

The Perceived Impact of the Patient Protection and Affordable Care Act on North Carolina's Free Clinics

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BACKGROUND The Patient Protection and Affordable Care Act of 2010 (ACA) may dramatically affect the demographics of the uninsured population and the funding prospects for free health clinics.

METHODS We conducted a cross-sectional survey of 64 of 80 free clinics (80.0% response rate) in North Carolina to assess free clinic directors' knowledge of the ACA and their perceptions of how the ACA would affect clinic operations.

RESULTS Free clinic directors were knowledgeable about well publicized aspects of the ACA (eg, lack of Medicaid expansion in North Carolina), but they were less knowledgeable about provisions such as the Federal Tort Claims Act and high-risk pools, which may have direct and indirect effects on free clinics. Directors expressed concern over the unintended consequences of the ACA, such as reduced funding and reduced volunteerism. Anticipated clinic changes as a result of the ACA include initiation of electronic medical records and, to a lesser extent, a move to become "hybrid" clinics (federally qualified health center look-alikes).

LIMITATIONS This study is focused on North Carolina free clinics that are members of the North Carolina Association of Free Clinics (NCAFC). Findings cannot be generalized to non-NCAFC free clinics or to free clinic networks outside the state.

CONCLUSIONS Despite its effort to expand health insurance coverage, the ACA may have unintended consequences to low-cost free clinics that serve uninsured populations.

Free clinics are often overlooked as a part of the US health care safety net because they do not accept government reimbursement for their services, are operated predominantly by volunteers, and almost exclusively serve uninsured individuals [1-3]. They can generally be described as private, 501(c)(3) tax-exempt nonprofit organizations that provide medical, dental, mental health, and/or pharmacy services directly to patients at little or no cost. They are distinct from federally qualified health centers (FQHCs), which receive federal funds, provide billed services to Medicare and Medicaid patients, and offer sliding-scale fees to their uninsured clients. Two independent studies in 2010 identified approximately 1,200 free clinics in the United States that served over 1.8 million patients, accounting for more than 3 million medical visits [1, 2]. Published data on free clinics are rare and are often limited to information about a single clinic; however, recent studies have shown that free clinics reduce utilization and costs of hospital services [4-6].

The Patient Protection and Affordable Care Act of 2010 (ACA) was predicted to have broad impacts on the American health care system, including a significant reduction in the number of uninsured individuals—the population served by free clinics. The ACA's primary strategy to reduce the number and proportion of uninsured individuals was to expand Medicaid to 133% of the federal poverty limit (FPL). (The expansion is effectively 138% of FPL due to the way it is calculated, which is why both numbers are often quoted in the media and scientific literature.) As of October 3, 2014, a total of 27 states and Washington, DC had implemented

Medicaid expansion; North Carolina opted not to expand Medicaid at this time [7]. Additionally, under the ACA, each state was required to have a health insurance exchange (HIE) by fall of 2013. HIEs are competitive, organized marketplaces intended to encourage uninsured people with incomes between 100% and 400% FPL to purchase subsidized health insurance. The Congressional Budget Office estimates that, by 2016, under current implementation, only 9% of the population (24.75 million people) will be uninsured—versus 20% without the ACA's implementation [7, 8].

The demographics of the uninsured population are expected to shift as a result of the ACA, with a disproportionate number of uninsured individuals being younger and/or undocumented persons [8, 9]. Additionally, newly enrolled Medicaid patients may lack access to care due to provider shortages, making them functionally uninsured [10]. The ACA could also lead to a misperception that all uninsured individuals are now insured and thus inadvertently reduce volunteerism and donations to free clinics [11]. Volunteerism by physicians and mid-level providers is generally declining and may be exacerbated by declining insurance reimbursements and rising operating costs in doctors'

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private practices [12, 13]. Declining volunteerism, coupled with a misperception that volunteerism is not needed, could be a devastating loss to free clinics. Indeed, new clinics often emerge in those communities where volunteer and hospital resources are sufficient to support the clinics, rather than in communities where the highest proportion of uninsured people in need of safety-net care are located [14].

North Carolina is a model state to study how the ACA affects free clinics. North Carolina has the largest number of free clinics of any state, and it has a statewide association to serve and lobby for their interests [15]. North Carolina has chosen not to expand Medicaid coverage and has deferred to the federal government to set up the state's HIE [7]. According to a 2012 annual outcomes report from the North Carolina Association of Free Clinics (NCAFC), North Carolina free clinics provided over \$200 million in free health care services to 95,000 patients in 2011, with an average of \$6.14 in health care provided for every dollar used to operate clinics [16].

