EXPLAINER

Disparities in Health Care Based on Immigration Status

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California Health Benefits Review Program (CHBRP)
University of California

The Disparities in Health Policy Series

CHBRP's explainer series, Disparities in Health Policy, examines barriers to healthcare access in California and how these barriers drive health disparities. Disparities are defined as "a particular type of health difference that is closely linked with economic, social, or environmental disadvantage" (Braveman, 2014). This series examines systemic challenges and potential policy approaches to address them. Consistent with the California Health Benefits Review Program's (CHBRP) commitment to objective, evidence-based analysis, each explainer is grounded in data and empirical research. Together, these explainers seek to inform policymakers and the public about how health policies can have different impacts across communities. See the complete series at www.chbrp.org.

This explainer discusses the disparities that people with different immigration statuses face regarding health status, health insurance coverage, and access to care and utilization of services. Immigration status refers to a person's legal standing in a country. Although there are many categories of immigration status in the U.S., this analysis focuses on U.S.-born citizens, naturalized citizens, and noncitizens due to limited availability of data on other categories.

Definitions

U.S.-Born Citizens: Refer to those who were born in the U.S. with full legal status.

Naturalized Citizens: Refer to those who were born outside of the U.S. but have gained legal status to be a U.S. citizen.

Noncitizens: Refer to those without U.S. citizen documentation. This includes lawful permanent residents, refugees and asylees, people on visa. and undocumented immigrants who lack legal immigration documentation who are not authorized to stay in the U.S.

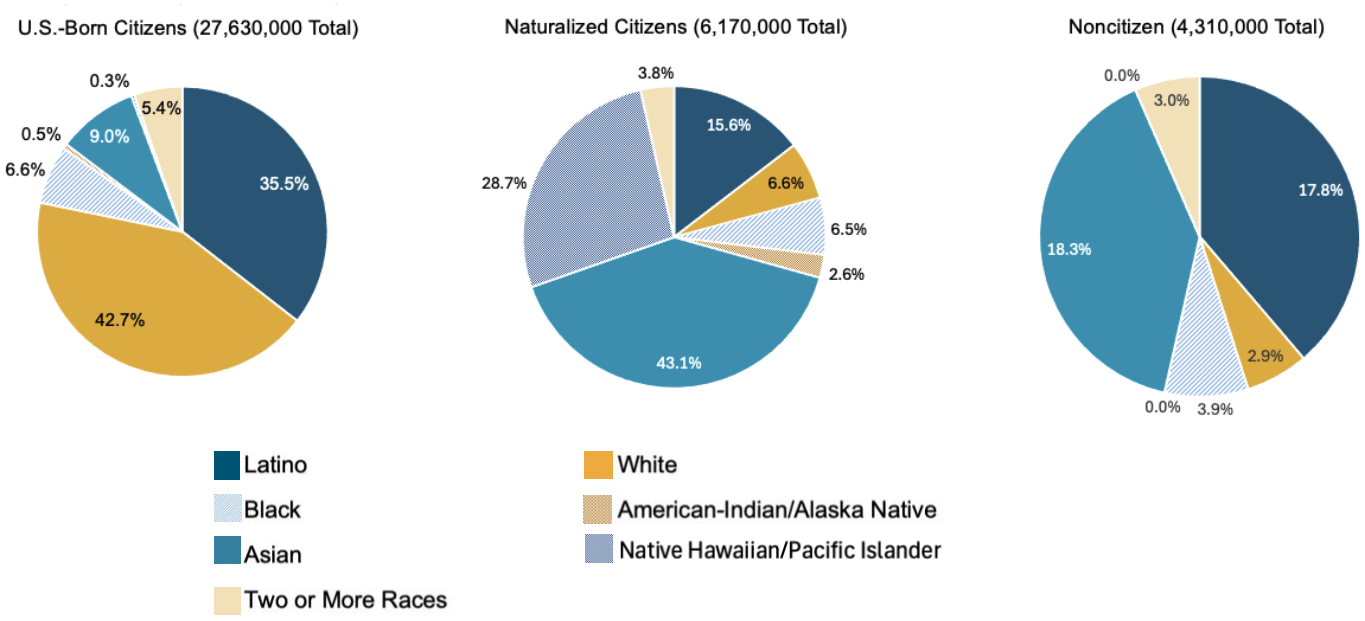
Demographic Context

As of June 2025, approximately 51.9 million immigrants[1] lived in the U.S., making up approximately 15.4% of the country's total population (Kramer and Passel, 2025). The largest portion (22%) of the nation's immigrant population live in California, where they comprise approximately 28% of the state's total residents (PPIC, 2026). In 2024, most immigrants in California were naturalized citizens (54%) and comprised 16.2% of the total population (PPIC, 2026; AskCHIS, 2024). Noncitizens made up 11.3% of the state's total residents in 2024 (AskCHIS, 2024). As shown in Figure 1, California's state's immigrant population is predominantly from Latin

[1] Immigrants are people who migrate from their birth country to another country to take up permanent residence.

