicating that patients are not very effective in comparison shopping among health providers. Or committee members who are strongly opposed to abortion might oppose embryonic stem cell research even if evidence comes to light that this research has strong scientific claims. For issues such as these, some members will not be persuaded no matter how much policy analysis is presented at hearings (Weaver 2000: 144).

But for the Medicare program, many of the issues are non-partisan, non-ideological, and pragmatic in nature. All committee members wish to control the costs of the program, while maintaining access for seniors and quality of care. Such goals can be accomplished by improving the coverage of preventative services, by creating prospective payments systems that reward efficiency in treatment, and by creating pricing systems for inpatient prescription drugs that create competition among drug companies. For these issues, committee members wish to “get it right,” and so care very much about the available policy analysis and recommendations from policy experts.

One counter-argument to this line of reasoning goes as follows: We all know that in politics, advocates often use research as “ammunition” to support their self-interested positions, not as information to help shape their positions (see Weaver 2000: 139). Lobbyists and legislators alike sift through research, indeed sometimes manufacture their own “research,” and discuss only those research findings that happen to support their existing policy preferences. In this case, one might expect that research-based arguments serve only to justify otherwise ideologically-driven issue positions. This counter-argument, however, is strongly contradicted by the results of this paper. Instead, it appears that the ideological tone of an issue tends to suppress the use of research in political discourse. The results suggest that when members in effect have a closed mind, lobbyists and committees alike recognize that constructing and consuming research-based arguments is not worthwhile, or not cost effective in terms of their time and organizational resource commitments.
Policy Implications

The results of this study illustrate a tension between pragmatism and ideology, a tension that many believe to be inherent to democracy itself. One might argue that debates within legislatures are supposed to express the ideologies that reflect the core values of our society. In its purest form, ideological thought is resistant to different perspectives and new information, since core values cannot be bargained over or traded off at the margin as if they were tradable commodities. To the extent debate is driven by ideological concerns, however, one might have good reason to be concerned if one believes that it is good for society for governmental decision makers make use of the best knowledge and information when constructing policies. The results show that committees tend to strike a balance between these two conflicting goals of democratic government when debating Medicare: they tend to seek new information when the issue is more pragmatic, and less information when the issue is more ideological.

For some issues, there may be a strategic advantage to invest time and resources into incorporating research... while on other issues research may confer no advantage or indeed a disadvantage.

Distinguishing between issues where members care about research and where they do not care about research can have several practical implications for practitioners, for political scientists, and for citizens in general. First, for policy analysts who wish to have their research have an impact on legislated policy, one might expect the marginal impact of research to vary across issues. On some issues, the marginal benefit of conducting research might be higher than on some other issues. Alternatively, it is possible that researchers have the capacity to reframe an issue from an ideological issue to one that is more pragmatic. As Quadagno and Street (2003: 65) note, market-based approaches can help to forge a pragmatic consensus between liberals and conservatives on social welfare policy. For example, a researcher might propose an innovative market mechanism that creates constructive competition among providers, and that allows patients to make informed choices. Such a mechanism could appeal to free market conservatives, fiscal conservatives interested in reducing government spending, and liberals interested in expanding program benefits for seniors.

Second, for policy advocates, knowing on which issues legislators care about research may help advocates think strategically about how to lobby committee members. For some issues, there may be a strategic advantage to invest time and resources into incorporating research to support arguments, while on other issues research may confer no advantage or indeed a disadvantage.

Empirical studies of this sort can also help improve the practical knowledge among political scientists of the mechanisms that enhance and suppress the use of policy analysis in legislative politics. If one assumes that arguments are more persuasive when backed by research findings, one might be concerned that this “advocacy use” of research creates biases in the discourse over legislative issues and decisions. But in situations where advocates on all sides of an issue support their claims with research, the net effect could be to make the issue well-informed overall. Rather than lament the biased use of research by a single advocate, the key may be to foster the conditions where all sides to a debate find incentives to invest in research and factual evidence to support their claims. This might suggest to Congress the need for a greater investment in policy research funding from scientific programs such as the NSF and NIH to make objective policy research more readily available to all sides of a debate. Congress might also consider increasing its own capacities to research issues through agencies such as the General Accounting Office and the Congressional Budget Office.

