Access to health care in Michigan

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Executive summary

Health care is critical to treat acute disease, manage chronic illnesses, and achieve well-being. It is also needed to prevent chronic illness, avoid unnecessary hospitalizations, and reduce medical costs. Obstacles to health care access can lead to escalation of chronic conditions, delayed treatment, reduced quality of life, and shorter life expectancy.

This brief examines barriers to health care access in Michigan and their disproportionate impact on rural residents, low-income families, and young adults. While health insurance coverage is often the focus of discussions about barriers to health care access, it is one of many factors. This brief discusses three key factors impacting access to care – health insurance coverage, provider shortages, and unmet social needs. It highlights Michigan's innovative approaches, such as telehealth expansion and provider incentives, while identifying additional opportunities to improve access.

Key factor 1: Health insurance coverage

Adequate health insurance coverage is associated with improved health outcomes, engagement with preventive services, reduced financial burden, and better access to the medications needed to manage conditions, among other benefits.[i]

There are three ways individuals generally receive health insurance coverage:

1. **Employer-sponsored insurance**: Many employers purchase group coverage for employees and their families, usually sharing the cost with employees. These plans offer varying levels of coverage, copayments, and deductibles. Employees may select a plan based on their own needs and expected out-of-pocket costs. In Michigan in 2023, 49.8 percent of people (4.89 million) have employer-sponsored health insurance.[ii]
2. **Individual insurance**: Individuals may purchase coverage for themselves and their families through the Affordable Care Act (ACA) Health Insurance Marketplace or from a private insurer or agent. Most people who buy coverage on the Marketplace receive substantial subsidies from the state and federal government based on income eligibility. In 2024, over 404,000 Michigan residents were enrolled in marketplace coverage.
3. **Government-funded insurance**: Medicare and Medicaid are government-funded health insurance plans that provide coverage for certain eligible populations.
    - Medicare is federally funded and primarily serves people 65 and older and those with certain disabilities. Many Medicare beneficiaries also purchase supplemental insurance coverage, such as Medicare Advantage plans, to reduce out-of-pocket costs and obtain additional benefits.
    - Medicaid is jointly funded by federal and state governments and covers low-income individuals and families and some moderate-income individuals who need long-term care services. The Healthy Michigan Plan is the term for the Michigan's expansion of Medicaid to individuals who earn up to 138 percent of the federal poverty limit. In 2025, the federal government is covering 65 percent of Medicaid costs in Michigan and 90 percent of Healthy Michigan Plan costs. As of October 2024, 2.6 million Michiganders were enrolled in Medicaid.[iii]

Insurance status

The uninsured. Michigan has historically had a lower uninsured rate compared to the national average. In 2023, the uninsured rate in Michigan was 4.5 percent, compared to 8 percent nationally.[iv]

Who is uninsured in Michigan? In Michigan, those with the highest rates of uninsurance include:

- Those without a high school diploma (10 percent are uninsured),
- Those who identify as 'some other race alone' (13.2 percent are uninsured), and
- Young adults aged 26 - 34 (8.9 percent are uninsured).[v]

Impact of the Healthy Michigan Plan on access to care

An evaluation of the Healthy Michigan Plan, conducted by the Institute for Health Policy Innovation (IHPI) at the University of Michigan found that by 2020, the Healthy Michigan Plan reduced the uninsured rate for low-income non-elderly adults by 7 percentage points relative to states that did not expand Medicaid.

Though some hospitals and providers may offer discounts to uninsured patients, self-paying for medical care can be cost prohibitive. Approximately 9 percent of Michigan residents have medical debt, which is more common among individuals that are uninsured.[vi]

The underinsured. Typically, an individual is considered underinsured if they cannot afford health care despite having some health insurance coverage.[1] This often occurs with high deductible health plans or when individuals bear a high portion of health care costs relative to their income.

Table 1.

