Original Investigation

What Can Health Communication Science Offer for ACA Implementation? Five Evidence-Informed Strategies for Expanding Medicaid Enrollment

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Context: Implementing the Affordable Care Act (ACA) in 2014 will require effective enrollment and outreach efforts to previously uninsured individuals now eligible for coverage.

Methods: From 1996 to 2013, the Health Communication Research Laboratory conducted more than 40 original studies with more than 30,000 participants to learn how to improve the reach to and effectiveness of health information for low-income and racial/ethnic minority populations. We synthesized the findings from this body of research and used them to inform current challenges in implementing the ACA.

Findings: We found empirical support for 5 recommendations regarding partnerships, outreach, messages and messengers, life priorities of low-income individuals and families, and the information environment. We translated these into 12 action steps.

Conclusions: Health communication science can inform the development and execution of strategies to increase the public's understanding of the ACA and

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to support the enrollment of eligible individuals into Medicaid or the Health Insurance Marketplace.

Keywords: Affordable Care Act, health communication, low-income, minority health.

AMONG THE GREATEST CHALLENGES TO IMPLEMENTING THE Affordable Care Act (ACA) in 2014 will be the enrollment of and outreach to previously uninsured individuals now eligible for coverage.^{1,2} The estimated 50 million uninsured include low-income individuals who may never have had insurance coverage, have been unable to afford coverage, have faced difficulties navigating public and private health insurance systems, or have been ineligible for coverage.³

With 26 states having decided to expand Medicaid in 2014, the Congressional Budget Office estimates that by 2016, 12 million to 13 million people may enroll through a Medicaid expansion for persons under 138% of the federal poverty level.⁴ Many will be eligible for Medicaid for the first time and will be navigating a program that always has been difficult to understand and carried a great deal of stigma.

By 2016, an additional 24 million to 25 million low-income individuals, young people, and people working for small businesses are expected to enroll in Health Insurance Marketplaces, and many will find it difficult to navigate the health insurance system, especially if the literacy demands are high.⁴ Both the federal government and the states must address these challenges.

In this article, we consider how the implementation of the ACA's expanded coverage might benefit from two decades of health communication research on diverse and low-income populations by the Health Communication Research Laboratory (HCRL) at Washington University in St. Louis. We believe that our findings and recommendations will be most helpful to state policymakers developing strategies for outreach and enrollment under the ACA, navigators providing outreach and enrollment support for newly insured persons, and, possibly, insurance organizations also keenly interested in implementing the ACA.

Methods

Research at the HCRL, one of 5 Centers of Excellence in Cancer Communication Research funded by the National Cancer Institute,⁵ seeks to identify promising strategies to increase the reach and effectiveness of health information to low-income, minority, and uninsured populations and to connect these groups to health services. The research spans a continuum from basic audience research (eg, understanding the life circumstances, priorities, values, experiences, and patterns of daily living for specific target populations), to measuring and describing health-related characteristics (eg, awareness, knowledge, beliefs, and behaviors), to developing communication-based strategies to change behavior (delivered in a variety of ways in community and clinical settings) and evaluating the effects of these solutions in controlled experiments and large randomized field trials.

For this article, we reviewed all of HCRL's work from 1996 to 2013 and identified studies that (1) focused on lower-income populations likely to be eligible for expanded health insurance coverage through the ACA and (2) contained material that could be applied to reaching, engaging, and/or communicating effectively with those populations about health insurance. Table 1 provides research and sample characteristics from 19 of these studies that met our criteria and are discussed in this article. These studies focus on many of the same populations that the ACA is trying to reach, particularly those people with low incomes and/or without a college education, single-parent households, and racial/ethnic minorities that may face some of the greatest challenges as the ACA is implemented. Figure 1 shows the distribution of these same characteristics across the population of currently uninsured individuals in the United States. Like the HCRL samples, nearly half the currently uninsured are below 300% of the federal poverty level and are disproportionately African American and Hispanic.

