UCLA School of Law
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Contraceptive Utilization and Access Among Cisgender Heterosexual and Bisexual California Women

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CONTENTS

EXECUTIVE SUMMARY

In November 2022, California became one of the first states to enshrine the right to choose or refuse contraception in its state constitution.[1] This constitutional amendment builds on strong existing legal protections for reproductive rights.[2] But despite existing laws, comprehensive, up-to-date information about contraception utilization among people who can get pregnant across the state is currently lacking. Prior research indicates that one in four women at risk of pregnancy in California is not using contraception;[3] however, information about the characteristics of these women and their reasons for not using contraception has been missing.

This study aims to fill that gap by utilizing 2020 California Health Interview Survey (CHIS) data to describe birth control utilization and pregnancy intention patterns among cisgender heterosexual and bisexual California women[4] ages 18-44 (N=2,282). Our primary analysis centered on two groups: sexually active cisgender heterosexual and bisexual California women ages 18-44 who do not intend to get pregnant in the next 12 months who ***are*** using contraception and those who ***are not*** using contraception. Information about the family planning needs of lesbian women and transgender people in California is reported in a supplemental fact sheet. Such information is needed to identify groups that may be underserved and to improve access to contraception across the state.

MAIN FINDINGS

Approximately 3.8 million women in California are ages 18-44, sexually active, have male partners, and do not intend to get pregnant in the next 12 months.

- Of these, three-quarters (75.3%) were using contraception—an estimated 2.9 million women.
    - Many women in the state, nearly 1.4 million, were using the most effective methods to prevent unplanned pregnancies—including sterilization (434,000) and long-acting reversible contraceptives, such as an IUD or implant (933,000).
    - Many others, slightly less than a million (933,000), were using methods such as oral

[1] CA Proposition 1, Constitutional Right to Reproductive Freedom (2022) ("The state shall not deny or interfere with an individual's reproductive freedom in their most intimate decisions, which includes their fundamental right to choose to have an abortion and their fundamental rights to choose or refuse contraceptives. This section is intended to further the constitutional right to privacy guaranteed by Section 1, and the constitutional right to not be denied equal protection guaranteed by Section 7. Nothing herein narrows or limits the right to privacy or equal protection.").

[2] *See* Cal. Health & Safety Code § 123462 et seq.; *People v. Belous*, 458 P.2d 194 (Cal. 1969) (finding that the California State Constitution protects a fundamental right to choose whether to bear children).

[3] Ayana Douglas-Hall, Kathryn Kost, & Megan L. Kavanaugh, *State-Level Estimates of Contraceptive Use in the United States, 2017,* GUTTMACHER INST. (Dec. 2018), https://www.guttmacher.org/sites/default/files/report_pdf/state-level-estimates-contraceptive-use-in-us-2017.pdf.

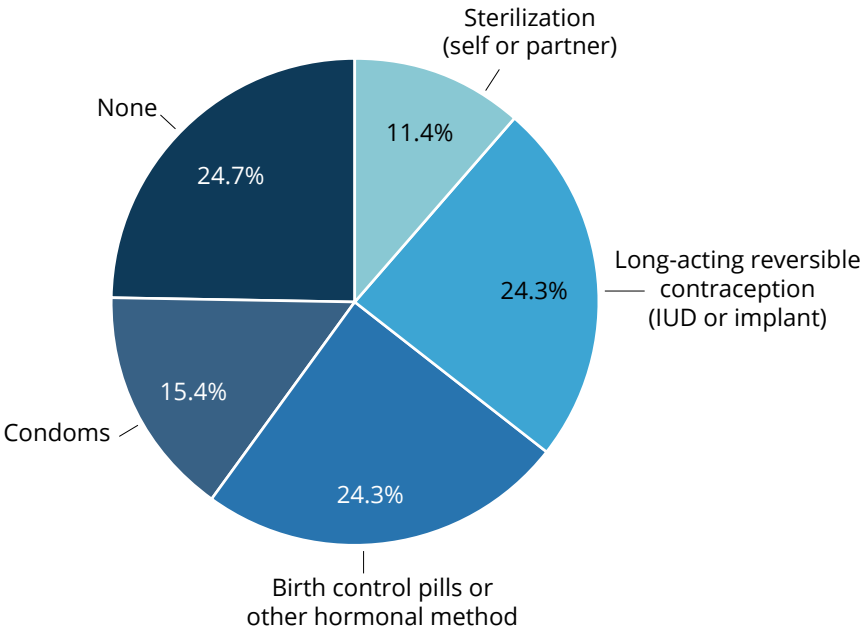
[4] Women who identified as lesbian or gay were not asked questions about contraceptive use on the CHIS survey and, thus, were ineligible for this study. Transgender people and those who identified as not sexual/celibate, as other or did not use a sexual identity term were excluded from this study due to sample size limitations.

contraceptive pills or another hormonal method (e.g., patch, vaginal ring, or shot).

- Slightly more than a half million (587,000) women were using condoms as their main method of contraception.

- One quarter (24.7%)—an estimated 943,000 women—were not using any form of contraception.

Birth control method used by cisgender California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=2,282), 2020 California Health Interview Survey



Main findings about groups of women who were overrepresented among those not using contraception are as follows:

- **Race and ethnicity.** While many women of color in California are using contraception, women of color were overrepresented among those not using contraception relative to White, non-Hispanic women. Specifically, 50.7% of Black women, 29.1% of Latinas, 24.9% of Asian women, 24.3% of non-Hispanic multi-racial women, and 14.2% of White, non-Hispanic women did not use contraception. As a group, women of color were at elevated risk of unintended pregnancy (Odds Ratio [OR] 2.5, 95% Confidence Interval [CI] 1.9, 3.3) compared to White, non-Hispanic women.
- **Language fluency.** Women who spoke both English and Spanish at home versus English only were at elevated risk (OR 1.7, 95% CI 1.2, 2.3) of unintended pregnancy.
- **Income.** Women with lower incomes were less likely to be using contraception than those

with higher incomes. The odds of not using birth control among women living at < 300% of the federal poverty level (FPL) (less than $61,773 per year for a family of three) were about twice as great as the odds of not using birth control among women living at 400% or more of the FPL ($82,364 or more per year for a family of three).

- **Insurance.** Women who were uninsured (OR 2.3, 95% CI 1.4, 4.0) or who had Medi-Cal (OR 1.8, 95% CI, 1.3, 2.4) were at greater risk of unintended pregnancy than those who had employment-based health insurance.
- **Usual source of health care.** Women who had no usual source of health care, including the emergency room and urgent care, were at elevated risk of unintended pregnancy (OR 1.6, 95% CI 1.1, 2.1) compared to those who had a usual source of care.
- **Receipt of birth control counseling.** Women who received birth control counseling or information from doctor or medical provider in the prior 12 months were at reduced risk of unintended pregnancy (OR 0.7, 95% CI 0.6, 0.9) compared to those who did not receive this information.
- **Other characteristics.** There were few differences in our study between those who used contraception and those who did not in terms of marital status, overall health status, and whether they lived in urban or rural areas.

When women who were not using contraception were asked why, 40.8% indicated that they were worried about side effects or health risks. In contrast, few (5.7%) women indicated that they do not believe in birth control.

Our main recommendations to improve access to contraception are to

- Ensure that the public and health providers have accurate information about contraceptive methods.
- Increase access to contraceptives through advanced practice providers, such as pharmacists, across the state.
- Increase the diversity of the reproductive healthcare workforce to increase the number of providers who are equipped to provide quality care to women of color and women who speak languages other than English only.
- Reduce or eliminate costs and eligibility requirements for publicly funded health care programs.

INTRODUCTION

Following the Supreme Court's decision in *Dobbs v. Jackson* overturning *Roe v. Wade* and suggesting that the right to contraception could also be rolled back,[5] policymakers in some states increased efforts to ensure access to contraception.[6] In November 2022, California became one of the first states to enshrine reproductive freedom in its state constitution, including the right to choose or refuse contraception.[7] But despite California's strong legal protections for reproductive rights,[8] comprehensive, up-to-date information about contraceptive utilization among women and other people who can become pregnant is lacking.