Average employee costs for health insurance in employer-sponsored health plans, 2023, Michigan. [vii]

For 2025, Michigan insurers enacted premium rate hikes of over 11 percent for small group employer plans and nearly 11 percent for individual plans.[viii]

Average Employee Premium Cost (% of Total Cost) - Individual	Average Employee Premium Cost (% of Total Cost) - Family	Average Deductible Cost - Individual
$1,666/year (21%)	$6,068/year (27%)	$1,400/year

A recent survey showed that 23 percent of working-age U.S. adults are underinsured. Of those, 66 percent are covered through an employer plan. In Michigan, the average cost of premiums and deductibles for employer-sponsored health plans in 2020 was 10 percent of the median income in the state.ix

Who is underinsured in Michigan? In Michigan, underinsurance is most common among:

- Low-income individuals and families,
- Adults with chronic health conditions, and
- Children with complex physical and mental health needs.[x]

[1]People are considered underinsured if they meet at least one of the following conditions: (1) Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income. (2) Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the federal poverty level ($29,160 for an individual or $60,000 for a family of four in 2023). (3) The individual or family deductible constituted 5 percent or more of household income.

The insured. As highlighted above, individuals can be insured through employer-sponsored, individual, or government-funded coverage. Though health insurance coverage is correlated with better health outcomes and improved access to care, health insurance policy limitations may present challenges for accessing care.

- Low reimbursement rates. Medicaid offers lower reimbursement rates to providers compared to private insurance, creating less incentive for providers to participate in Medicaid and to treat Medicaid patients. This can make it difficult for Medicaid beneficiaries to find providers who accept their insurance. Medicaid beneficiaries have more difficulty accessing primary care services and dental care than those with individually purchased or employer-sponsored health plans.
- Narrow provider networks. Many health insurance plans contract with limited networks of providers in specific geographic areas. Limited networks can lower insurance premium costs for employers and beneficiaries, but they can also make it more difficult to access care. In Michigan, this can be especially challenging for individuals residing in rural parts of the state where fewer health care providers are located.

Key factor 2: Provider shortages

Health care provider shortages are a challenge throughout the country, including in Michigan. Seventy-two of Michigan's 83 counties are designated as Health Professional Shortage Areas (HPSAs) by the Health Resources and Services Administration (HRSA). This means there are not enough health care providers for people in those specific geographic areas or within certain health care facilities. HRSA divides the country into regions, with Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin falling under Region 5 (Table 1). In Michigan, 2.7 million people live in an HPSA.[xi]

Table 2.

Among Midwest states, Michigan has greater unmet need for primary care providers and dentists.

This table shows unmet provider needs in Michigan compared to the HRSA average for health professional shortage areas in the Midwest.[xii] Provider shortages result in long wait times for care and often force patients, especially those in rural areas, to travel long distances for care or to forgo care altogether. Additionally, provider shortages overburden the health care workforce that serves HPSAs, leading to burnout and increased attrition.

	Primary Care Percent of Provider Need Met	Mental Health Percent of Provider Need Met	Dental Health Percent of Provider Need Met
HRSA Region 5	49.78%	30.57%	29.64%
Michigan	45.96%	40.26%	27.65%

Who is most impacted?

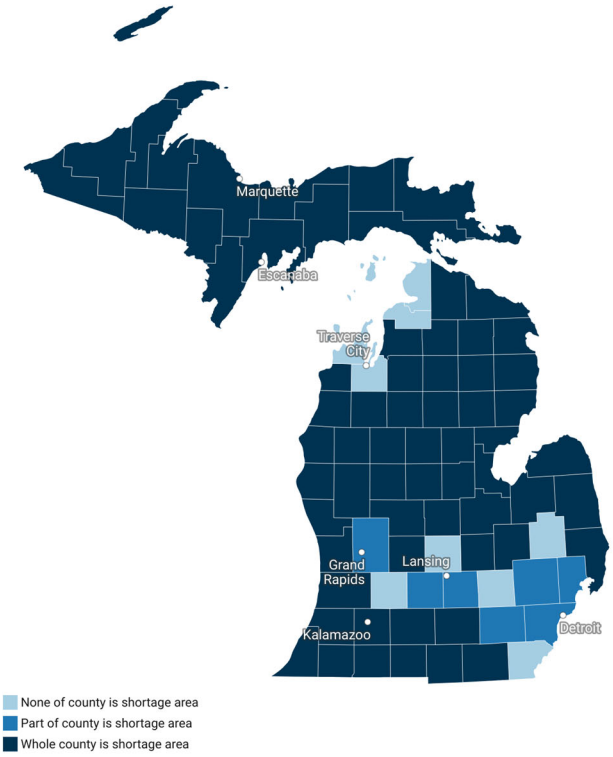
Rural populations are often most impacted by provider shortages. Specialists like oncologists and gastroenterologists are usually concentrated in urban areas, making it more difficult for rural populations to access specialty care.