Drawing on this body of HCRL research, we sought to determine what health communication science can tell us about how to best reach, inform, and help low-income individuals and families enroll in health care coverage and actively participate in their health care. We hope that our findings from these studies can help states implement the expanded coverage of health care under the ACA. This article organizes these findings into 5 areas—*Partnerships, Outreach, Messages and Messengers,*

TABLE 1
Research and Sample Characteristics of Selected HCRL Studies Highlighted in This Report

Research Focus and Design		Socioeconomic Status			
Study Topic	Type ^a	N	Uninsured (%)	Income ^b	Education ^c
Health outreach through computer kiosks ²⁵⁻²⁷	Usage/GIS	7,297	22	—	—
Health referrals to 2-1-1 callers ¹⁰	RCT	1,898	40	86% < \$25K	60% ≤ 12 yrs
Health risks of 2-1-1 callers ⁸	Survey	1,408	34	—	—
Testing culturally tailored messages ³⁵	RCT	1,227	—	71% < \$20K	68% ≤ 12 yrs
Black newspaper readers and health-1 ⁵⁹	Survey	783	—	53% < \$25K	46% ≤ 12 yrs
Testing cultural appropriateness strategies ²⁹	RCT	771	14	37% < \$20K	39% ≤ 12 yrs
Black newspaper readers and health-2 ⁵⁸	Survey	710	—	42% < \$25K	39% ≤ 12 yrs
Understanding Food Stamps clients	Survey	685	31	—	69% ≤ 12 yrs
Evaluating a mobile research van ³¹	Survey	599	—	78% ≤ \$20K	69% ≤ 12 yrs
Using stories for health improvement ²⁸	RCT	489	—	77% < \$20K	67% ≤ 12 yrs
Social networks and ACA knowledge ⁵³	Network analysis	398	34	79% < \$20K	56% ≤ 12 yrs
Testing tailored calendars in FQHCs ⁵⁰	Quasi Experiment	321	—	—	—
Testing health disparity messages ³⁶	Experiment	300	—	43% < \$25K	89% ≤ 12 yrs
Feasibility of health screening in 2-1-1 ⁹	Survey	297	26	—	—
Finding keys to effective stories ⁴⁰	Experiment	200	—	82% ≤ \$20K	75% ≤ 12 yrs
Journalists' reactions to disparities ³⁸	Experiment	175	—	—	—
Measuring cultural values ⁴⁷	Survey	72	—	mean = \$15K	mean = 12 yrs
Emotions and stories ⁴²	Experiment	59	—	34% ≤ \$20K	19% < 12 yrs
Developing cultural health messages ³⁷	Formative	49	—	62% < \$20K	44% ≤ 12 yrs

^aRCT = randomized controlled trial
^bannual pretax household income
^c12 years = high school diploma/GED

FIGURE 1. Characteristics of the US Uninsured Population.

Source: Analysis of March 2012 and 2013 Current Population Surveys by Washington University.

Priorities of Vulnerable Populations, and *The Information Environment*—and concludes with 12 recommendations about how these findings might be applied.

Key Findings from Five Areas of HCRL Research

Partnerships Can Expand Reach

Reaching low-income, uninsured individuals and families to help them enroll in expanded Medicaid or the Health Insurance Marketplace will be a fundamental challenge for those implementing the ACA. Outreach strategies cannot rely solely on contact through health care organizations because the target audiences often are not engaged in systems of care.

Moreover, health care providers and insurers (including Medicaid) have a mixed record of reaching and engaging low-income populations.¹

In contrast, many large public agencies and other national systems have been quite successful in doing so. For example, the HCRL has partnered with programs and systems like Food Stamps and 2-1-1 to reach vulnerable populations with health information.

The 2-1-1 system is a 3-digit telephone information and referral service that connects people to health and social services in their community. The nearly 200 2-1-1 call centers in the United States handle 16 million interactions per year and serve populations that are disproportionately low-income, low-education, and/or unemployed.^{6,7} The overwhelming majority of 2-1-1 callers are seeking assistance with basic human needs such as finding or paying for shelter, heat, electricity, or food. In surveys of 2-1-1 callers across the United States, we found that 26% to 43% are uninsured and, compared with the general population, use clinical prevention services much less often and are more likely to engage in risk behaviors like smoking.⁸⁻¹⁰