In 2017, 72% of California women aged 18-49 who completed the state's representative Behavioral Risk Factor Surveillance System survey and 76.6% of those at current risk of unintended pregnancy—those who indicated that they had a male sexual partner, were not currently pregnant or trying to become pregnant, and had not had a hysterectomy—were using contraceptives.[9] Based on these data, California ranked 16th out of 40 reporting jurisdictions for overall contraception utilization and 15th out of 40 for utilization among those at risk of unintended pregnancy. In 2016, California served a higher proportion (64%) of women in need of publicly supported contraceptive services—defined as being under age 20 or between ages 20-44 and under 250% of the federal poverty level—than all jurisdictions but West Virginia (66%) and D.C. (88%) and performed well above the national average of 45%.[10] Despite this relative success, many women at risk of pregnancy in the state may not have access to the resources they need to delay or to prevent pregnancy. Between 2013-2016, less than a third of low-income (living below 138% of the federal poverty level) women ages 18-44 who completed the California Health Interview Survey reported receiving contraceptive counseling and contraception.[11]

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[5] *See Dobbs v. Jackson Women's Health*, 142 S.Ct. 2228 (2022); *Id.* at 2301 (Thomas, J. concurring) ("The Court today declines to disturb substantive due process jurisprudence generally or the doctrine's application in other specific contexts. Cases like *Griswold v. Connecticut*, 382 US 479 (1965) (right of married persons to obtain contraceptives) . . . are not at issue. . . . For that reason, in future cases, we should reconsider all of this Court's substantive due process precedents, including *Griswold*[.]").

[6] *See Dobbs v. Jackson Women's Health*, 142 S.Ct. 2228 (2022); *Id.* at 2301 (Thomas, J. concurring) ("The Court today declines to disturb substantive due process jurisprudence generally or the doctrine's application in other specific contexts. Cases like *Griswold v. Connecticut*, 382 US 479 (1965) (right of married persons to obtain contraceptives) . . . are not at issue. . . . For that reason, in future cases, we should reconsider all of this Court's substantive due process precedents, including *Griswold*[.]").

[7] CA Proposition 1, *supra note 1.*

[8] Cal. Health & Safety Code § 123462.

[9] Ayana Douglas-Hall, Kathryn Kost, & Megan L. Kavanaugh, *State-Level Estimates of Contraceptive Use in the United States, 2017*, Guttmacher Inst. (Dec. 2018), https://www.guttmacher.org/sites/default/files/report_pdf/state-level-estimates-contraceptive-use-in-us-2017.pdf.

[10] Jennifer J. Frost et al., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Impact, 2016*, Guttmacher Inst. Table 11 (Oct. 2019), https://www.guttmacher.org/report/publicly-supported-FP-services-us-2016.

[11] Dawnte R. Early et al., *Publicly Funded Family Planning: Lessons From California, Before And After The ACA's Medicaid Expansion*, 37 Health Aff (Millwood) 1475 (Sept. 2018).

Current information about contraceptive use among women who do become pregnant in the coming year is needed to guide public health efforts to make contraception available to those who might choose to use it now or in the future. This study aims to fill this gap by utilizing 2020 California Health Interview Survey data to describe contraceptive utilization and receipt of birth control counseling among cisgender heterosexual and bisexual California women ages 18-44. People whose sex assigned at birth was female and reported that they are unable to get pregnant or identified as lesbian or gay could not be included in analyses due to incomplete data produced by skip patterns in the California Health Interview Survey. Transgender people assigned female sex at birth and those who indicated that they were not sexual or identified with other terms were excluded from the analysis due to inadequate cell sizes.[12] This study provides information about the demographic, socioeconomic, and health service characteristics of cisgender women who do not plan to become pregnant in the next year by contraceptive utilization status.

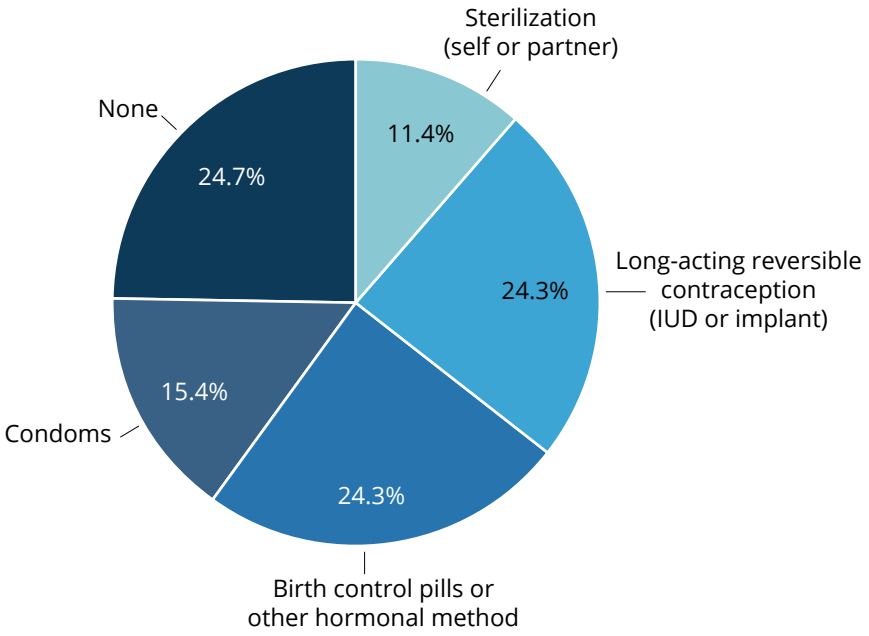
[12] Of the 3,923 people assigned female sex at birth ages 18-44 who answered a question about pregnancy intention, a total of 350 reported that they were unable to get pregnant (8.8%, 95% confidence interval [CI] 7.6, 10.1); 90 women identified as gay/lesbian (2.9%, 95% CI 2.2, 3.7); 48 identified as male (1.7%, 95% CI 1.3, 2.3) and are referred to as transgender men, and 76 identified as not sexual/celibate, as other or did not use a sexual identity term (2.7%, 95% CI 1.9, 3.5).

FINDINGS

Approximately 3.8 million cisgender women in California were ages 18-44, identified as heterosexual and bisexual, were sexually active with male partners, and did not intend to get pregnant in the next 12 months. Of these, three-quarters (75.3%) were using contraception, an estimated 2,895,000 women, and 24.7%, an estimated 943,000 women, were not.

About a third of the state's 3.8 million sexually active straight and bisexual women were using the most effective methods[13] to prevent unplanned pregnancies—including sterilization (11.4%) and long-acting reversible contraceptives (e.g., IUD, implant) (24.3%). Another quarter (24.3%) were using methods such as oral contraceptive pills or another hormonal method (e.g., patch, vaginal ring, or shot), and another 15% were using condoms as their main method of contraception.

Birth control method used by cisgender California Women ages 18-44 who do not intend to get pregnant in the next 12 months (N = 2,282), 2020 California Health Interview Survey.



[13] *See* ACOG., Effectiveness of Birth Control Methods (Oct. 2021), https://www.acog.org/womens-health/infographics/effectiveness-of-birth-control-methods.

Main contraceptive method used by cisgender heterosexual and bisexual California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=2,282), 2020 California Health Interview Survey, percentage and population estimate

	%	95% CI	Population estimate
Sterilization (tubal ligation or partner vasectomy)	11.4	9.9, 13.1	434,000
Long-acting reversible contraception (IUD or implant)	24.3	21.9, 26.8	933,000
Birth control pills or other hormonal methods	24.3	21.9, 26.8	933,000
Condoms or other*	15.4	13.3, 17.8	587,000
None	24.7	22.3, 27.1	943,000

*96.5% of this group reported using condoms as their main method of birth control and 3.5% reported using another method. Note: the sum of the estimates for specific birth control methods differs from the total estimated number of women using contraception (2,895,000) due to rounding.

The characteristics of women who did not intend to get pregnant in the next 12 months and were using any form of contraception, and those not using contraception, are presented in Table 1. Information about contraceptive use and non-use within specific sociodemographic groups is shown in Table 2. Odds ratios (OR) comparing the odds of non-use vs. use within two demographic or health characteristics groups are presented in Table 3.

WOMEN WHO DO NOT USE CONTRACEPTION

As shown in Table 1, over a fifth (23.0%) of women who were not using contraception were 40 to 44 years old. Most women at risk of unintended pregnancy were heterosexual (96.2%). Women of color were the majority (82.4%) of those who were not using contraception. Over half (56.7%) of women who were not using birth control spoke more than English only at home. Nearly 60% of women at risk of unintended pregnancy were living at < 300% of the federal poverty level, a third (31.1%) had Medi-Cal, 12.3% were uninsured, and one quarter (25.9%) had no usual source of health care. More than a third (39.3%) of women who were not using contraception had not received birth control counseling or information from doctor or medical provider in the prior 12 months.