To date, there is no information on free clinic directors' knowledge and perceptions of the ACA or clinics' anticipated response to the ACA. We filled this gap by surveying NCAFC's clinic directors on their knowledge and perceptions of the ACA as they pertain to their clinic.

Methods

Human Subjects

The research protocol was approved by the human subjects' institutional review board of Davidson College.

Sample

The NCAFC granted permission for the research team to attach questions to its annual outcomes survey; these extra questions related to the impact of the ACA on free clinic operations. Clinics were asked to have only clinic executive directors complete the section related to the ACA. Data collection was conducted via web-based survey during February 2013. Of the estimated 150 free health clinics in North Carolina, 80 clinics were members of the NCAFC at the time of data collection.

Measurement

Survey items related to the ACA were developed by reviewing the ACA legislation that specifically pertains to free clinics (eg, high-risk pool, expansion of Medicaid); survey items included both knowledge and perception questions. These questions were developed in partnership with NCAFC staff members, who fielded questions and concerns from executive directors regarding the ACA's impact on free clinics, and questions were reviewed by a NCAFC board member and free clinic executive director to ensure they reflected understanding and common misperceptions of the ACA.

Knowledge of the ACA

There were 7 true-or-false questions regarding changes implemented by the ACA; for example, questions asked

about the following statements: "States have the option to opt in or out of the expansion of Medicaid" and "North Carolina has a high-risk pool." Survey respondents had the option of answering "true," "false," or "I don't know." The questions focused on acts of the ACA that directly relate to free clinics. Correct responses were coded as 1, while incorrect responses or "I don't know" responses were coded as 0. Scores on individual items were used to create an index of knowledge related to the ACA (possible scores of 0–7, with 7 being the best score). Survey respondents were also asked to rate how informed they, their staff members, volunteers, and donors were about the ACA; they were given the options of "Well informed," "Somewhat informed," and "Not informed."

The ACA and Perceived Impact on Clinic Operations

Respondents were asked questions regarding how their clinic operates—for example, "Does your clinic use electronic medical records (EMRs)?" and "Does your clinic see Medicaid patients?"—and they were asked whether they were considering making changes to their clinic's operations—for example, "Is your clinic considering obtaining an EMR?" and "Is your clinic planning on starting to see Medicaid patients?" If executive directors indicated that they were considering changing their operations, they were asked whether that specific change was due to the ACA. Clinics had the option to respond "Yes," "No," or "In part." Respondents were also asked questions regarding the perceived effects of the ACA on their operations—for example, "Do you think that the Affordable Care Act will affect the number of donations you receive?" and "Approximately what percentage of your patients do you believe will be eligible for Medicaid at 133% of the federal poverty limit?"

General Clinic Characteristics

Characteristics of the clinics (size, expenditures, and patient demographic characteristics) were obtained from the annual outcomes survey and were merged with the ACA items for descriptive purposes. The physical address of each clinic was manually entered into the US Department of Health & Human Services, Health Resources and Service Administration's "Find Shortage Areas" tool in order to determine whether clinics were located in a medically underserved area (MUA) or whether they served a medically underserved population (MUP).

Analysis

Responses were stratified based on whether the clinic provided medical services (with or without a pharmacy) or pharmacy-only services. Clinics that operate only as a pharmacy may be less affected by the ACA than medical clinics and therefore may have different plans and perceptions. Descriptive statistics (means and frequencies) were computed for all items in the survey.

Results

Characteristics of Free Medical Clinics and Pharmacy-Only Clinics

Of the 80 NCAFC member clinics that were sent the 2012 outcomes survey, 64 clinics responded to our optional survey about the ACA (80.0% response rate). A comparison of respondents and nonrespondents revealed no differences in terms of clinic location or size. The data presented here include only the 64 clinics that completed the ACA survey; there were a total of 57 medical clinics and 7 pharmacy-only clinics.

Responding medical clinics cared for an average of 1,185 unduplicated patients in 2012, with a mean of 2,910 patient visits. Although the mean expenditure of these medical clinics was \$369,979.81, there was wide variation in expenditures, ranging from \$8,075 to \$1,496,869 [15]. Clinic directors were asked to indicate their actual cash expenditures for the year and to exclude in-kind donations from the calculation.