The uninsured population's use of 2-1-1 makes its local and regional call centers highly attractive as partners for health outreach in general⁷ and for implementing the ACA in particular.¹¹ Some 2-1-1s already have adopted these roles. In San Diego, specially trained 2-1-1 health care navigators give callers information about health insurance coverage, screen them for Medi-Cal (California's version of Medicaid) eligibility, and help them complete and submit their application.¹² In Los Angeles, 2-1-1 information specialists screen callers with young children for signs of developmental delay and autism and help those who might be at risk enroll in appropriate follow-up, support, and assistance programs.¹³ In Toronto, 2-1-1 offers specialized services to help immigrants navigate health care services.¹⁴

In our HCRL research on 2-1-1 Missouri, we screened a random sample of 4,761 callers for 6 health risks and enrolled a subset of them into a randomized trial to address the risks that we identified. Overall, one-quarter of callers who received proactive health referrals contacted at least one referral within the next month.¹⁰

The Food Stamps program—now formally the Supplemental Nutrition Assistance Program (SNAP)—helps poor people buy food. More than 40 million persons receive SNAP benefits,¹⁵ with participation rising since the 2007-2009 recession.

In a 2009 random sample survey of 685 Food Stamps participants in St. Louis, HCRL researchers found that the lack of health insurance was

common (31%), that participants were more likely to report using ER services in the last year than having a personal doctor (61% vs 55%), and that the need for specific health services was great.¹⁶

A statewide project in Missouri partnered HCRL researchers with Food Stamps offices to integrate health and social service systems.¹⁷ The survey had shown that although both smoking rates (42%) and interest in quitting smoking were high among Food Stamps recipients, their awareness of the state's free and evidence-based tobacco Quitline service was low.¹⁸ In September 2011, the Missouri Department of Social Services sent a letter to Food Stamps office managers encouraging them to distribute Quitline referrals to their clients who smoke. Within four weeks, every Food Stamps office in Missouri ($n = 117$) had ordered customized Quitline referrals from HCRL,¹⁹ and site visits conducted eight months later found that all but two were still distributing the referrals.²⁰

In developmental studies and audience research, the HCRL has demonstrated the potential benefits of partnerships with other large, national programs that serve low-income populations, including Public Housing, Low-Income Home Energy Assistance Program (LIHEAP), Unemployment Services, and School Lunch Programs. HCRL research found that in addition to their wide reach, these programs are often better known among low-income populations than are many health-focused programs designed to reach the same groups.

As Oberlander described, these systems might enhance the implementation of the ACA in four broad ways: screening for eligibility, providing application assistance, making referrals to exchanges or support services, and amplifying awareness and communication campaigns.¹¹ Although bureaucratic obstacles may impede partnering with large public agencies,²¹ because these programs are usually administered at the state and local level, they provide an opportunity to experiment with different partnership models and strategies and to build on the most successful approaches.

Meet People Where They Live

Using place-based strategies for more effective public health education and outreach to at-risk populations has a long history. Health promotion programs delivered through barbershops,²² beauty salons,²³ and

TABLE 2
Percentage of Uninsured Kiosk Users, by Setting

Setting (# of kiosk users)	Percent Uninsured	
	Age < 40	Age ≥ 40
Libraries (1,744)	25.4	25.8
Laundromats (1,076)	20.9	25.8
Churches (286)	20.4	12.8
Beauty salons (511)	18.8	10.5
Neighborhood health centers (2,180)	16.4	28.1
Social service agencies (1,188)	15.9	18.1
Health fairs (312)	6.0	7.7

churches²⁴ are among the best-known examples of this approach, along with other applications such as outreach through community centers, grocery stores, and pharmacies.

From 2004 to 2008, we undertook a large field study to identify the most promising community venues for distributing breast cancer screening information to low-income African American women through interactive computer kiosks. Our analyses showed that laundromats and libraries were by far the most promising places for breast cancer education and outreach because (1) they reached the most women per day and (2) the women who used a kiosk in these settings had the greatest need for screening-related information.^{25,26} As Table 2 shows, the proportion of kiosk users with no health insurance also was highest in these settings.

In Geographic Information System (GIS) analyses as well, the same two settings—laundromats and libraries—were found to have the most localized catchment areas.²⁷ On average, women who used a kiosk in one of these settings lived within a 2-mile radius of the place where they used the kiosk. For other settings, the “range” was 4 to 6 miles. Thus, certain venues might be especially useful for outreach efforts targeting geographically defined areas.