In addition, rural hospitals are facing further financial strain since COVID-19 pandemic relief programs have been discontinued. Rural hospitals generally have lower patient volumes, higher proportions of Medicaid patients, and narrow operating margins. During the pandemic, direct relief payments and temporary continuous Medicaid eligibility for patients boosted the financial health of rural hospitals. With the end of this funding, some rural

hospitals have stopped providing certain services (e.g., obstetric care) and some facilities are closing altogether. These closures are exacerbating gaps in health care access for rural populations in Michigan.

People in need of behavioral health care, those with substance use disorders and/or mental illnesses, are also impacted by health provider shortages, especially children. Michigan has only 13 child and adolescent psychiatrists per 100,000 people, far below the recommended 47 providers per 100,000 people. Fifty-eight percent of Michigan counties have no child and adolescent psychiatrists at all.[xiii] Often, those seeking behavioral health services in Michigan endure long waits for outpatient appointments and in emergency departments ("ED boarding"). In addition, many community behavioral health providers do not accept insurance and/or have waitlists for appointments. Access problems in outpatient settings increase the demand for emergency psychiatric care as individuals cannot appropriately manage their conditions through routine care. A 2022 report by Altarum found that the highest rates of unmet behavioral health needs in Michigan are in southeast Michigan (Prosperity Regions 9 and 10).[2, xiv]

Primary Care Shortage Areas in Michigan, October 2024



Adapted from the Rural Health Information Hub by CHRT
Source: ruralhealthinfo.org • Created with Datawrapper

Key factor 3: Unmet social needs

Health-related social needs (HRSNs) impact the prevalence of chronic conditions, health outcomes, and life expectancy. A person's social circumstances also play an important role in their ability to access appropriate, timely care. HRSNs are wide ranging, and can include food insecurity, lack of social support, and even racism and discrimination. Some HRSNs that impact access to care are transportation, high-speed internet access, time off from work, and access to childcare.

Who is most impacted?

Transportation. Transportation can present significant challenges to accessing health care. People who live in rural areas, health professional shortage areas, or communities without robust public transportation systems must rely on private transportation to access health care. This becomes a major barrier for people who do not own a car, cannot afford regular maintenance or gas, or cannot drive.

A recent study found that socioeconomically disadvantaged and Black populations are more reliant on public transportation for health care access and have to travel longer distances for care.[xv] In Michigan, Medicaid beneficiaries in need of behavioral health treatment report a lack of transportation as a major barrier to accessing care.[xvi] Rural populations are less likely to live near health care facilities, requiring longer travel and private transportation for in-person care. In addition, older adults often struggle with transportation to medical appointments if they cannot safely drive themselves. They may also have more difficulty with travel-related expenses.

[2] Prosperity Region 9: Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw. Prosperity Region 10: Macomb, Oakland, Wayne.

High-speed internet access. Telehealth allows patients to interact with their providers using their personal computers and smartphones. In addition, providers can track patient symptoms using technology designed to share health information. As health care continues to embrace telehealth, accessing consistent high-speed internet is imperative. Inconsistent access to broadband internet can limit telehealth services, further restricting access to health care. Reliable internet access continues to be a challenge for parts of the state. Less than 80 percent of Michigan's Prosperity Regions 1, 2, and 3 have reliable broadband access.[xvii,3]

Access to childcare. A lack of childcare is often cited as the number one reason for missed appointments –both for routine care and to address an acute issue – among women of reproductive age. Bringing children to appointments can also hinder patients' ability to engage with their health care providers.[xviii] In 2022, Michigan increased the income level for families to receive the childcare subsidy to 200 percent of the federal poverty level, allowing more Michigan families to get support with their childcare expenses. However, less than 1% of the state's spending on schools is used to support publicly funded childcare programs in Michigan.[xix]

Innovations to improve access to health care

There are innovative strategies to address barriers to accessing health care, many of which are employed in Michigan and targeted toward the unique needs in the state. However, there are additional opportunities to improve health care access in Michigan – especially for rural populations, older adults, and the underinsured. Innovations may focus on the location of care delivery, improving provider incentives to serve rural and Medicaid patients, and the implementation of place-based care.