Medical clinics in our sample dispensed an average of 13,927 medications in 2012 through onsite pharmacies,

physician-dispensed samples, and patient assistance programs. The average clinic expenditure per patient (based on the average clinic expenditure divided by the number of active patients) was \$309.61. All clinics were asked if they were affiliated with hospitals or religious organizations. Most clinics (n = 60; 93.8%) were freestanding facilities unaffiliated with hospitals (n = 50; 78.1%) or religious organizations (n = 54; 84.4%). None of the clinics charged a fee for services, and only 20 clinics (31.3%) asked for a donation from patients. Few medical clinics accepted Medicare patients (n = 11; 19.3%) or Medicaid patients (n = 9; 15.8%).

The vast majority of medical clinic directors reported an increase in their number of patients during the past 3 years (n = 41 clinics; 71.9%), and many clinics had expanded services (n = 37; 64.9%). While nearly all medical clinics offer their services to patients residing in an MUA or serve people in areas with an identified MUP (n = 53; 93.0%), only half of the clinics were potentially eligible to become a FQHC or FQHC look-alike (ie, physically located in an MUA or serving a MUP).

On average, pharmacy clinics were 3 times larger than medical clinics in terms of expenditures, with the average

TABLE 1.
Characteristics of Free Medical and Pharmacy-Only Clinics Affiliated With the North Carolina Association of Free Clinics

	Medical clinics (n = 57)	Pharmacy-only clinics (n = 7)
	n (%)	n (%)
Average number of patients	1,185	2,061
Race/ethnicity of patients		
White	587 (49.5%)	869 (42.2%)
African American	305 (25.7%)	869 (42.2%)
Hispanic	245 (20.7%)	250 (12.1%)
Other (eg, American Indian, Asian)	48 (4.1%)	73 (3.5%)
Number of female patients	716 (60.4%)	1,285 (62.3%)
Age of free clinic population		
Younger than 18 years	44 (3.7%)	17 (0.8%)
18–64 years	1,104 (93.2%)	1,783 (86.5%)
65 years and older	37 (3.1%)	260 (12.6%)
Average number of medical patient visits	2,910	—
Average number of prescriptions dispensed	13,927	48,388
Number of clinics serving Medicare patients ^a	11 (19.6%)	5 (71.4%)
Number of clinics serving Medicaid patients ^a	9 (16.1%)	1 (14.3%)
Number of hybrid clinics	4 (7.0%)	—
Number of federally qualified health centers (FQHCs) and FQHC look-alikes ^a	2 (3.6%)	—
Patient numbers in the past 3 years ^a		
Increased	41 (73.2%)	4 (57.1%)
Decreased	4 (7.1%)	2 (28.6%)
No change	11 (19.6%)	1 (14.3%)
Clinics services in the past 3 years ^b		
Expanded	37 (67.3%)	3 (42.9%)
Contracted	4 (7.3%)	1 (14.3%)
No change	14 (25.5%)	3 (42.9%)

^aOne medical clinic director did not respond (n = 56).

^bTwo medical clinic directors did not respond (n = 55).

expenditure being \$903,747. Pharmacy clinics also managed 72% more patients on average than medical clinics (2,061 versus 1,185). They provided an average of 23.5 prescriptions per patient, which is approximately 2 prescriptions per patient per month for an entire year. Most pharmacy-only clinics served Medicare patients (n = 5; 71.4%), but only 1 clinic served Medicaid patients.

Free Clinics' Knowledge of the ACA

Clinic directors were asked 7 true-or-false questions about the ACA. On average, respondents answered 4.8 questions correctly (standard deviation [SD] = 1.6; range 1–7; see Table 2). Approximately half of the medical clinic directors responded correctly that the ACA expanded medical malpractice insurance coverage under the Federal Tort Claims Act (FTCA) to include nonmedical personal (n = 30; 52.6%).

Clinic directors were less knowledgeable about the implementation of the ACA in North Carolina. Nearly half of medical clinic directors were unaware that North Carolina has a high-risk pool (n = 33; 57.9%) or that North Carolina decided to let the federal government implement and control the state's HIE (n = 33; 57.9%). Directors of pharmacy-only clinics appeared to be as knowledgeable about the ACA as were medical clinic directors. When asked whether stakeholders were well informed about the ACA, respondents of medical clinics and pharmacy-only clinics reported that few stakeholders were well informed; this included 22.6% of executive directors, 4.8% of staff, 3.2% of donors, and 1.6% of volunteers.