The aforementioned survey of Food Stamps recipients also provided insights into those community settings frequented by low-income individuals and families. Most of the respondents indicated that in the last 30 days, they had gone to a park near their home, a thrift store, or a public library. They also engaged in activities that were strongly linked to place. For example, a majority of the respondents had purchased a

money order in the last month, meaning that they visited a point of sale such as a convenience store, post office, or grocery store.

We also had success going directly to the places where people live, their homes and neighborhoods. Our mobile research facility, the Neighborhood Voice, is a shuttle-like vehicle refitted for one-on-one or group interactions with up to 8 participants. For a range of large trials²⁸⁻³⁰ and smaller audience research studies, we drove the Neighborhood Voice into neighborhoods where the data showed elevated health risks. Using door-to-door canvassing and other approaches, we invited residents to come into the vehicle to view and respond to health information videos and other materials and to complete surveys or interviews.

This approach reached a large number of residents who had never before participated in a research study (72%). Overall, 93% were aware of the Neighborhood Voice before they came aboard, mostly from seeing it in their neighborhood or elsewhere in St. Louis, on a flyer, in the media or from hearing about it through word of mouth. Two-thirds rated their experience aboard the vehicle as “excellent,” with convenience (eg, “it came to my neighborhood”) and comfort (eg, “the chairs were comfortable”) being important factors in their positive experiences.³¹

Different settings provide access to different subgroups of low-income populations. For example, thrift stores reach more women than men, and laundromats are often located in areas with a high proportion of renters and young children. We do not presume that our findings about “place” generalize to all low-income populations. Our studies were conducted in primarily urban settings with disproportionately African American samples and often focus on cancer-related outcomes. But our approach of using data to inform place-based outreach should translate well to any population of interest for expanded ACA coverage.

How Messages Are Framed and Who Delivers Them Is Important

It has long been presumed that health information for diverse population subgroups is more effective when it is “culturally appropriate” to that group’s members. But until recently, evidence supporting this presumed benefit was lacking.³² We identified four cultural values of African American women—spirituality, collectivism, racial pride, and time orientation—around which health information might be framed.

We found that these cultural values were associated with health protective behaviors³³ and positive reactions to health information.³⁴

We also found that presenting health information in the context of these values increased the odds that women would get mammograms and improve their diets.³⁵ For example, a highly spiritual woman would receive information that emphasized how medical advances like screening technology were “a gift from God” and how together with “the power of prayer” a mammogram could help save women’s lives. Findings from these HCRL studies suggest that the impact of health information can be enhanced by framing it in ways that reinforce or build on existing cultural values and beliefs.

For a long time, one of the most common message strategies to motivate action in vulnerable populations has been to call attention to a problem and its magnitude or disparity in a given group. The implicit assumption is that showing such data to group members will be sufficiently alarming or threatening to stimulate a response. HCRL studies suggest that not only is this conventional wisdom wrong but that the opposite may be true: exposure to group-specific information that emphasizes a group’s health shortfalls may actually *reduce* the likelihood that group members will take health-protecting action.

In a randomized, double-blind experiment, African American men and women viewed different versions of a mock newspaper article on colorectal cancer (CRC) and screening. One version emphasized *disparities*, showing that African Americans had higher rates of CRC and lower rates of screening than whites did. Another version emphasized *progress*, showing rates only for African Americans and over a 20-year time frame to illustrate the steady improvements being made. Findings showed that the disparity-framed article elicited significantly more negative emotional reactions, fewer positive reactions, and less interest in getting screened for CRC than did the progress-framed article.³⁶ Qualitative research in a separate sample reinforced these findings.³⁷

In a follow-up experiment, 175 health reporters and editors from US news media outlets read the same articles. Across every category of news values, the disparity-framed story was rated as significantly more newsworthy than the progress-framed story.³⁸ But this study had an interesting twist: journalists who were shown the findings from the first disparity-framing study before viewing the articles saw equal value in reporting progress. Given that progress framing appears more motivating to vulnerable populations, public information about efforts

to expand health insurance coverage might focus on enrollment successes and benefits.