America (49%) and Asia (41%); these two regions together make up over 96% of the state's total foreign-born population (PPIC, 2026; AskCHIS, 2024).

Figure 1: Race and Ethnicity of Californians by Immigration Status, 2024



Source: California Health Benefits Review Program, 2025; data from AskCHIS, 2024.

The majority of naturalized citizens (70.6%) and noncitizens (83.5%) in California are adults aged 18 and 64, compared to 55.6% of U.S. citizens (AskCHIS, 2024). Fewer than 10% of naturalized citizens (3.6%) and noncitizens (8.8%) are younger than 18 (AskCHIS, 2024). Immigrant families commonly live in “mixed-status households,” where some members of the family are U.S. citizens while others can have legal immigration status or are noncitizens. Approximately 44% of children in California have at least one immigrant parent (PPIC, 2026).

Immigration Status and Health Disparities

Immigration status shapes both health outcomes and the ability to access and utilize medical care. In California, health insurance coverage and utilization of services vary considerably by immigration status.

Health Insurance Coverage

About 85% of noncitizens have health insurance, while over 95% of both U.S. citizens and naturalized citizens have coverage (AskCHIS, 2024). Of those with health insurance, about half of U.S.-born citizens and naturalized citizens have health benefits through their employer (51.9% and 46.9%, respectively) – the most common form of health insurance in California – compared to only a third (34%) of noncitizens (AskCHIS, 2024). Noncitizens also depend more on Medi-Cal for health coverage, with 34.1% of noncitizens enrolled in the program compared to 19.1% of U.S.-born citizens, and 13.7% naturalized citizens (AskCHIS, 2024). Medi-Cal beneficiaries may face additional barriers including provider shortages in low-income areas and lower participation rates compared to private insurance (Burns et. al., 2025).

Health Status

Self-reported health status varies depending on immigration status (AskCHIS, 2024). While over 60% of U.S.-born citizens in California report being in "excellent" or "very good" health, this figure drops among naturalized citizens, 64.7% of whom reported "very good" to "good" health. Noncitizens reported the lowest health levels on average and the highest rates of “fair” or “poor” health (at 24.2%, versus 20.5% among naturalized citizens and 11.7% among U.S.-born citizens) (AskCHIS, 2024).

Access to Care and Utilization of Health Care Services

Over half of U.S.-born citizens and naturalized citizens in California use the doctor’s office, Health Maintenance Organizations (HMOs), or Kaiser[2] as their usual source of care, compared to about one-third of noncitizens (AskCHIS, 2022-2024). Noncitizens are more likely to use community clinics, government clinics, and community hospitals as their usual source of care.[3] As shown in Table 1, utilization rates of services and delays or avoidance of care vary depending on immigration status (AskCHIS, 2022-2024).

Table 1: Access to Care and Utilization by Immigration Status

Access to Care and Utilization	U.S.-born Citizens	Naturalized Citizens	Noncitizens
Access to Care			
Type of usual source of care			
Doctor’s Office / HMO / Kaiser (a)	65.0%	58.8%	36.2%
Community clinic/government clinic / community hospital	15.5%	21.9%	32.6%
Emergency room/Urgent Care	1.2%	0.8%	2.6%
Some other place / No single place	1.9%	1.1%	1.2%
No usual source of care	16.4%	17.5%	27.3%
Utilization			
Delayed or didn’t get other medical care in the past 12 months	15.8%	14.1%	15.1%
Had to forgo needed medical care (b)	53.0%	45.6%	56.5%
Routine Checkups			
Had a routine check-up in past 12 months	68.2%	75.3%	63.8%
Had a routine check-up more than 12 months ago	30.0%	21.5%	29.3%
Never had a routine check-up	1.8%	3.1%	6.9%
Visited an emergency room in the past 12 months	18.3%	17.4%	17.7%
Number of doctor visits in past year			
0 visits	15.2%	15.4%	26.5%
1-4 visits	62%	61.2%	56.2%
5+ visits	22.9%	23.4%	17.4%

Source: California Health Benefits Review Program, 2026. Adapted from AskCHIS, pooled data from 2022-2024.