Perceived Impact of the ACA

The most significant change that clinic staff plan to make is implementation of an EMR system (n = 25; 43.9% of all

clinics; 78.1% of clinics that do not have an EMR), and nearly one-third of these clinics were doing so in response to the ACA (n = 8; 32.0%; see Table 3). More than 10% of clinics were considering serving Medicare patients, and over one-quarter of clinics were considering accepting Medicaid patients. Most clinic directors who were considering expanding services to Medicare and/or Medicaid patients were doing so because of the ACA. Ten of the 57 medical clinic executive directors who responded to the survey were considering transitioning their free clinic to a hybrid clinic, with 9 clinics considering becoming FQHCs. The majority of clinic directors indicated that their consideration to transform their clinic was in response to the ACA.

Over half of medical clinic directors indicated that clinic staff intended to help patients navigate the state's HIE, and one-third of clinics plan to or have produced informational material for patients about the ACA. Nearly all clinic directors have or plan to discuss the ACA and its possible effects with their boards of directors. Two-thirds of clinics plan to contact donors to educate them about the ACA and its effect (or lack thereof) on free clinics. Only one-quarter of clinic directors thought that the ACA would decrease volunteerism; however, most directors thought that the ACA would negatively affect private donations, public funding, and/or private funding, with 50% of clinic directors reporting that it would hurt all 3 types of funding.

A majority of medical clinic directors (n = 45; 83.3%) and all pharmacy-only clinic directors thought that fewer than 25% of their patients would utilize the state's HIE, with 12 medical clinic directors (22.2%) and 1 pharmacy-only clinic director (14.3%) reporting that none of their patients would utilize the exchange (see Table 4). If North Carolina were to expand Medicaid, free clinics could be greatly affected. Over half of medical clinic directors (53.7%) and

TABLE 2.
North Carolina Free Clinic Directors' Knowledge of the Patient Protection and Affordable Care Act

	Correct responses from medical clinic directors (n = 57)	Correct responses from pharmacy-only clinic directors (n = 7)
	n (%)	n (%)
The Affordable Care Act originally expanded Medicaid coverage to 133% of the FPL. (TRUE) ^a	43 (75.4%)	7 (100.0%)
States have the option to opt in or out of the expansion of Medicaid. (TRUE)	54 (94.7%)	6 (85.7%)
The Affordable Care Act brought greater funding for rural health centers, community health centers, and rural hospitals. (TRUE)	27 (47.4%)	5 (71.4%)
The Affordable Care Act expanded the coverage of the Federal Tort Claims Act (FTCA) to include protections for officers, governing board members, employees, and contractors from medical malpractice suits. (TRUE)	30 (52.6%)	1 (14.3%)
North Carolina has a high-risk pool. (TRUE)	33 (57.9%)	5 (71.4%)
The Affordable Care Act provides tiered subsidies to help low-income US citizens (133–400% FPL) purchase health insurance. (TRUE)	50 (87.7%)	6 (85.7%)
North Carolina has agreed to design and implement a state-controlled health insurance exchange. (FALSE)	36 (63.2%)	4 (57.1%)
Knowledge Index Score (out of 7) (average ± SD)	4.8 ± 1.6	4.7 ± 1.4
Range	1–7	3–6

Note. FPL, federal poverty level; SD, standard deviation.

^aThe federal poverty level (FPL) can vary for different groups. Most people responded to this question correctly, even though the 133% FPL option was given.

TABLE 3.
Potential Impact of the Patient Protection and Affordable Care Act on Clinic Operations^a

	Medical clinics (n = 57)	Pharmacy-only clinics (n = 7)
	n (%)	n (%)
Planning on changing clinic eligibility requirements ^b	12 (21.1%)	1 (14.3%)
Due to the ACA	12 (100.0%)	1 (100.0%)
Planning to get an electronic medical record system (n = 32 medical clinics; n = 7 pharmacy-only clinics)	25 (78.1%)	2 (28.6%)
Due to the ACA	8 (32.0%)	1 (50.0%)
Considering serving Medicare patients (n = 45 medical clinics) ^b	7 (15.5%)	0 (0.0%)
Due to the ACA	5 (71.4%)	0
Considering serving Medicaid patients (n = 48 medical clinics; n = 6 pharmacy-only clinics)	15 (31.3%)	1 (16.7%)
Due to the ACA	14 (93.3%)	1 (100.0%)
Considering becoming a hybrid clinic (n = 53 medical clinics)	10 (18.9%)	—
Due to the ACA	9 (90.0%)	
Considering becoming a federally qualified health center (FQHC) or FQHC look-alike (n = 54 medical clinics)	9 (16.7%)	—
Due to the ACA	6 (66.7%)	
Have made or are planning to make changes to board policies ^b	15 (26.8%)	—
Due to the ACA	7 (46.7%)	
Plan on aiding patients in navigating the health insurance exchanges (n = 54)	31 (57.4%)	4 (57.1%)
Plan to contact private donors with information about the ACA and how it may affect the clinic ^b	37 (66.1%)	5 (71.4%)
Have or plan to increase translator services ^b	19 (33.9%)	1 (14.3%)
Have discussed or plan to discuss with their board of directors the ACA and its possible effects ^b	51 (91.1%)	6 (85.7%)
Planning to produce informational material for patients about the ACA ^b	37 (66.1%)	5 (71.4%)