A third major strand of the HCRL's messaging research explored the potential power of stories or narrative forms of communication. Stories have distinctive capabilities, including helping people—especially those with lower literacy—understand and use health information.³⁹

In a series of randomized experiments and intervention trials with very low-income African American women, HCRL scientists compared the effects of narrative and informational videos on beliefs about breast cancer and use of mammography. Women who watched a DVD of personal stories from African American breast cancer survivors were significantly more likely than those who watched an informational DVD to rate it as easier to understand, recall core content, perceive breast cancer as an important problem, talk to family members about it, perceive fewer barriers to getting a mammogram, have more motivation to get a mammogram, and—among women with less than a high school education—get a mammogram during a 6-month follow-up period.^{40,41}

Ancillary studies highlighted the critical roles of emotion and engagement in achieving these outcomes^{42,43} and the importance of trusted and credible messengers. When viewers identified with the storyteller—liked her and felt similar to her—it increased their engagement in the story, positive evaluations of the story, and recall of story content.³⁰

With the success of breast cancer survivors as messengers, we explored the potential of using lay health coaches, or navigators, to provide a wider range of health information to low-income callers through 2-1-1 Missouri. Our findings showed that callers who had telephone interaction with a health coach were more than twice as likely to contact a health referral agency compared with those receiving only a verbal referral.¹⁰

Health Is Among Many Needs of Vulnerable Populations

One of the most important findings from HCRL research has been the critical role of unmet basic needs in shaping the lives and health-related actions of low-income individuals and families. Those living in poverty often struggle finding or paying for shelter, heat, electricity, and food and even ensuring their own physical safety in dangerous neighborhoods or threatening relationships. People faced with these

challenges understandably perceive nonacute health issues—certainly disease prevention—as less relevant or, at best, a secondary priority.⁴⁴

Our HCRL research began measuring and observing these basic needs in study samples. Across one sample of 2-1-1 callers ($n = 1,898$), only 5% had no unmet basic needs; 16% had 1 unmet basic need; 33% had 2 unmet basic needs; and nearly half (46%) had 3 or more unmet basic needs.⁴⁵ Those with no health insurance had significantly more unmet basic needs than did those with health insurance.

We also compared the effectiveness of higher- and lower-intensity interventions among 2-1-1 callers with varying levels of unmet basic needs. The interventions were equally effective when unmet basic needs were low, but when basic needs were high, the higher-intensity intervention (ie, health coach/navigator) was significantly more effective.⁴⁵ Efforts to enroll low-income populations in expanded health insurance coverage should adopt strategies that can help address basic needs while making it as simple as possible to obtain enrollment and access services.

Understanding the sources of happiness, pleasure, pride, and other positive attributes and assets in target populations is equally important. While surveying a racially diverse sample of 685 Food Stamps participants in St. Louis, we asked how much they enjoyed each of 15 activities. The top-rated responses were listening to music, watching movies, cooking, reading, writing, dancing, playing cards, and bowling—all with mean scores of 7 or higher on a scale of 1 to 10. Marketing professionals routinely collect and use this sort of information to help formulate strategies to reach and appeal to specific target audiences, including the tobacco industry's well-documented efforts.⁴⁶ The same information also can be used for purposes like enrollment in health insurance programs.

As an example, we were able to increase children's vaccination rates by giving their parents something they valued, pictures of their baby. To encourage vaccination for their babies 0 to 24 months of age, the ABC Immunization Calendar, a simple software program built by the HCRL for use in neighborhood health clinics, created personally tailored calendars for parents. When parents learned that we would be taking their child's picture and putting it on a personalized calendar, many went home and returned with their baby dressed up for a picture. Providing pictures kept them coming back and increased vaccination rates.⁴⁷

In a survey of 1,227 African American women patients from Federally Qualified Health Centers and neighborhood health clinics in St. Louis, we found that women endorsed collectivism more strongly

than other values.⁴⁸ *Collectivism* is a cultural norm in which the needs and interests of the group take precedent over those of the individual. This interdependence—for example, sharing limited resources—is highly functional among groups living in poverty.⁴⁹

In our sample, large majorities of women (72%-83%) reported that it was very important that they and their family “take responsibility for caring for older family members,” “do everything they can to help each other move ahead in life,” “turn to each other first in times of trouble,” and “raise each other’s children whenever there is a need.”³⁴ Women who endorsed these beliefs most strongly were more likely than other women to view health messages as personally relevant.