Location innovations

Many novel strategies for improving access to care came out of the COVID-19 pandemic, allowing patients to regularly access care in non-traditional settings.

Satellite and mobile clinics in non-urban areas. Michigan has 217 specially designated Federally Qualified Health Centers (FQHCs), called rural health clinics, which are funded to provide preventive and primary care to rural patients.[xx] In addition, mobile health clinics operate in vehicles across the state and can meet patients in their communities to provide care.[xxi]

Telehealth. During the COVID-19 public health emergency, the Centers for Medicare and Medicaid relaxed restrictions on payment for telehealth services for many provider types and services, including behavioral health services, to promote remote access to care for vulnerable populations. Coverage for some remote services, such as audio-only tele-mental health services, were made permanent, and some have been temporarily extended into 2025. Recent progress has made broadband services more available in Michigan with the implementation of the Broadband Equity, Access, and Deployment program – however, reliable broadband access remains a challenge in rural parts of the state.[xxii]

Provider incentives

Some strategies to improve access to care encourage physicians to serve certain populations through monetary incentives.

[3] Prosperity Region 1: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft. Prosperity Region 2: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford. Prosperity Region 3: Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon.

Practice locations. Provider incentive programs encourage physicians and other providers to start and continue practicing in rural areas, which can greatly increase a population's access to care. Michigan's MIDOCs program, established in 2019 with funding from the state legislature, aims to train, recruit, and retain physicians for rural and urban underserved communities through loan repayment incentives.

Patient-Centered Medical Homes (PCMH). In the PCMH model, patients receive comprehensive, coordinated access to primary, preventive, mental health, and acute care services that prioritize the patient-provider relationship and involve different types of providers in patient care. State legislatures across the country have established special committees to assess PCMH models and engage primary care associations to understand policies that support them. PCMH practices receive quality incentives and other payments for participating in the model. For over a decade, Michigan has been a leader in PCMH model implementation, advancing multi-payer primary care reform to provide more comprehensive care to patients.[xxiii]

Value-based payment (VBP). Rather than patients or insurers paying providers and health facilities for each service they deliver, VBP ties provider payments to the quality, cost, and equity of the care they deliver, improving the care experience for providers and patients, and increasing access by facilitating more flexible and personalized care. Pennsylvania is piloting an alternative payment model focused exclusively on rural hospitals. The model provides hospitals with a continuous fixed payment to cover all inpatient and outpatient expenses while incentivizing quality improvements. Pennsylvania has enacted legislation to support the model.[xxiv]

Place-based care

Place-based care considers unique aspects of a community to ensure that providers are responsive to a population's specific needs.

Social needs screening. Screening patients for and addressing HRSNs, such as transportation, housing, employment, and social isolation is required in most health care settings and occurs in health systems statewide. This information gathering enables providers to identify barriers to care access, tailor patient care, and offer supportive services that enhance health care utilization.

Care coordination and community care hubs. Community care hubs organize community-based organizations into networks that address HRSNs where patients live. Michigan has 14 community care hubs, called Social Determinant of Health Hub Pilots, with a recent effort adding hubs to 16 counties: Chippewa, Cheboygan, Presque Isle, Montmorency, Alpena, Benzie, Leelanau, Huron, Saginaw, Tuscola, Sanilac, Lapeer, Berrian, Kent, and Wayne counties.[xxv] Michigan's community care hubs are made up of local organizations that understand the specific needs of their communities and are uniquely in tune to local issues related to accessing care.

A transportation pilot to alleviate barriers to care

MI Community Care (MiCC), a regional health collaborative in Washtenaw and Livingston Counties, partnered with three local transportation vendors to provide transportation services to individuals with complex medical and health-related social needs. Seventy percent of rides were for medical appointments, and the remaining were to address health-related social needs, including food access.

Conclusion

Many factors influence access to health care in Michigan – including health insurance coverage, provider availability, and social circumstances. To ensure all Michiganders have access to health care, legislators should consider sustained investments in rural provider recruitment, permanent telehealth funding, and community care hubs tailored to local needs.