Note. ACA, Affordable Care Act.

^aClinics already responding affirmatively to the question are removed from the denominator.

^bOne medical clinic director did not respond to this question (n = 56).

nearly half of pharmacy-only clinic directors (42.8%) indicated that at least 50% of their patients would become eligible for Medicaid with the expansion. Further, 18 medical clinic directors (33.3%) and 1 pharmacy-only clinic director (14.3%) reported that 75% or more of their patients would become eligible for Medicaid if the program were expanded in North Carolina (see Table 4).

General Perceptions of the ACA

The ACA aims to improve the American health care safety net by decreasing the number of uninsured individuals and by expanding funding to some parts of the safety net that care for uninsured populations. However, the executive directors of North Carolina free clinics, as a whole, have mixed feelings about the ACA. Directors from 11 of the 50 clinics who responded to this question wished that the ACA would be repealed completely, and 18 of 50 directors wished that parts of the ACA would be repealed; the researchers did not inquire as to why the respondents felt this way. When asked whether the ACA would benefit their clinic, 18 of the 53 medical clinics directors who responded to this question (34.0%) believed that the ACA will not benefit their clinics, with half of clinic directors (n = 29; 54.7%) responding that

it is too soon to tell. These responses were mirrored by the directors of pharmacy-only clinics.

Discussion

While the ACA will expand insurance coverage by an estimated 30 million people in the United States, it will still fall short of providing universal coverage [8, 9]. With North Carolina's current decision not to expand Medicaid, its decision to default to the federal HIE, and its high proportion of undocumented immigrants, the state will still have a large number of uninsured individuals after full ACA implementation [17]. An expected 319,000 people who would have been Medicaid-eligible had North Carolina expanded Medicaid will fall into the coverage gap [17]. It has been predicted that 1.1 million North Carolinians would gain coverage, out of 1.7 million currently uninsured persons, assuming the state expanded Medicaid to 560,000 individuals by 2019 [18, 19]. We expect free clinics will continue to play a very important role in the provision of safety-net care for uninsured individuals in North Carolina and that the clinics' anticipation of and preparation for full implementation of the ACA will impact their day-to-day operations and survival.

Knowledge of the ACA is relevant to free clinics, not only

due to the ACA's expansion of health insurance to more people and its potential to affect volunteerism and funding, but also due to lesser-known provisions, such as the expansion of the FTCA Medical Malpractice Program. For clinic directors who complete the application process, the FTCA program is intended to increase charitable health care volunteering among licensed professionals by reducing perceived liability risk through free malpractice insurance. This has important implications for free clinics that depend on volunteers, many of whom are retired and may not have malpractice coverage from their primary employer. The ACA also expanded FTCA

coverage to clinic board members, staff, contractors, and nonmedical volunteers, which will provide increased protection from litigation for these individuals.

Free clinic executive directors were generally knowledgeable about the highly publicized aspects of the ACA, including states' autonomy in opting in or out of Medicaid expansion, the tiered subsidies to purchase insurance on the HIEs, and the original expansion of Medicaid coverage. A free clinic's ability to operate is tied directly to volunteerism, especially of physicians (which is already declining), and the potential lack of knowledge about the ACA among volunteers and donors may have significant negative consequences for free clinics [12]. Donors who lack an understanding of the ACA and its limitations may erroneously assume that free clinics no longer need private financial resources in order to provide health care for the uninsured population. This possibility, compounded by a possible decrease in private and public funding, is a perceived concern by the majority of clinic directors in this study, as it may leave clinics with insufficient funds to continue their current level of operation. While free clinic directors are more optimistic about volunteer participation than they are about funding, almost 28% think that volunteerism in their clinics will decline. While we currently do not know whether any of these unintended consequences of the ACA have happened or will happen, the possibility has proven sufficient to shift operational activities in free clinics; for example, some clinics have begun providing services to Medicaid and/or Medicare patients, as has been reported in the media [11].