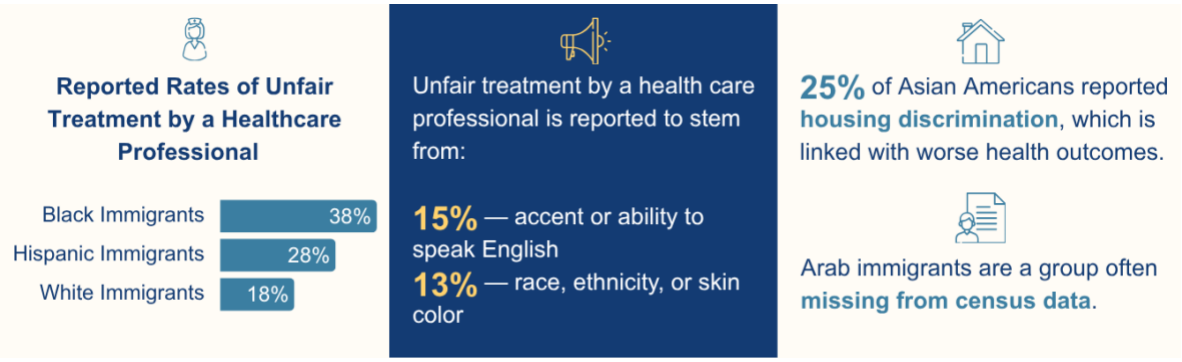
[2] Doctor’s Office, HMO, Kaiser refers to having a regular private doctor with shorter wait times, more personalized care, and more healthcare practitioner choices (AskCHIS, 2024).
[3] Community clinics/government clinics/community hospitals shall refer to non-profit centers providing care to medically underserved populations like uninsured, low-income individuals.

Notes: (a) Doctor's Office, HMO, Kaiser refers to having a regular private doctor with shorter wait times, more personalized care, and more healthcare practitioner choices (CHIS, 2022-2024). (b) Asked of respondents who delayed / did not get other needed medical care in past 12 months (CHIS, 2022-2024).
Key: HMO = health maintenance organization.

Structural Drivers of Disparities

Immigrants in California face a range of interrelated barriers that shape their health and access to care, including language access, immigration enforcement, employment conditions, acculturation, and racism. These factors have contributed to self-reported experiences with discrimination among the immigration population in California (Figure 1).

Figure 2: Experiences with Discrimination Among Immigrants



Source: California Health Benefits Review Program, 2026; Adapted from Misra, et al, 2022 and KFF, 2023.

Language Barriers

Among Californian adults aged 18 and older, naturalized citizens and noncitizens have significantly higher rates of limited English proficiency (LEP) than U.S.-born citizens. Although over 43% of California's health workforce speaks a language other than English — with Asian and Pacific Islander languages most represented and Spanish most underrepresented — language barriers persist in clinical settings (HCAI, 2024). Over a third of naturalized citizens (40.2%) and nearly half of noncitizens (49.5%) report difficulty understanding their doctor (AskCHIS, 2022–2024). Despite the enactment legislation to provide health care language assistance,[4] those with LEP continue to face language barriers: 29% of people with LEP rely on family members or friends to help understand their doctors, and 23% are unaware of their rights to an interpreter (CHCF, 2024).

Immigration Enforcement

Research links fear of deportation to chronic stress and health conditions, such as hypertension, obesity, and mood disorders (Mariotti, 2015; Sanches et al., 2016). These effects also extend to immigrants with legal status: one study found that the threat of deportation significantly lowered birthweight among babies born to undocumented immigrant women due to the heightened perinatal stress (Ybarra, 2025), and children of immigrants who experience prolonged separation are more vulnerable to anxiety, depression, and behavioral problems (Fortuna et. al, 2025). Fear of detention and deportation also leads to avoidance of public benefit enrollment, which is associated with worse health outcomes, including delayed medical care and prescription fills (Wolstein, 2022; KFF, 2025).

[4] SB 853 (2003) requires health plans and health insurers to provide their enrollees with interpreter services, translated materials, and to collect data on race, ethnicity, and language to address health inequities.

Employment

Noncitizen immigrants have employment rates similar to U.S.-born and naturalized citizens but higher uninsured rates, largely because they are more likely to work in jobs that do not provide health benefits (KFF, 2025). Undocumented immigrants face even greater challenges due to lack of work authorization, increasing risk of potential workplace abuse, violations of wage and hour laws, and poor working and living conditions (KFF, 2025). Noncitizen workers are also more likely to have an income below 200% of the FPL due to lack of work authorization, lack of familiarity with the U.S. labor market, and lack of professional and social networks (KFF, 2025); in California, one in four noncitizens lived below the federal poverty level in 2024 (AskCHIS, 2024). Among college-educated immigrants, skill underutilization is also linked to declines in mental health (KFF, 2023).