References

[i] Abigail R. Barker and Linda Li, "The cumulative impact of health insurance on health status", *Health Services Research* 55, no.S2 (July 2020): 815-822; Access to healthcare and disparities in access, 2021 National Healthcare Quality and Disparities Report (Agency for Healthcare Research and Quality, December 2021) https://onlinelibrary .wiley.com/doi/10.1111/1475-6773.13325; The importance of health coverage, (American Hospital Association, October 2019) https://www.aha.org/guidesreports/report-importance-health-coverage#:~:text=Why%20is%20health%20insurance%20important,Affordable%20Care%20Act%20(ACA).

[ii] Health care in Michigan, (KFF, September 30, 2024) https://www.kff.org/statedata/election-state-fact-sheets/michigan, accessed December 12, 2024.

[iii] Samantha Iovan, Nailah Henry, and Nancy Baum, Michigan Medicaid: A primer for legislators and policymakers. (CHRT, August 2024) https://chrt.org/publication/michigan-medicaid-a-primer/; Green book report of key program statistics (Michigan Department of Health and Human Services, October 2024) https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Inside-MDHHS/Reports-and-Statistics---Human-Services/Green-Book/2024_10_GreenBook.pdf?rev=00193aed0e41495c918c95a64a851744

[iv] America's Health Rankings analysis of U.S. Census Bureau American Community Survey, United Health Foundation, AmericasHealthRankings.org , accessed 2025; Jennifer Tolbert, Rakesh Singh, and Patrick Drake, The uninsured population and health coverage, (KFF, May 28, 2024), https://www.kff.org/health-policy-101-the-uninsured-population-and-health-coverage/?entry=table-of-contents-introduction, accessed 2025.; Michigan, (United States Census Bureau, January 16, 2025), https://data.census.gov/profile/Michigan?g=040XX00US26#health, accessed 2025.

[v] Uninsurance rates for Michigan in 2022 and 2023, (State Health Access Data Assistance Center, September 12, 2024), https://shadac-pdf-files.s3.us-east-2.amazonaws.com/s3fs-public/2025-01/aff_s2701_MI_2022_2023.pdf, accessed 2025.

[vi] Health care in Michigan, (KFF, September 30, 2024) https://www.kff.org/statedata/election-state-fact-sheets/michigan/, accessed December 12, 2024.

[vii] Employer-based health insurance premiums and deductibles, State health facts (KFF, 2025) https://www.kff.org/state-category/health-costs-budgets/employer-based-health-insurance-premiums/, accessed 2025.

[viii] 2025 Michigan health insurance rate change requests (Department of Insurance and Financial Services, October, 23, 2024) https://www.michigan.gov/difs/-/media/Project/Websites/difs/OIRF/EHB/PDFs/2025_Approved_Rate_Changes.pdf?rev=bc8ae3a308cb44a98590c8f31cdd9dc9&hash=422B17A5424E022B5587EC1362E45A84, accessed 2025.

[ix] Sara R. Collins, David C. Radley, and Jesse C. Baumgartner, State trends in employer premiums and deductibles, 2010-2020, (The Commonwealth Fund, January 12, 2022), https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020, accessed 2025.

[x] Validova, A., Strane, D., Matone, M., Wang, X., Rosenquist, R., Luan, X., & Rubin, D. (2023). Underinsurance Among Children With Special Health Care Needs in the United States. *JAMA network open*, *6*(12), e2348890.; Sara R. Collins, Petra W. Rasmussen, Sophie Beutel, and Michelle M. Dorsey, The problem of underinsurance and how rising deductibles will make it worse, (The Commonwealth Fund, May 20, 2015), https://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-underinsurance-and-how-rising-deductibles-will-make-it, accessed 2025.

[xi] Michigan Physician Shortage Facts, (Cicero Institute, March 28, 2024), https://ciceroinstitute.org/research/michigan-physician-shortage-facts/, accessed 2024.; Scoring Shortage Designations, (Health Resources & Services Administration, December, 2022), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation/scoring, accessed 2024.

[xii] Designated Health Professional Shortage Areas Statistics, (Health Resources & Services Administration, January 1, 2025).