WOMEN WHO USE CONTRACEPTION COMPARED TO THOSE WHO DO NOT USE CONTRACEPTION

Older, heterosexual, women of color, and naturalized citizens were overrepresented among those who were not using contraception relative to those under the age of 35, bisexual, White, non-Hispanic, and U.S.-born California women. In addition, women with an associate degree and lower incomes were overrepresented among those not using contraception compared to women with a four-year college degree and higher incomes. Women who were uninsured, had Medi-Cal, or had no usual source of health care were also overrepresented among those who were not using contraception relative to those who had private insurance and a usual source of health care.

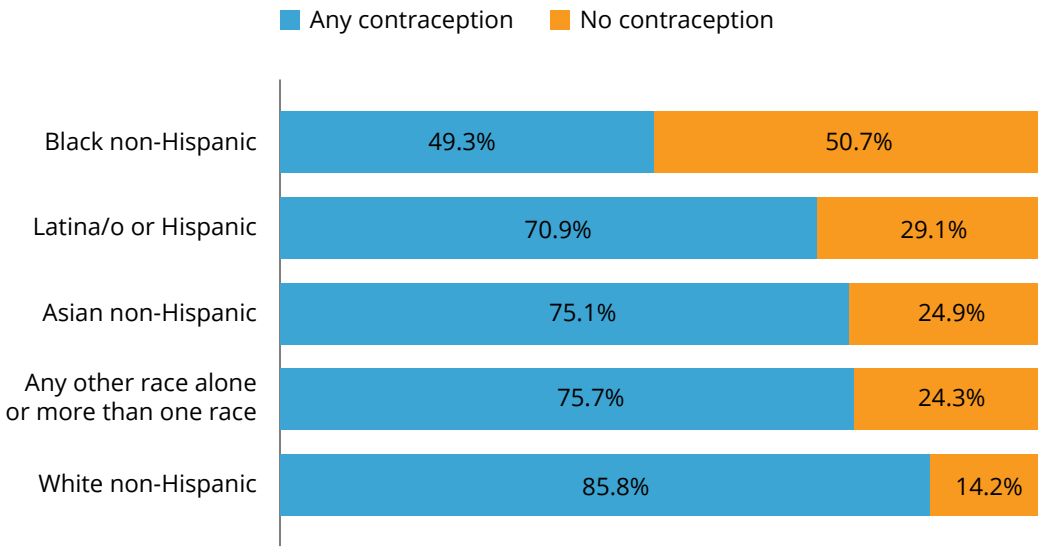
Age. More older women than younger women were not using contraception. Nearly a third (32.3%) of women ages 40 to 44 were not using contraception as compared to about a fifth of women ages 18 to 34 (Table 2). As reflected in the odds ratios presented in Table 3, older (40+) women were at greater risk of unintended pregnancy compared to younger women (< 35 years of age).

Marital status. Marital status was not associated with contraceptive use.

Sexual orientation. More heterosexual than bisexual women were not using contraception. About a quarter (25.9%) of heterosexual women did not use contraception compared to 11.2% of bisexual women. Bisexual women had lower odds of no contraceptive use (OR 0.4, 95% Confidence Interval [CI] 0.2, 0.6) compared to heterosexual women, which is likely due, at least in part, to the younger age composition of the bisexual group.

Race and ethnicity. More women of color than White, non-Hispanic women were not using contraception. Specifically, 50.7% of Black women, 29.1% of Latinas, 24.9% of Asian women, 24.3% of non-Hispanic multi-racial women, and 14.2% of White, non-Hispanic women did not use contraception. As a group, women of color were at elevated risk of unintended pregnancy (OR 2.5, 95% CI 1.9, 3.3) compared to White, non-Hispanic women.

Contraceptive use among California women ages 18-24 who do not intend to get pregnant in the next 12 months (N=2,282) by race-ethnicity, 2020 California Health Interview Survey.



Language fluency. More women who spoke English and Spanish at home were not using contraception than those who spoke English only, 31.2% versus 21.2%, respectively. Women who spoke both English and Spanish at home versus English only were at elevated risk (OR 1.7, 95% CI 1.2, 2.3) of unintended pregnancy.

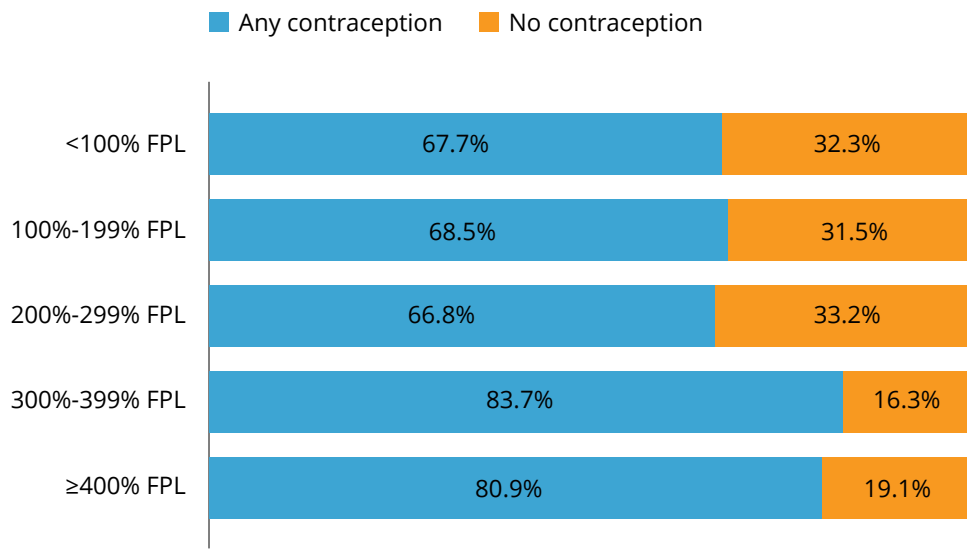
Citizenship status. More women who were naturalized versus U.S.-born citizens were not using birth control, 32.2% versus 23.0%, respectively**.** Women who were naturalized citizens were at elevated risk (OR 1.6, 95% CI 1.2, 2.2) of unintended pregnancy compared to US-born women.

Urbanicity. Urbanicity was not associated with contraceptive use.

Education. More women with an associate degree or some college were not using contraception than women with a bachelor's degree or more, 30.3% versus 21.4%, respectively. Women with an associate degree or some college were at greater risk (OR 1.6, 95% CI 1.2, 2.2) of unintended pregnancy compared to those with a bachelor's degree or more.

Income. More women with lower incomes were not using contraception than those with higher incomes. The odds of not using birth control among women living at < 300% (less than $61,773 per year for a family of three)[14] of the federal poverty level (FPL)[15] were about twice as high as the odds of not using birth control among women living at 400% or more of the FPL ($82,364 for a family of three).

Contraceptive use among California women ages 18-24 who do not intend to get pregnant in the next 12 months (N=2,282) by race-ethnicity, 2020 California Health Interview Survey.



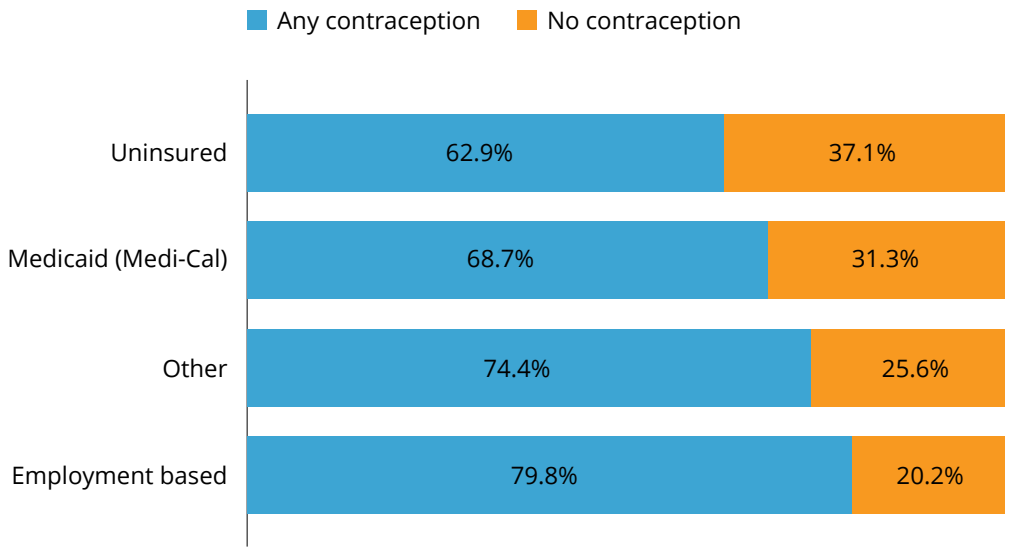
Health insurance. More women who were uninsured or who had Medi-Cal were not using contraception than women with employment-based insurance, 37.1%, 31.3%, and 20.2%, respectively.

