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THE WELLNEST WATCH — MICHIGAN HEALTH POLICY

Health policy decisions made today shape Michigan tomorrow

Healthcare is infrastructure. The decisions Michigan makes today lock in tomorrow's outcomes.

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Last winter, I visited a small community hospital in Michigan whose expansion plans had been quietly shelved.

"We've stopped thinking about growth," an administrator told me. "We're just trying to survive the year."

At the time, it sounded like a local problem. Today, it reads like an early warning.

Michigan is approaching a narrow decision window. Federal health-coverage changes tied to recent budget legislation, along with related Medicaid and marketplace policy shifts summarized by congressional and state agencies, are beginning to translate into real pressure on

hospitals, clinics and public health systems. These changes are often described as fiscal adjustments. On the ground, they function more like stress tests, and many parts of Michigan's health system are already operating close to the limit.

Healthcare is not a marginal sector in Michigan. It is a central piece of the state's economic and social infrastructure. Medicaid alone supports more than 2.6 million Michigan residents, including children, older adults, people with disabilities and working families enrolled through the Healthy Michigan Plan. When federal policy tightens eligibility, increases administrative complexity or constrains

financing flexibility, the effects are immediate and local.

— WHAT'S AT STAKE IN MICHIGAN

2.6M

Michiganders rely on **Medicaid** — children, older adults, people with disabilities and working families on the Healthy Michigan Plan.

When federal financing tightens, the pressure lands on hospitals, clinics and local health departments — quietly, one unfilled position at a time.

State budget officials have warned that large reductions in federal Medicaid support would create a gap Michigan cannot easily absorb. Unlike federal agencies, states cannot deficit-finance indefinitely. That means pressure shifts quickly to providers and local systems — delayed reimbursements, frozen hiring, postponed capital projects and reductions in services that are essential but not legally mandated.

One of the most damaging effects is instability. Coverage churn, people losing and regaining insurance because of paperwork hurdles or reporting requirements, disrupts care continuity and increases costs. Hospitals still treat emergencies, but reimbursement becomes unpredictable. Clinics struggle to plan staffing. Rural facilities, already operating on thin margins, have little room to absorb shocks. Once a service line closes or a hospital consolidates, reopening is rarely an option.

Public health absorbs a different kind of damage. Prevention programs and community partnerships are often the first areas trimmed when budgets tighten. These programs don't generate headlines, but they quietly reduce

emergency visits, manage chronic disease and detect outbreaks early. When they are weakened, costs do not disappear; they surface later, in emergency rooms, disability rolls and lost productivity.

Policy volatility compounds the problem. In early January, the Centers for Disease Control and Prevention announced an updated structure for the childhood immunization schedule, emphasizing categories such as universal recommendation, high-risk groups, and shared clinical decision-making, while maintaining coverage requirements. Regardless of one's view, when there are shifts in national guidance, states, health departments and providers are forced to divert time and resources toward recommunication and compliance, which is time not spent strengthening trust, improving uptake or preparing for the next public health threat.

Michigan's health ecosystem is tightly interconnected. When Medicaid financing becomes unstable, costs and risks spill outward, to employers facing higher benefit costs, to local governments managing public health capacity, and to families delaying care because coverage feels uncertain. What looks like savings at the

federal level often reappears as higher costs and weaker resilience at the state and community

level.

Healthcare is infrastructure. It requires predictable investment and long-term planning, not constant recalibration.

This is where urgency matters. Hospitals do not close overnight, and public health departments do not disappear in a single budget cycle. The damage accumulates quietly, one unfilled position, one canceled program, one postponed investment at a time. By the time the effects are obvious, rebuilding takes years and costs far more than what was saved.

Michigan policymakers still have choices. The state can invest in enrollment assistance to reduce coverage churn, prioritize rural access and protect local health departments that carry the prevention load. Health systems can strengthen regional partnerships so that smaller

facilities are not left to absorb shocks alone. But these actions are time-sensitive.

Once institutions are dismantled and professionals leave the field, recovery is no longer a budget decision; it becomes a generational one. Healthcare is infrastructure. It requires predictable investment and long-term planning, not constant recalibration. If Michigan waits until the consequences are undeniable, the most expensive outcome will already be locked in. Survival should not be the best our health system can aim for, and the decisions that determine that outcome are being made now.



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