[xiii] Workforce Maps by State, (American Academy of Child & Adolescent Psychiatry, 2025), https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx, accessed 2025.

[xiv] Corwin Rhyan, Ani Turner, Matt Daly, and Danielle Hurdle-Rabb, (Altarum, December, 2022), https://mihealthfund.org/wp-content/uploads/2022/12/Health-Fund-2022-Behavior-Health-Access-Study-1.pdf, accessed 2024.

[xv] Labban, M., Chen, C.R., Frego, N., et al. (2023). Disparities in Travel-Related Barriers to Accessing Health Care From the 2017 National Household Travel Survey. JAMA network open, 6(7), e2325291.

[xvi] SUPPORT Act Section 1003: Exploring Michigan's SUD Treatment Capacity and Access, (MDHHS, October, 2022), https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Keeping-Michigan-Healthy/BH-DD

/Recovery-and-Substance-Use/SUPPORT_Act1003_Project_Final_Report.pdf?rev=19d3ff8507394f0a85504334e177a6e7&hash=E9B06444D29B91F3893212B61F09A2A8, accessed 2024.

[xvii] Michigan High-Speed Internet, (Michigan Department of Labor & Economic Opportunity, 2025), https://www.michiganbroadbandmap.com/map, accessed 2025; Alex Cottrill, Juliette Cubanski, and Tricia Neuman, What to know about Medicare coverage of telehealth, (KFF, October 2, 2024), https://www.kff.org/medicare/issue-brief/what-to-know-about-medicare-coverage-of-telehealth/, accessed 2025.

[xviii] Gaur, P., Ganguly, A.P., Kuo, M., et al. (2024). Childcare needs as a barrier to healthcare among women in a safety-net health system. BMC public health, 24(1), 1608.; Gaur, P., Kuo, M., & Kho, K. A. (2020). Demonstrating lack of child care as a barrier to health care for women in Parkland health & hospital system [04H]. *Obstetrics & Gynecology*, *135*, 82S; Alvarez, K.S., Bhavan, K., Mathew, S., et al. (2022). Addressing childcare as a barrier to healthcare access through community partnerships in a large public health system. *BMJ Open Quality*, *11*(4), e001964.

[xix] Michigan Governor's FY25 Budget Proposal: Key Wins and Missed Opportunities for Children, Youth, and Families, Budget Basics, (Michigan's Children, February, 2024), https://acrobat.adobe.com/id/urn:aaid:sc:US:cc6ba46a-b3ed-4d3f-bb18-71ce6e820f9f?viewer%21megaVerb=group-discover, accessed 2024; Anne Kuhnen, Childcare is a mess for parents and providers in Michigan, (Michigan Advance, September 7, 2024), https://michiganadvance.com/2024/09/07/childcare-is-a-mess-for-parents-and-providers-in-michigan/, accessed 2025.

[xx] Malone, N.C., Williams, M.M., Smith Fawzi, M.C. *et al.* (2020). Mobile health clinics in the United States. *Int J Equity Health* 19, 40.

[xxi] Mobile Health Map, (Harvard Medical School, 2025), https://www.mobilehealthmap.org/clinics/?_state=michigan, accessed 2025.

[xxii] Michigan High-Speed Internet, (Michigan Department of Labor & Economic Opportunity, 2025), https://www.michiganbroadbandmap.com/map, accessed 2025

[xxiii] Michigan Multipayer Initiatives, (Michigan Multipayer Initiatives, 2025), https://mimultipayerinitiatives.org/, accessed 2025.

[xxiv] House Bill No. 248, General Assembly of Pennsylvania, Session of 2019, https://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2019&sessInd=0&billBody=H&billTyp=B&billNbr=0248&pn=0217; Pennsylvania Rural Health Model, (Commonwealth of Pennsylvania), https://www.pa.gov/agencies/health/facilities/in-patient-healthcare-facilities/hospitals/rural-health-model.html, accessed 2025.

[xxv] SDOH Hubs, (MDHHS, 2025), https://www.michigan.gov/mdhhs/inside-mdhhs/legislationpolicy/2022-2024-social-determinants-of-health-strategy/sdoh-hubs, accessed 2025.