[14] US Census Bureau. Poverty thresholds. https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html

[15] US Census Bureau. How the Census Bureau measures poverty. https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html

Women who were uninsured (OR 2.3, 95% CI 1.4, 4.0) or who had Medi-Cal (OR 1.8, 95% CI, 1.3, 2.4) were at greater risk of unintended pregnancy than those who had employment-based health insurance.

Contraceptive use among California women ages 18-24 who do not intend to get pregnant in the next 12 months (N=2,282) by race-ethnicity, 2020 California Health Interview Survey.



Usual source of health care. More women who lacked a usual source of health care were not using contraception than women who had a usual source of care—31.5% and 22.9%, respectively. Women who had no usual source of health care, including the emergency room and urgent care, were at elevated risk of unintended pregnancy (OR 1.6, 95% CI 1.1, 2.1) compared to those who did have a usual source of care.

A slightly larger percentage of those who delayed or did not obtain needed medical care in the prior 12 months were using contraception compared to those who did not delay or do without needed medical care in the prior 12 months, 82.5% versus 73.6%. The reason for this counterintuitive association is not immediately clear and is likely due to correlations with other demographic characteristics.

Health status. Health status was not associated with contraceptive use.

Receipt of birth control counseling. More women who received birth control counseling or information from a doctor or medical provider in the prior 12 months reported use of contraception compared to those who did not (78.7% vs. 73.2%), respectively. Women who received birth control counseling or information from doctor or medical provider in the prior 12 months were at reduced risk of unintended pregnancy (OR 0.7, 95% CI 0.6, 0.9) compared to those who did not receive this information.

REASONS FOR NON-USE OF CONTRACEPTION

When women who were not using contraception were asked their reasons for not doing so, 40.8% indicated that they were worried about side effects or health risks. In contrast, few (5.7%) women indicated that they do not believe in birth control. Other reasons for not using contraception were endorsed by few women and included not wanting to use contraception or not perceiving a need to use it, wanting a baby, and “other” reasons.

DISCUSSION

In order to formulate recommendations to improve access to contraception for under-served groups of women, we used a framework provided by the American Congress of Obstetricians and Gynecologists' (ACOG) Committee Opinion on Access to Contraception to summarize the literature on barriers that prevent women from accessing contraception or using it effectively.[16] These include 1) lack of information, misperceptions, and misinformation about side effects, 2) unnecessary medical practices, 3) cost and coverage barriers, 4) objections to contraception by Catholic hospitals, and 5) laws and policies that limit access to reproductive health care. In addition, racism, both structural and interpersonal, is discussed as a determinant of access to reproductive health care.

Lack of information, misperceptions, and misinformation, including about side effects. First, lack of knowledge and misperceptions about contraceptives serve as an obstacle to their use. Studies have shown that significant numbers of women incorrectly believe that oral contraceptives are linked to major health problems[17] or that IUDs carry a high risk of infection.[18] For example, based on their 2020 Women's Health Survey, Kaiser Family Foundation (KFF) found that almost one third (29%) of sexually active women who did not use contraception in the past year were concerned about or disliked the side effects.[19] Similarly, our analysis found that 40.8% of women who were not using contraception did not do so because they were worried about side effects or health risks.

An emphasis on abstinence-only sex education in the U.S. leaves many young people without access to accurate information about the effectiveness and harms of contraception.[20] While California law requires school districts to ensure that students in grades seven to twelve receive inclusive comprehensive sexual health education, including HIV prevention education, [21] some school districts have refused to comply with the law,[22] leaving students to seek information elsewhere. Groups that

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[16] ACOG, *Committee Opinion No. 615, Access to Contraception* (Jan. 2015), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/01/access-to-contraception.

[17] *Id*. (citing Daniel Grossman et al., *Perceptions of the Safety of Oral Contraceptives Among a Predominantly Latina Population in Texas*, 81 Contraception 254 (Mar. 2010), https://pubmed.ncbi.nlm.nih.gov/20159184/).

[18] *Id.* (citing Katherine J. Hladky et al., *Women's Knowledge About Intrauterine Contraception*, 117 Obstet. Gynecol. 48 (Jan. 2011), https://pubmed.ncbi.nlm.nih.gov/21173643/).

[19] Brittni Frederiksen et al., *Women's Sexual and Reproductive Health Services: Key Findings from the 2020 KFF Women's Health Survey*, KFF Women's Health Pol'y (Apr. 21, 2021), https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2020-kff-womens-health-survey/. This study did not differentiate between concerns about side effects and direct experiences of side effects (e.g., breast soreness or "breakthrough" bleeding).

[20] ACOG, *supra*.

[21] The "California Healthy Youth Act" was enacted via A.B. 329 in 2015 and enacted at Cal. Ed. Code §§ 51930-51939 (2015).

[22] *See, e.g.*, David Washburn, *Most Districts Complying with California's Sex Ed Law, but Resistance Remains*, EdSource (Sept. 13, 2018), https://edsource.org/2018/most-districts-complying-with-californias-sex-ed-law-but-resistance-remains/602236;

seek to limit abortion access,[23] especially post-*Dobbs*,[24] are promoting misinformation that certain types of contraception are abortifacients.

Unnecessary medial practices. In addition, the ACOG Committee noted that women, especially adolescents, may be deterred by standard but unnecessary medical practices, such as requiring a pelvic examination or cervical cancer screening before initiating hormonal contraception[25] or requiring multiple appointments. For instance, some providers may require patients to have an initial consultation appointment and then return for a second appointment to have an IUD inserted, when only one visit is necessary.[26,27] Other studies show that many OB/GYNs are hesitant to recommend or place IUDs for patients who have not previously given birth, despite their suitability for most women of reproductive age.[28]

Cost and coverage barriers. Further, cost and insurance practices remain a barrier for some women. Kaiser Family Foundation reports that among the 18% of women who are not using their preferred form of contraception, 25% report that this is because they cannot afford it.[29] While almost two thirds of privately insured women have full contraceptive coverage through their plans, 21% of women with private insurance are still paying some out-of-pocket costs for contraception.[30] Similarly, our analysis found that lower income women and those without health insurance had greater odds of not using birth control.

Further, insurance practices such as restricting patients to receive only one month's supply of contraception at a time have led to difficulties obtaining refills in a timely manner.[31] Since 2017,

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[23] *See* Joerge Dreweke, *Contraception is Not Abortion: The Strategic Campaign of Antiabortion Groups to Persuade the Public Otherwise*, 17 Guttmacher Pol'y Rev. 14 (2014), https://www.guttmacher.org/sites/default/files/article_files/gpr170414.pdf;

[24] Michael Ollove, *Some States Already Are Targeting Birth Control*, Pew Stateline (May 19, 2022), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/05/19/some-states-already-are-targeting-birth-control.

[25] ACOG, *supra* (citing F.H. Stewart et al., *Clinical Breast and Pelvic Examination Requirements for Hormonal Contraception: Current Practice vs. Evidence*, 285 JAMA 2232 (2001), https://jamanetwork.com/journals/jama/fullarticle/193803).

[26] M. Antonia Biggs, Cynthia C. Harper, & Claire D. Brindis, *California family planning health care providers' challenges to same-day long-acting reversible contraception provision, 126* Obstet Gynecol. 338 (2015).

[27] Jaclyn Serpico et al., *Access to Single-Visit IUD Insertion at Obstetrician-Gynecology Practices in Ohio: An Audit Study, 102* Contraception 190 (2020).

