but not Hispanics) were significantly less likely to use prescription methods. Being employed and being single were also significantly associated with increased levels of prescription contraceptive use. Women who considered their health only good, fair or poor were less likely than those who rated their health as excellent to report use of a prescription contraceptive. Lack of health insurance was associated with 20–40% reductions in the likelihood of prescription contraceptive use in all age, racial and ethnic, income and marital status subgroups, despite relatively low overall levels of use in some (not shown).

**DISCUSSION**

The typical American woman spends three decades trying to avoid unintended pregnancy. Despite these efforts, it is estimated that half of all pregnancies in the United States are unintended, and half of those pregnancies end in abortion. This analysis helps elucidate barriers that may prevent some women from using the most effective methods to prevent unintended pregnancy.

This study presents the first population-based analysis to suggest that insurance has an independent association with prescription contraceptive use, even among subgroups who are relatively unlikely to use a prescription method. These findings are consistent with insured women’s having greater access to health care providers and lower out-of-pocket expenses for prescription methods, and suggest that insurance coverage may provide improved access to prescription contraceptives for all American women at risk of unintended pregnancy, regardless of their background characteristics.

**Limitations**

One important limitation of the BRFSS data is the lack of direct measures of some factors central to identifying women at risk of unintended pregnancy. For example, with no direct question on current sexual activity, we characterized respondents as not sexually active if they listed lack of sexual activity or lack of a partner as a reason for not using contraceptives or as a contraceptive method. Under these criteria, 15% of women 18–44 were categorized as not sexually active. By comparison, in the 2002 National Survey of Family Growth (NSFG), 13% of such women reported not being sexually active. Thus, our analysis may have led to an underestimation of those at risk of unintended pregnancy. In addition, an equally important limitation of BRFSS data is that, as in all surveys of sexual behavior, self-reports of sexual activity and use of birth control may be subject to biased reporting.

Another limitation of using the BRFSS for this analysis is that the insurance variable collapses all types of insurance into a single dichotomous variable, thereby eliminating the possibility of analysis by insurance type. Women who are covered by Medicaid may have different contraceptive use patterns than women covered by private insurance, particularly those in unregulated self-insured plans. We are unable to evaluate these differences using the BRFSS.

A woman’s choice of contraceptive method depends on many factors other than those covered here. Prescription contraceptives are not the most appropriate method for all women. For example, the BRFSS does not address the use of condoms for the dual purpose of contraception and disease prevention. Women who choose condoms as their primary form of contraception may be appropriately considering their risks of acquiring STDs when making their decision.

Finally, the decision to become pregnant is complex. Women who responded that they did not use birth control because they desired to become pregnant were excluded from the definition of at risk of unintended pregnancy. However, this simple question may not fully capture real-life decisions that lead to pregnancies that, although unintended, may not be unwanted. In fact,