Helping ensure health insurance coverage for one’s immediate and extended family is consistent with collectivist values and suggests that certain family members might bring ACA information to their kin and social networks and help them with enrollment. This concept of familial influence through a family health “kin keeper” has shown promise as a strategy for disease prevention.⁵⁰

How People Get Their Information Is Crucial

The availability, accessibility, and suitability of health information vary based on where one lives, who one is, and with whom one interacts. Economically vulnerable populations often live in information-poor environments,⁵¹ which may limit their exposure to health information.⁵² HCRL research has sought to understand and enrich the information environment in such communities.

From June 2010 to June 2012 we asked a random sample of 2-1-1 callers in Missouri ($n = 1,177$) what their perceptions of the ACA were. Forty-one percent of callers had no health insurance, and 68% reported annual household income of < \$15,000; hence many stood to benefit greatly from the ACA’s expanded coverage. Yet only 26% felt that they understood how health care reform would affect them, and just 22% thought that they would be better off under the new health reform law.⁵³ Knowledge of the ACA was consistently greater in the general US population than in the 2-1-1 sample.⁵⁴ For example, respondents from the general population were more likely than 2-1-1 callers to know that the new law would help low-income Americans buy health insurance (72% vs 42%), make sure insurance does not deny coverage because

of medical history (67% vs 49%), and cover low-income adults with Medicaid even if they do not have children (also 72% vs 42%).

Our HCRL research observed similar discrepancies in other health information domains, for instance, that low-income women patients at Federally Qualified Health Centers were much less likely than other women to have heard about a highly publicized controversy over mammography guidelines.⁵⁵

These findings likely reflect differential access to health information from multiple sources, such as interpersonal contacts and social networks. When 2-1-1 callers were asked if they had family members whose advice they trusted when they had questions about health, 1 in 5 said no. Among Food Stamps recipients, those who were uninsured were more likely than those with insurance to report the lack of a family contact for health issues.

This information gap extends as well to the organizations that serve vulnerable populations. In 2011, we surveyed 125 leaders from state and local health departments, community health centers, nonprofit health agencies, and other community-based organizations about the adequacy of their health information resources to promote cancer screening.⁵⁶ Respondents were largely unsatisfied with the *number* and *quality* of cancer screening resources they had for patients and providers. These organizations are important “infomediaries” reaching diverse population subgroups, and equipping them with appropriate information resources is a critical part of any public awareness, education, and outreach effort.

The main sources of publicly available information about health are online and mass media. But there are gaps here, too. When HCRL studies showed the promise of cancer survivor stories, we evaluated online content to see if such narratives would be equally available from different population subgroups. They were not: all racial and ethnic minority groups combined accounted for less than 10% of online cancer survivor stories, despite making up at least 16% of prevalent cancer cases and more than 30% of the US population.⁵⁷

The HCRL also studied black newspapers, which have a cumulative circulation in the tens of millions. Compared with general-audience newspapers, black newspapers were more trusted in African American communities, regarded as more fair and balanced in their reporting, and perceived as covering issues and events not covered in general population newspapers.⁵⁸

Interviews with staff members at black newspapers revealed, however, that they had few reporters and rarely wrote their own health stories, relying instead on press releases and wire stories. We sought to enrich the information environment by providing them with localized, community- and race-specific stories about cancer prevention and control. To do so, we created the Ozioma News Service. From 2005 to 2007, we generated cancer news releases customized for communities using local data. The result was that in a community randomized trial in 24 US cities, cancer coverage increased in those newspapers receiving Ozioma, compared with the newspapers in control communities.⁵⁹

In a follow-up study in 36 cities, we expanded Ozioma to provide greater localization by training citizen journalists to interview local residents and provide a local photograph along with the story. Again, the results were conclusive. From 2009 to 2011, news releases with enhanced localization were published more than twice as often as news releases using only local data. Typical were three news releases about the ACA: of 10 publications based on these releases, 7 had enhanced localization.