Acculturation

Acculturation — the process by which immigrants adopt aspects of their host country's culture — can affect health in complex ways. Greater differences between heritage and host environments are associated with stress-related health conditions, including cardiovascular disease and depression. Immigrants with limited proficiency in the host country's language face reduced access to care and engage in fewer health-seeking behaviors (Fox et al., 2018).

Racism[5]

Research shows that immigration enforcement and policy have disproportionately affected people of color, creating differential experiences of healthcare access and social inclusion (Menjívar, 2021; Misra et al., 2022). The racialization of "illegality" disproportionately affects Latino groups — especially Mexican, Salvadoran, and other Central American immigrants — who face both social stigma and systemic targeting by law enforcement, while Asian and European immigrants are often seen as "arousing the lowest levels of suspicion" (Menjívar, 2021). This racialization can homogenize entire ethnic groups regardless of nativity or legal status. For Asian immigrants, "model minority" stereotypes may allow some to "pass" as legal, but can also discourage them from seeking social services or health care out of fear, isolation, or shame (Menjívar, 2023).

Evidence on Reducing and Eliminating Disparities

Reducing and/or eliminating disparities surrounding documentation and immigration status requires a multifaceted approach to address them on all levels (Misra, et al., 2021).

Pathways to Citizenship

The Deferred Action for Childhood Arrivals (DACA) program, which provided temporary deportation protection and work authorization to individuals who arrived before age 16, improved health outcomes for Asian and Pacific Islander young adults by providing economic stability, educational opportunities, social and community resources, and access to healthcare (Sudhinaraset, et al., 2017). Another study found that children whose mothers were protected from deportation by DACA had 50% fewer diagnoses of anxiety disorder than children with mothers who were unprotected (Hainmueller, et al., 2017).

Expanded Health Coverage

Studies have shown that state coverage expansions reduce uninsured rates, increase health care use, lower costs, and improve health outcomes (KFF, 2025). In California, noncitizen children's health status improved by 10% following the Medi-Cal Expansion in 2016 (California Budget & Policy Center, 2024), and children residing in states that expanded

[5] See CHBRP's explainer on systemic racism and healthcare

coverage regardless of immigration status were more likely to use medical, dental, and preventive care than children in non-expansion states (KFF, 2025). Expanding Medi-Cal to low-income, noncitizen adults could reduce California's uninsured population by as much as one-quarter (Lucia, 2019). Insuring immigrant adults through Medicaid expansion has been reported to cost less than half as much per person as insuring U.S.-born adults (KFF, 2025).

Culturally Competent Health Care

Culturally competent health care is a framework in which providers understand and apply cultural context to work effectively across diverse populations (Saadi, 2024). Beyond bilingual providers, healthcare practitioners who practice cultural curiosity — by engaging with immigrant communities and understanding their own self-awareness — can help practitioners identify and address power imbalances of the provider-patient relationship (Saadi, 2024). Studies have shown that providing culturally competent healthcare improves patient health outcomes and delivers quality care that reduces racial and ethnic health disparities (Hickson, 2022).

Conclusion

Despite high rates of insurance coverage and employment among California's immigrant population, significant disparities persist in health status, health insurance coverage, and access to and utilization of healthcare services. These disparities are most pronounced between noncitizens and their U.S.-born or naturalized counterparts.

Noncitizens face a compounding set of structural barriers — including limited access to employer-sponsored insurance, greater reliance on Medi-Cal, language barriers, and fear of public charge designation — that reduce their likelihood of seeking and receiving timely care. Broader forces, including immigration enforcement, workplace vulnerabilities, acculturation stress, and racialization, further shape health outcomes across immigrant communities.

Evidence suggests that targeted policy interventions can reduce these disparities. Expanding health coverage to noncitizens, creating pathways to citizenship or deportation protection, and investing in culturally competent care have each been shown to improve health outcomes and increase healthcare utilization among immigrant populations. Given that immigrants make up nearly 28% of California's residents, policies that reduce barriers to care for this population have broad implications for the health of the state as a whole.

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About the California Health Benefits Review Program (CHBRP)

Drawing on the experience and assistance of multi-disciplinary faculty, researchers, and analysts based at the University of California, CHBRP provides the California Legislature with timely, independent, and rigorous evidence-based analyses of introduced health insurance benefits-related legislation. Most frequently, CHBRP analyzes proposed health insurance benefit mandates (e.g., mandates to cover a test, treatment, or service, such as continuous glucose monitors). For more about CHBRP's 60-day analysis process, see the resource Academic Rigor on a Legislature's Timeline.

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