[28] *Id.* (citing Alicia T. Luchowski et al., *Obstetrician-Gynecologists and Contraception: Practice and Opinions about the Use of IUDs in Nulliparous Women, Adolescents and Other Patient Populations*, 89 Contraception 572 (June 2014), https://pubmed.ncbi.nlm.nih.gov/24679477/; Cynthia C. Harper et al., *Challenges in Translating Evidence to Practice: The Provision of Intrauterine Contraception*, 111 Obstet. Gynecol. 1359 (June 2008), https://pubmed.ncbi.nlm.nih.gov/18515520/; Cynthia C. Harper et al., E*vidence-Based IUD Practice: Family Physicians and Obstetrician-Gynecologists*, 44 Fam. Med. 637 (Oct. 2012), https://pubmed.ncbi.nlm.nih.gov/23027156/).

[29] Frederiksen et al., *supra*.

[30] *Id.*

[31] *See* Anita L. Nelson, Carolyn Westhoff, & Sharon Myoji Schnare, *Real-World Patterns of Prescription Refills for Branded Hormonal Contraceptives: A Reflection of Contraceptive Discontinuation*, 112 Obstet. Gynecol. 782 (Oct. 2008).

California law has allowed health service plans and health insurance policies to cover a 12-month supply of FDA-approved contraception, including the ring, patch, or oral contraceptive pills.[32] Most employer-based and all Covered California health plans cover 12 months of contraception.[33] A study conducted by the UCSF Bixby Center found that a 12-month supply of contraception decreased unplanned pregnancies by 30% compared with a supply of just one or three months.[34]

Religious or moral objections to contraception. While few participants in our study (5.7%) reported that they do not believe in birth control, for any reason, people who can get pregnant face a system of health care providers that are increasingly more likely to hold religiously based objections to contraception. For example, from 2001 to 2016, the number of Catholic owned or affiliated acute care hospitals in the US increased by 22%; at the same time, the overall number of acute care hospitals decreased by 6%.[35] In 2018, 17% of California's hospital beds were in Catholic hospitals.[36] Catholic hospitals must operate according to the Ethical and Religious Directives set by the U.S. Conference of Catholic Bishops, which generally forbid provision of contraception, sterilization, and abortion. As a result, women seeking care at Catholic hospitals are not able to access the full range of reproductive health care options, including some contraceptive options which are otherwise the standard of care, such as post-C-section tubal ligations (sterilization). Research shows that the increased market share of Catholic hospitals has restricted conceptive access for women, in general, and for women of color in particular.[37]

Laws and policies that limit access to reproductive health care. Finally, in recent years the law and policy landscape has resulted in restricted access to reproductive health care, including contraception. At the federal level, court decisions and agency regulations have permitted increasingly broad exemptions from the ACA's contraceptive coverage requirement.[38] For example, the federal Title X

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[32] S.B. 999, 2015-16 Reg. Sess. (Ca. 2016) (enacted at Ca. Bus. Prof. Code § 4064.5; Health & Safety Code § 1367.25; Ins. Code § 10123.196; Welfare & Inst. Code § 14000.01).

[33] Press Release, California Attorney General Bonta Issues Consumer Alert Reminding Californians of Their Right to Access Free or Low-Cost Birth Control (Sept. 26, 2022), https://oag.ca.gov/news/press-releases/california-attorney-general-bonta-issues-consumer-alert-reminding-californians.

[34] Diane Greene Foster et al., *Number of Oral Contraceptive Pill Packages Dispensed and Subsequent Unintended Pregnancies, 117* Obstet Gynecol. 566 (Mar. 2011), https://pubmed.ncbi.nlm.nih.gov/21343759/.

[35] Lois Uttley & Christine Khaikin, *Growth of Catholic Hospitals and Health Systems: 2016 Update of the Miscarriage of Medicine Report,* MergerWatch (2016), https://static1.1.sqspcdn.com/static/f/816571/27061007/1465224862580/MW_Update-2016-MiscarrOfMedicine-report.pdf.

[36] Tess Solomon et al., *Bigger and Bigger: The Growth of Catholic Health Systems*, Community Catalyst (2020), https://www.communitycatalyst.org/resources/publications/document/2020-Cath-Hosp-Report-2020-31.pdf; Kira Shepherd & Katherine Franke, *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Pub. Rights/Private Conscience Project, Columbia L. School & Pub. Health Solutions 4, 29 (Jan. 2018), https://lawrightsreligion.law.columbia.edu/sites/default/files/content/BearingFaith.pdf.

[37] *See* Solomon et al., *supra*, at 4, 29.

[38] *See Hobby Lobby v. Burwell*, 573 US 682 (2014); Robert Pear et al., *Trump Administration Rolls Back Birth Control Mandate*, N.Y. Times (Oct. 6, 2017), https://www.nytimes.com/2017/10/06/us/politics/trump-contraception-birth-control.html; Press Release, Ctr.

program—the nation's only dedicated source of federal funding for family planning services—was weakened under the Trump administration. In 2019, regulations governing Title X substantially diminished the network of providers available to provide low-income and uninsured clients with family planning services by disqualifying clinics who "perform, promote, or support abortion as a method of family planning."[39] As a result, providers who offer or refer their patients for the full scope of reproductive health care services were pushed out of the program; Planned Parenthood, which prior to the regulation served 40% of the 4 million patients who got care through the program, was forced to give up Title X funding,[40] while providers such as federally qualified health centers, city and county health departments, hospitals, universities, and urban Indian health centers, were prohibited from sharing comprehensive reproductive health information with their patients.

As a result of the 2019 regulations, the capacity of the Title X program to provide women with contraceptive services was reduced by at least 46% and affected an estimated 1.6 million female contraceptive patients nationwide; California was one of seven states whose network capacity was reduced between 50-89%.[41] While the Biden Administration has since repealed the 2019 regulations,[42] their limitations were in effect in 2020—the year that CHIS data were examined for this report.

RACISM AND ACCESS TO CARE FOR WOMEN OF COLOR

In addition to factors identified by the ACOG, it is important to recognize the history and ongoing existence of systemic bias and discrimination against racial and ethnic minorities in the U.S. health care system,[43] particularly around reproductive health care and decision-making. Our analysis found that more women of color than White, non-Hispanic women were not using contraception. This was particularly true for Black women, who were over three times as likely than White, non-Hispanic women not to be using contraception (50.7% v. 14.2%).

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for Repro. Rights, President Trump Signs Measure Reversing Obama Era Rule Protecting Women's Access to Basic Health Care (April 13, 2017), https://reproductiverights.org/president-trump-signs-measure-reversing-obama-era-rule-protecting-womens-access-to-basic-health-care/.

[39] Compliance With Statutory Program Integrity Requirements, 84 Fed. Reg. 7714, 7717 (March 4, 2019) (codified at 42 C.F.R. 59) ("This rule finalizes the revocation of the requirement that Title X project refer for abortion, and finalizes the prohibition against using Title X funds to refer for abortion as a method of family planning, or to perform, promote, or support abortion as a method of family planning").

[40] *See Press Release, One Year After Being Forced Out of Title X, Planned Parenthood Continues to Fight for Patients,* Planned Parenthood (Aug. 19, 2020), https://www.plannedparenthood.org/about-us/newsroom/press-releases/one-year-after-being-forced-out-of-title-x-planned-parenthood-continues-to-fight-for-patients.

[41] Ruth Dawson, *Trump Administration's Domestic Gag Rule Has Slashed the Title X Network's Capacity by Half,* Guttmacher Inst. (Feb. 5, 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half.

[42] Ensuring Access to Equitable, Affordable, Client-Centered Quality Family Planning Services, 86 Fed. Reg. 56144 (Oct. 7, 2021) (codified at 42 C.F.R. 59).

[43] *See* Inst. of Med., Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003), https://www.ncbi.nlm.nih.gov/books/NBK220358/.