Finally, citizens of this democracy may find it reassuring that our elected representatives make at least some use of policy analysis while they consider reforms to the Medicare program. Indeed, the results in Figure 3 indicate the glass is perhaps more than half full: among the full set issues reported in the table, only one issue is distinctly below average of the informativeness scale. Overall, Congress makes extensive use of research at most of these hearings—a finding that may reassure us about the health of our democratic institutions.
Notes

1 This research was supported in part by a grant from the Robert Wood Johnson Foundation, and in part by a grant from the UCR Academic Senate. The statements made herein do not necessarily reflect the positions or beliefs of these funding agencies.

2 See Christopher Lee, “Shift in Congress Puts Health Care Back on the Table; Expecting a Mixed Reaction Across the Aisle, Democrats Plan to Offer Ideas on Drug Cost, Safety,” The Washington Post, December 25, 2006; Page A12


5 http://www.allhealth.org/mission.asp

6 http://www.kff.org/about/index.cfm

7 http://www.norc.org/issues/health5.asp

8 Technically speaking, Figure 2 shows the results of an ANOVA analysis, which tests whether the average informativeness of witnesses for a given topic is statistically different from a baseline topic. For the baseline topic, I chose the topic with the median degree of informativeness: Managed Care. The dark bars indicate categories that are statistically different from the baseline topic.

9 This is not to say that advocates abandon research on ideological issues, or that think tanks never manufacture research to support ideological positions for use in legislative politics. This is a relative claim that ideology has a tendency to suppress research-based arguments compared to pragmatism.

Appendix

I coded data from 138 witnesses who gave testimony in a random sample of hearings held between January 2000 and December of 2003. To conduct the analysis in Figure 3, I construct a measure of how informative is each witness’s testimony. I use confirmatory factor analysis to construct the informativeness scale. In the model, I allow the following four variables to load on a single latent variable: 1) The number of research based arguments in the witness’s testimony. This variable has a mean of 7.9 and a standard deviation of 9.9. In addition, the model controls for the total number of sentences I coded for each witness (mean of 71.6, standard deviation 18.5). 2) A dummy variable that is one if the witness cited research in footnotes or endnotes and zero otherwise (mean of 0.25, standard deviation of .43). 3) A count of the number of data tables included in the witness’s testimony (mean of 0.47, standard deviation of 1.6). 4) A dummy variable that is one when the testimony summarizes the witness’s original research and zero otherwise (mean of 0.06, standard deviation of 0.24).

In addition, to test the validity of the informativeness scale as a measure of legislators’ demand for information (see discussion on p. 6 above), I include a count of the number of falsifiable, analytical questions that committee members ask at each hearing (mean of 87.9, standard deviation of 90.7), holding constant the total number of questions asked (mean of 177, standard deviation of 174.2).

<table>
<thead>
<tr>
<th>Table A.1 - Measurement Model Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of research-based arguments</strong></td>
</tr>
<tr>
<td><strong>Presence of footnotes and references in testimony</strong></td>
</tr>
<tr>
<td><strong>Number of data tables</strong></td>
</tr>
<tr>
<td><strong>Testimony summarizes original research</strong></td>
</tr>
<tr>
<td><strong>Number of analytical questions from committee member</strong></td>
</tr>
</tbody>
</table>

Mean of the Informativeness Scale = 6.53
Variance of the Informativeness Scale = 2.44* (SE=0.62)

Number of Level 1 Units = 572
Number of Level 2 Units = 131
*p<0.05
Huber-White robust standard errors in parentheses
*Equation controls for the total number of lobbyist arguments coded
bEquation controls for the total number of questions from committee members
change the scale from standard deviation units to a scale that ranges from zero to ten. The rescaled variable has a mean of 6.5.

References


Policy Matters
Volume 1, Issue 2

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When is Policy Analysis Used in Congress? The Case of Medicare Policy

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