Free clinic directors are preparing to address the unintended consequences of the ACA and the lack of knowledge about the ACA among their stakeholders. Most directors have discussed or plan to discuss the impact of the ACA with their boards of directors, and the NCAFC has made ACA education a priority at its annual meetings. Two-thirds of clinic directors anticipate providing information about the ACA to their patients, and a modest majority of medical clinics are planning to help patients navigate the HIEs.

One potential positive impact of the ACA is the adoption of EMRs. Twenty-seven of the medical and pharmacy-only clinics surveyed are planning to implement EMRs, and 9 of the 27 are doing so as a result of the ACA. EMRs have the advantage of allowing for audit and feedback within a clinical setting, which can improve quality control and management. Moreover, funders are increasingly interested in patient outcomes, and EMRs provide a distinct advantage over paper records for data collection and analysis, thus allowing free clinics to better leverage scarce resources.

This study evaluated knowledge and perceptions of the potential impact of the ACA on free clinics, a critical part of the safety-net care system. Our study focused exclusively on NCAFC member clinics, which limits its generalizability. Moreover, we had no way to control for executive directors' experience or prior knowledge about the ACA, nor are we certain that our survey captured all of the foreseeable

TABLE 4.
Potential Impact of the Patient Protection and Affordable Care Act on Volunteerism, Funding, and Patients^a

	Medical clinics (n = 55)	Pharmacy-only clinics (n = 7)
	n (%)	n (%)
How will the ACA affect volunteer participation at the clinic?		
Increase	1 (1.8%)	0 (0.0%)
Decrease	15 (27.3%)	0 (0.0%)
Have no effect	38 (69.1%)	7 (100.0%)
How will the ACA affect the number of private donations the clinic receives?		
Increase	1 (1.8%)	0 (0.0%)
Decrease	29 (52.7%)	5 (71.4%)
Have no effect	25 (45.5%)	2 (28.6%)
How will the ACA affect the clinic's public funding?		
Increase	3 (5.5%)	1 (14.3%)
Decrease	32 (58.2%)	4 (57.1%)
Have no effect	20 (36.4%)	2 (28.6%)
How will the ACA affect private funding?		
Increase	1 (1.8%)	0 (0.0%)
Decrease	32 (58.2%)	4 (57.1%)
Have no effect	22 (40.0%)	3 (42.9%)
Perceived percentage of patients who will utilize the North Carolina health insurance exchange in 2014 (n = 54 medical clinics)		
0%	12 (22.2%)	1 (14.3%)
10%	20 (37.0%)	3 (42.9%)
25%	13 (24.1%)	3 (42.9%)
50%	7 (13.0%)	
75% or greater	2 (3.7%)	
Perceived percentage of patients who would be eligible for the Medicaid expansion (n = 54 medical clinics)		
0%	5 (9.3%)	
10%	10 (18.5%)	2 (28.6%)
25%	10 (18.5%)	2 (28.6%)
50%	11 (20.4%)	2 (28.6%)
75% or greater	18 (33.3%)	1 (14.3%)

Note. ACA, Affordable Care Act.

^aTwo medical clinic directors did not respond to any of these questions (n = 55).

changes affecting free clinics that may result from the ACA. Despite these limitations, this study reveals that free clinics are indeed preparing for the ACA and that they believe its effects may be radical enough to change the landscape of care for the uninsured population.

The safety-net system in North Carolina may look different in the coming years, as an increasing number of clinics enter the realm of government-supported safety nets, and the remaining free clinics shift their eligibility requirements, spend time helping patients understand and utilize newly available insurance options, expand service to undocumented immigrants (who are ineligible for Medicaid or participation in the HIE), and increasingly rely on EMRs. We believe this study provides a preliminary evaluation of the ACA, and, with more than 1,200 free and charitable clinics in the United States, there is an opportunity to expand this study to other states that may have opted to expand Medicaid and/or operate a state-run HIE.

Free clinics provide medical, pharmacy, dental, and/or behavioral health care services to uninsured individuals at a remarkably low cost and a high return on investment [1, 2, 12, 15, 16, 20-23]. They are also medical homes for many uninsured people and have been shown to reduce non-emergent visits to emergency departments [24-26]. While free clinics were likely never considered as the ACA was drafted, this act has already begun to impact their plans; therefore, states should anticipate meaningful and unanticipated consequences to the safety-net system for the uninsured population as a whole. **NCMJ**

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