Historic racist abuses include gynecological experimentation on enslaved Black women.[44] Later, women of color in the United States—particularly Black, Indigenous, and Puerto Rican women—were targeted for forced or coerced sterilization from the mid-1900s through the 1970s. In the 1950s, the first large-scale human trials of the modern birth control pill were conducted on Puerto Rican women without informed consent.[45] In the 1990s, Norplant (the first subdermal implant contraceptive) was publicly hailed as a potential solution to low-income and teenage childbearing and was targeted at low-income women and women of color, through practices such as Medicaid reimbursement laws paying for insertion but not removal of Norplant, or state programs promoting Norplant in schools and publicly funded clinics.[46] In California, between 2006-2010, close to 150 women—most of them Black and Latina—were sterilized in California state prisons without proper consent procedures.[47] In addition to these reproductive abuses, young Black women and Latinas have reported experiencing "implicit pressure" from providers, either to use contraception, in general, or to use specific methods.[48]

Women of color have long been denied full reproductive autonomy by medical providers. Mistrust of the health care system and of health providers is a response to historical mistreatment and current experiences of discrimination. Racial discrimination in health care[49] contributes to poorer reproductive health,[50] including reduced access to effective contraceptive methods,[51] lower rates of contraceptive use,[52] and higher rates of unintended pregnancies[53] among women of color compared to White

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[44] *See Keith Wailoo, Historical Aspects of Race and Medicine,* 320 JAMA 1529 (2018).

[45] *See Drew C. Pendergrass & Michelle Y. Raji, The Bitter Pill: Harvard and the Dark History of Birth Control,* The Crimson (Sept. 28, 2017), https://www.thecrimson.com/article/2017/9/28/the-bitter-pill/.

[46] Dorothy Roberts, Killing the Black Body (1999).

[47] Bill Chappell, *California's Prison Sterilizations Reportedly Echo Eugenics Era*, NPR (July 9, 2013), https://www.npr.org/sections/thetwo-way/2013/07/09/200444613/californias-prison-sterilizations-reportedly-echoes-eugenics-era; Corey G. Johnson, *Female Inmates Sterilized in California Prisons without Approval*, Reveal News (July 7, 2013). https://revealnews.org/article/female-inmates-sterilized-in-california-prisons-without-approval/.

[48] Anu Manchikanti Gomez & Mikaela Wapman, *Under (Implicit) Pressure: Young Black and Latina Women's Perceptions of Contraceptive Care*, 96 Contraception 221 (Oct. 2017).

[49] *See, i.e, Kelly Treder et al., Racism and the Reproductive Health Experiences of US-Born Black Women,* 139 Obstet. Gynecol. 407 (Mar. 2022); Rachel G. Logan et al., *"When is Health Care Actually Going to Be Care?" The Lived Experiences of Family Planning Care Among Young Black Women,* 31 Qual. Health Research 1159 (2021).

[50] Cynthia Prather et al., *Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Reproductive Health, 2* Health Equity 249 (Sept. 2018).

[51] *See Karla Klossler et al., Perceived Racial, Socioeconomic and Gender Discrimination and its Impact on Reproductive Choice, 84* Contraception 273 (Sept. 2011); Michele Troutman, Saima Rafique, & Torie Comeaux Plowden, *Are Higher Unintended Pregnancy Rates Among Minorities a Result of Disparate Access to Contraception*, 5 Contracept. Reprod. Med 15 (2020).

[52] *See Christine Dehlendorf et al., Racial/Ethnic Disparities in Contraceptive Use: Variation by Age and Women's Reproductive Experiences,* 210 Am. J. Obstet. Gynecol. 526 (June 2014); Christine Dehlendorf et al., *Disparities in Family Planning*, 202 Am. J. Obstet. Gynecol. 214 (Mar. 2010).

[53] Guttmacher Inst., *Unintended Pregnancy in the United States* (Jan. 2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states; Diana G. Foster et al., *Contraceptive Use and Risk of Unintended Pregnancy in California*, 70 Contraception 31-9 (July 2004); Tanya M. Phares, Yan Cui, & Susie Baldwin, *Effective Birth Control Use among Women at Risk for Unintended*

women. Medical mistrust is negatively associated with satisfaction with contraceptive counseling and services.[54] More generally, medical mistrust is associated with delays in care and not following medical advice or filling prescriptions.[55] Improvements in the health care system and changes in the workforce are needed to establish trust and to improve the quality of reproductive health care for women of color.[56]

THE POLICY CONTEXT FOR CONTRACEPTIVE ACCESS IN CALIFORNIA

The Affordable Care Act, enacted 2010, requires most private health insurance plans to cover "all FDA-approved contraceptive methods," including barrier methods, hormonal methods, implanted devices, emergency contraception, sterilization, and patient education and counseling at no additional cost.[57] In 2014, California expanded upon this requirement and requires most private insurance and Medi-Cal managed care plans in California to cover all FDA-approved contraceptive methods, contraceptive counseling, and voluntary sterilization for women without cost-sharing.[58] These laws ensure patient choice and prohibit an insurer from preventing someone from selecting the contraceptive method that works best for them.[59]

In addition, the Family Planning, Access, Care and Treatment ("Family PACT" or "FPACT") program, covers all FDA-approved contraceptive methods for individuals with incomes at or below 200% of the federal poverty level with no other sources of reproductive health care and who are not otherwise eligible for Medicaid services.[60] FPACT offers comprehensive family planning services, including contraception, pregnancy testing, and sterilization, and serves 1.1 million eligible people through a network of 2,400 public and private providers.[61]

Pregnancy in Los Angeles, California, 22 Women's Health Issues e351 (2012).

[54] Huysman BC, Paul R, Nigaglioni Rivera A, Tal E, Maddipati R, Madden T. *Patient and counselor satisfaction with structured contraceptive counseling by health center staff in federally qualified health centers.* Contraception. 2021 Feb;103(2):97-102. doi: 10.1016/j.contraception.2020.10.020. Epub 2020 Nov 5. PMID: 33160909; PMCID: PMC7856096. Oakley LP, Harvey SM, López-Cevallos DF. *Racial and Ethnic Discrimination, Medical Mistrust, and Satisfaction with Birth Control Services among Young Adult Latinas.* Womens Health Issues. 2018 Jul-Aug;28(4):313-320. doi: 10.1016/j.whi.2018.03.007. Epub 2018 May 2. PMID: 29729838.

[55] Thomas A LaVeist, Lydia A Isaac, & Karen Patricia Williams, *Mistrust of Health Care Organizations is Associated with Underutilization of Health Services*, 44 Health Serv. Res. 2093 (Dec. 2009).

[56] *See Martha Hostetter & Sarah Klein, Understanding and Ameliorating Medical Mistrust Among Black Americans,* CommonWealth Fund (Jan. 14, 2021), https://www.commonwealthfund.org/publications/newsletter-article/2021/jan/medical-mistrust-among-black-americans.

[57] 45 CFR 147.130(a)(1)(iv); *see* US Dep'ts. HHS, DOL, & Treasury, *FAQs About Affordable Care Act Implementation Part 54* (July 28, 2022), https://www.cms.gov/files/document/faqs-part-54.pdf

[58] S.B. 1053, 2013-14 Reg. Sess. (Ca. 2014) (enacted at Cal. Health & Safety Code § 1367.25; Cal. Insurance Code § 10123.196; Cal. Welfare & Inst. Code § 14132); *see* Nat'l Health L. Prog., *Lessons from California: Contraceptive Coverage* (Sept. 2014), https://healthlaw.org/resource/lessons-from-ca-contraceptive-coverage/.

[59] *See* Nat'l Health L. Prog. Lessons from California: Contraceptive Coverage (Sept. 2014), https://healthlaw.org/resource/lessons-from-ca-contraceptive-coverage/.

[60] Cal. Dep't. of Health Care Servs., Family PACT, https://familypact.org/.

[61] Cal. Dep't. of Health Care Servs., Office of Family Planning, https://www.dhcs.ca.gov/services/ofp/Pages/OfficeofFamilyPlanning.