Ideas for Applying HCRL Findings to ACA Implementation

Our findings suggest at least 12 evidence-supported ideas for those who will be helping expand coverage as part of the ACA, such as state Medicaid officials, Medicaid managed care providers, local and national health foundations seeking to assist in ACA implementation, and consultants working with any of these organizations. Although our recommendations are neither comprehensive in scope nor definitive as solutions, we hope they will be a useful addition to the strategies to achieve ACA goals and improve public health.

Partnerships

1. Identify potential partners among established nonhealth programs, systems, and services that reach large numbers of low-income individuals and families.

2. Jointly explore ways that an ACA partnership could be beneficial to an organization and its clients, carried out in a sustainable way that does not disrupt work flow.
3. Provide government incentives to state and local agencies to pursue and rigorously evaluate innovative partnerships among organizations. Establish a formal mechanism for sharing nationally the best practices that emerge.

Outreach

4. For each specific target population, learn where people go in the course of their daily lives. Go to those places, establish a presence, make it easy for people to engage with ACA representatives there, and provide an experience that is both interesting and valuable.

Messages and Messengers

5. Provide lay navigators to help people understand health insurance information and support eligibility screening, decision making, and enrollment.
6. Motivate enrollment by emphasizing the target group's progress, not its problems or deficiencies.
7. Use the personal stories of members of the target population to explain health insurance information and convey the importance, value, and ease of enrollment.

Priorities of Vulnerable Populations

8. Recognize that for many low-income people, basic needs will often trump health insurance as a life priority. Align ACA outreach and enrollment efforts with services addressing basic needs.
9. Develop strategies to reach low-income individuals through family and social networks, perhaps training and rewarding natural network leaders for outreach and enrollment efforts.
10. Understand the positive aspects of vulnerable populations and link ACA-related appeals to their valued life activities, culture, and other sources of happiness and pride.

The Information Environment

11. Tap into trusted, targeted local media sources, especially the large number of minority-serving media, with information about the ACA that is specific to the community and population.
12. Equip a wide range of community-based organizations, especially those employing mobile and other outreach activities, with high-quality ACA information resources designed specifically for the unique populations they serve.

Limitations

These recommendations are based on our findings from studies of behavioral outcomes, most of which were related to cancer prevention, conducted in study samples that were uniformly low in income, but consisted largely of African Americans and women. Generalizability to other outcomes (eg, health insurance enrollment) and populations is therefore uncertain. Yet many of the insights from our work—understanding people’s priorities and life circumstances, using familiar places and messengers—are not unique to a given problem or group.

Indeed, the evidence suggests that many of the lessons from our research may apply more broadly. For example, many African American *men* also report difficulty accessing and using online health information and are more likely to favor and use resources like targeted minority media and navigators.⁶⁰ The value of minority media has also been demonstrated for other groups, especially for reaching *Hispanics* with health information.^{61,62} In addition, the difficulty that uninsured adults have in understanding health insurance terminology appears to be linked more to literacy than to race or ethnicity.⁶³

Still, our findings may be less directly relevant to some populations (eg, higher-income individuals and families, the so-called young invincibles, and those with mental illness). These subgroups make up an important, if smaller, proportion of the uninsured (eg, about 13% of the uninsured have incomes above 400% of the federal poverty level). The utility of our work for these groups lies less in the specific strategies and tactics recommended and more in the processes we applied to arrive at those findings. Audience research, message testing, social network analysis, and other methods described in this article can be

applied to any population subgroup to gain insights that could enhance the ACA's outreach. For example, Food Stamps and 2-1-1 may not be ideal partner organizations for reaching men, but other social institutions and community venues (eg, auto parts and home improvement stores, bowling alleys) could provide greater access. Systematic audience and communication research can help identify such opportunities.

Conclusion

Our findings suggest specific outreach strategies that could help state policymakers, insurers, navigators, and other groups involved in the ACA's implementation to reach, engage, and assist many priority populations in obtaining health insurance through the Affordable Care Act. Some of these recommendations will seem familiar to longtime outreach experts, but providing strong empirical support for approaches that otherwise rely on case studies, anecdotes, or gut feelings may encourage a wider application of promising strategies. We believe that this article also offers new insights and concrete solutions that could aid in ACA implementation and illustrates the value of strong communication science in improving the public's health.

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