In an effort to further facilitate access to contraception for all people, regardless of income, California pharmacists were able to directly prescribe self-administered hormonal contraceptive pills, patches, rings, and injections under SB 493 starting in 2016.[62] However, in 2017, only 11% of pharmacies across the state offered pharmacist-provided prescription contraceptive services.[63] Similarly, a 2017 mystery shopper study found that only one in ten Los Angeles County pharmacies were providing pharmacist-prescribed hormonal contraception and that many low-income, racial-ethnic minority neighborhoods did not have pharmacies at all.[64]

In recognition of the need to increase the state's reproductive health care service capacity following the *Dobbs* decision,[65] the California legislature passed several bills which aim to expand access to reproductive health care generally, including both abortion and contraception. One new law created the California Reproductive Health Service Corps, with the purposes of recruiting, training, and retaining a diverse workforce of professionals who will be part of reproductive health care teams to work in underserved areas.[66] Another established the California Reproductive Health Equity Program within the Department of Health Care Access and Information to ensure that both abortion and contraception services are affordable for and accessible to all patients in the state. The program administers grants to Medi-Cal enrolled providers who provide contraception and abortion services to patients who are uninsured or whose health insurance coverage does not include both abortion and contraception but who are not otherwise eligible for Medi-Cal and Family PACT programs.[67]

RECOMMENDATIONS FOR PRACTICE AND POLICY

Access to Information

- Ensure that people of all ages across the state have access to medically accurate information about pregnancy and contraception—particularly before they become sexually active—through compliance with the California Healthy Youth Act sex education.
- Increase public awareness about options for publicly funded contraception, including Medi-Cal and FPACT.
- Increase public awareness about contraceptive access through pharmacists.

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aspx.

[62] Bill Text - SB-493 Pharmacy practice. 2013. Accessed February 22, 2023. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201320140SB493.

[63] Anu Manchikanti Gomez, *Availability of Pharmacist-Prescribed Contraception in California*, 318 JAMA 2253 (2017).

[64] Dima Mazen Qato et al., *Pharmacist-Prescribed And Over-The-Counter Hormonal Contraception In Los Angeles County Retail Pharmacies*, 39 Health Affairs 7 (July 2020), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01686.

[65] *See* Sears et al., *People Traveling to California and Los Angeles for Abortion Care if* Roe v. Wade *is Overturned*, Ctr. on Reproductive Health, L., & Pol'y (June 2022), https://law.ucla.edu/sites/default/files/PDFs/Center_on_Reproductive_Health/California_Abortion_Estimates.pdf

[66] A.B. 1918, 2021-22 Reg. Sess. (Ca. 2022).

[67] A.B. 2134, 2021-22 Reg. Sess. (Ca. 2022).

Workforce Development and Expansion

- Ensure that women of color providers and linguistically appropriate services are available to provide care to underserved populations, including women who speak Spanish and Asian languages including Cantonese, Korean, Vietnamese, and Tagalog.
- Ensure that providers have accurate and up-to-date information about various forms of contraception and can debunk myths about contraception.
- Increase the number of providers who are prescribing contraception at pharmacies and elsewhere across the state, including by advanced care providers such as pharmacists nurse practitioners, and physician assistants.

Cost, Coverage, and Other Strategies to Increase Access

- Make birth control pills available over the counter without a prescription through state legislation.
- Eliminate cost-sharing for all forms of contraception, including office visit co-pays and costs for required screenings.
- Ensure Medi-Cal access for undocumented immigrants of all ages.
- Expand income eligibility requirements FPACT and ensure FPACT eligibility regardless of sexual orientation.
- Expand state funding for family planning clinics that serve low-income populations.
- Ensure that insurance companies are complying with the ACA contraceptive coverage mandate.

Research and Evaluation

- Monitor the implementation and success of California's new initiatives to increase access to contraception, particularly in relation to underserved communities.
- Initiate information-gathering about contraceptive use and barriers to use among underserved populations in health surveillance systems and monitor change over time.

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APPENDIX

METHODS

2020 California Health Interview Survey (CHIS) data were analyzed for this report. CHIS is a health survey managed by the UCLA Center for Health Policy Research. CHIS data are collected via an annual survey from a representative household sample of about 20,000 adults ages 18 and up on a range of health-related topics including reproductive health and birth control utilization.

Households were randomly selected using address-based sampling and were mailed an invitation to complete the CHIS survey on-line. Following the initial invitation, a reminder postcard and a second letter were sent to the household encouraging their participation. If a household did not complete the survey online, and received all three letters, interviewers attempted to complete the interview over the telephone. Households could also opt to complete the survey over the phone. Both online and phone surveys were available in English, Spanish, Cantonese, Korean, and Vietnamese. Phone surveys could also be completed in Tagalog. The mailings sent to each address were customized to include messages in multiple languages, based on languages spoken in a potential volunteer's neighborhood.

Survey participants responded to a series of questions about reproductive health and birth control utilization. Questions about current pregnancy status (To your knowledge, are you now pregnant?) and intention (Which of the following statements best describes your pregnancy plans?) were first asked. Responses for current pregnancy status were "Yes", "No", and "Not Applicable." Responses for pregnancy intention were "I do not plan to get pregnant within the next 12 months", "I am not sexually active", "I am planning to get pregnant within the next 12 months", "I am currently pregnant", and "I am not able to get pregnant". If respondents did not report being pregnant, were not gay, lesbian, or homosexual, were not unable to get pregnant, did not indicate that they were not sexually active, they were then asked about general birth control use ("Are you or your male sex partner currently using a birth control method to prevent pregnancy?). Responses for this question were "Yes", "No", and "No male sexual partner." If respondents answered "Yes", they were asked about birth control methods used ("Which birth control method or methods are you using?"). Response options included "Tubal ligation (tubes tied cut)," "Vasectomy (male sterilization)," "IUD (Mirena®, Paragard®, Skyla®, Kyleena®, Liletta®, etc.)," "Implant (Implanon®, Nexplanon®, etc.)," "Birth control pills", "Other hormonal methods (Injection/Depo-Provera, patch, vaginal ring/NuvaRing®)," "Condoms (male)," "Other(Specify:____)."

Based on responses to these questions, we limited our analytic sample to women ages 18-44 who were assigned female at birth, who were not gay/lesbian/homosexual- or not sexual/other-identified, who did not indicate that they were unable to get pregnant, and who did not intend to get pregnant in the next 12 months. Respondents were classified as birth control users (of any type, including sterilization) or not. We performed descriptive analyses using design-based F-tests (Rao-

Scott Chi-square tests) of differences in proportions to assess whether sociodemographic and health characteristics varied across contraceptive use groups at an alpha of 0.05. Confidence intervals (95% CI) were included to communicate the degree of uncertainty around and estimate due to sampling error.

Non-overlapping confidence intervals were deemed indicative of statistically significant differences in two proportions at an alpha of 0.05. Nominal and binomial logistic regressions were used to estimate the odds of not using contraception among a demographic or health characteristic group of interest relative to the odds of not using contraception among a referent group. Odds ratios with 95% CI that did not include one were deemed indicative of statistical significance differences at an alpha of 0.05 All analyses were conducted using Stata v17.1 and weighted using person-level weights provided by the UCLA Center for Health Policy Research. All sample sizes (n) are unweighted.

Approach to Population Estimation

To estimate the number of sexually active cisgender heterosexual and bisexual women who have male partners and do and do not use contraceptives, we relied upon estimates available through AskCHIS – an on-line data query platform maintained by the UCLA Center for Health Survey Research. We restricted our query of pregnancy intention and birth control use (sexually active females ages 18 to 44) to heterosexual and bisexual people in 2020 and obtained counts of those who use contraception (2,905,000) and those who do not (947,000) – ignoring those who indicate that they did not have a male sexual partner. We then conducted an additional query of birth control use (sexually active females ages 18 to 44) and transgender/cisgender status, restricted to heterosexual and bisexual people in 2020, to obtain counts of transgender people who were using birth control (10,000) and those who were not (4,000) (again, ignoring those who did not have a male sexual partner). We confirmed that these counts reflected transgender people who did not intend to become pregnant and then subtracted them from our first set of estimates to general final estimates of cisgender women who met all inclusion criteria for this study. In total, there were an estimated 2,895,000 sexually active cisgender heterosexual and bisexual women ages 18-44 in the state who do not intend to become pregnant in the next 12 months in 2020 and were using birth control to prevent pregnancy. An estimated 943,000 women were not using contraception. Together, there were an estimated 3,838,000 sexually active cisgender heterosexual and bisexual women ages 18 to 44 in the state of California who did not intend to become pregnant in the next 12 months.

To estimate the number of women who used specific contraceptive methods, we applied percentages from our analyses of the 2020 California Health Interview Survey (CHIS) data to the population estimates described above.

TABLES

Table 1. Sociodemographic, health, and -related characteristics of cisgender heterosexual and bisexual California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=2,282) by contraceptive utilization (any vs. none), 2020 California Health Interview Survey

	All N=2,282		**Any contraception n=1,767**		**No contraception n=515**		**F test**
	%	**95% CI**	**%**	**95% CI**	**%**	**95% CI**	**p-value**
	100%	**--**	**75.3**	**72.9, 77.6**	**24.7**	**22.4, 27.1**	
Demographic Characteristics							
Age							
18-25	26.0	23.8, 28.3	27.0	24.2, 30.0	22.8	18.5, 27.7	**0.01**
26-29	17.1	15.5, 18.9	18.4	16.3, 20.8	13.2	10.0, 17.4	
30-34	20.7	18.8, 22.7	21.1	18.6, 23.9	19.4	16.0, 23.3	
35-39	18.6	16.7, 20.6	17.6	15.3, 20.2	21.6	17.1, 26.8	
40-44	17.6	16.3, 19.0	15.8	14.1, 17.8	23.0	19.1, 27.5	
Marital status							
Married	40.5	37.8, 43.3	40.3	37.3, 43.3	41.2	35.7, 46.9	0.12
Living w/ partner	20.4	17.5, 23.5	21.8	18.7, 25.2	16.0	11.4, 21.9	
Widow/separated/divorced	4.2	3.4, 5.2	3.8	3.0, 4.8	5.4	3.5, 8.3	
Never married	35.0	32.4, 37.6	34.1	31.2, 37.2	37.5	31.6, 43.7	
Sexual orientation							
Straight/heterosexual	91.6	90.1, 92.8	90.1	88.0, 91.8	96.2	94.2, 97.5	**<0.001**
Bisexual	8.4	7.2, 9.9	9.9	8.2, 12.0	3.8	2.5, 5.8	
Race-ethnicity (detailed)							
White, non-Hispanic	30.4	28.7, 32.1	34.6	32.5, 36.7	17.6	14.1, 21.7	**<0.0001**
Latino/a or Hispanic	47.2	45.1, 49.3	44.4	41.8, 47.1	55.8	50.8, 60.6	
Asian, non-Hispanic	14.6	12.9, 16.5	14.6	12.5, 17.0	14.8	11.5, 18.9	
Black, non-Hispanic	3.9	3.0, 5.1	2.6	1.7, 3.9	8.1	5.1, 12.7	
Any other race alone, or more than one race	3.8	3.1, 4.7	3.8	2.9, 4.9	3.8	2.3, 6.0	

	All N=2,282		Any contraception n=1,767		No contraception n=515		F test
	%	95% CI	%	95% CI	%	95% CI	p-value
Race-ethnicity (two-group)							
White, non-Hispanic	30.4	28.7, 32.1	34.6	32.5, 36.7	17.6	14.1, 21.7	**<0.0001**
All other racial-ethic groups	69.6	67.9, 71.3	65.4	63.3, 67.5	82.4	78.3, 85.9	
Language spoken at home							
English only	50.3	47.6, 53.0	52.6	49.2, 56.0	43.3	37.8, 48.9	**0.02**
Spanish only	7.4	5.5, 10.0	7.2	5.0, 10.4	8.0	5.3, 11.9	
English & Spanish	26.9	24.2, 29.5	24.5	21.8, 27.5	34.0	28.7, 39.8	
English & Asian languages	6.8	5.4, 8.5	6.5	4.9, 8.7	7.6	5.3, 10.8	
Other language(s)	8.6	7.3, 10.2	9.1	7.5, 11.0	7.1	4.9, 10.3	
Citizenship status							
US-born	71.9	68.8, 74.7	73.4	69.9, 76.7	67.1	61.8, 72.0	0.05
Naturalized	11.7	9.8, 13.9	10.5	8.5, 12.9	15.3	12.0, 19.3	
Non-citizen	16.4	13.9, 19.3	16.0	13.0, 19.6	17.7	13.9, 22.2	
Urbanicity							
Urban	90.3	88.7, 91.7	90.7	88.5, 92.6	89.0	85.8, 91.6	0.40
Rural	9.7	8.3, 11.3	9.3	7.4, 11.5	11.0	8.4, 14.2	
Education							
High school or less	25.2	22.4, 28.2	24.7	21.3, 28.3	26.7	21.4, 32.9	**0.03**
Associates or some college	23.0	20.8, 25.3	21.3	18.7, 24.1	28.3	23.3, 33.8	
Bachelor's or more	51.8	49.0, 54.6	54.0	50.8, 57.3	45.0	39.9, 50.2	
Poverty							
<100% federal poverty level (FPL)	16.6	14.4, 19.2	14.9	12.4, 17.9	21.8	17.4, 27.0	**<0.0001**
100%-199% FPL	14.8	12.6, 17.2	13.4	11.1, 16.1	18.9	14.5, 24.2	
200%-299% FPL	13.1	10.8, 15.9	11.6	9.7, 13.9	17.7	12.6, 24.1	
300%-399% FPL	11.0	9.4, 13.0	12.3	10.4, 14.4	7.3	4.8, 11.1	
≥ 400% FPL	44.4	41.7, 47.3	47.7	44.6, 50.8	34.4	29.6, 39.4	

	All N=2,282		Any contraception n=1,767		No contraception n=515		F test
	%	95% CI	%	95% CI	%	95% CI	p-value
Health & Health Service Characteristics							
Health insurance type							
Uninsured	8.2	6.3, 10.5	6.8	4.8, 9.6	12.3	8.8, 16.9	**<0.01**
Medicaid (Medi-Cal)	24.4	21.6, 27.4	22.3	19.2, 25.6	31.0	25.9, 36.6	
Employment-based	60.5	57.5, 63.5	64.1	60.5, 67.5	49.6	43.7, 55.4	
Other	6.9	5.3, 9.1	6.8	5.5, 8.5	7.2	3.6, 13.9	
Self-reported health							
Poor/fair	8.2	6.4, 10.5	8.7	6.5, 11.6	6.6	4.1, 10.7	0.34
Good/very good/excellent	91.8	89.5, 93.6	91.3	88.4, 93.5	93.4	89.3, 95.9	
Has usual source of health care							
Yes (doctor's office/HMO/Kaiser/ community or government clinic/ community hospital/other/multiple)	79.8	76.6, 82.6	81.6	78.0, 84.8	74.1	69.1, 78.6	**0.01**
No (None/emergency room/urgent care)	20.2	17.4, 23.4	18.4	15.5, 22.0	25.9	21.4, 30.9	
Had trouble finding general doctor in the past 12 months							
Yes	7.7	6.3, 9.4	8.3	6.4, 10.6	6.1	4.1, 8.9	0.24
No	92.3	90.6, 93.7	91.7	89.4, 93.6	93.9	91.1, 95.9	
Delay or never obtain needed medical care in the past 12 months							
Yes	19.6	17.4, 21.9	21.4	19.0, 24.0	13.9	10.5, 18.2	**<0.01**
No	80.4	78.1, 82.6	78.6	76.0, 81.0	86.1	81.8, 89.5	
Delay or never obtained needed prescription in the past 12 months							
Yes	9.9	8.2, 11.9	9.8	7.8, 12.3	10.2	7.2, 14.2	0.87
No	90.1	88.1, 91.8	90.2	87.7, 92.2	89.8	85.8, 92.8	
Received birth control counseling or information from doctor or medical provider in the past 12 months							
No	62.4	59.9, 64.9	60.7	57.9, 63.4	67.7	62.2, 72.5	**0.02**
Yes	37.6	35.1, 40.1	39.3	36.6, 42.1	32.3	27.5, 37.4	

CI: Confidence Interval. Bold p-values are statistically significant.

Table 2. Contraceptive use* within sociodemographic and health-related characteristic groups of cisgender heterosexual and bisexual California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=2,282), 2020 California Health Interview Survey

	Any contraception n=1,767		No contraception n=515	
	%	95% CI	%	95% CI
Demographic Characteristics				
Age				
18-25	78.4	72.7, 83.1	21.6	16.9, 27.3
26-29	81.0	74.9, 85.8	19.0	14.2, 25.1
30-34	76.9	71.5, 81.6	23.1	18.4, 28.5
35-39	71.4	65.0, 77.0	28.6	23.0, 35.0
40-44	67.7	61.4, 73.5	32.3	26.5, 38.6
Marital status				
Married	74.9	71.6, 78.0	25.1	22.0, 28.4
Living w/ partner	80.7	74.0, 86.0	19.3	14.0, 26.0
Widow/separated/divorced	68.1	56.4, 77.8	31.9	22.2, 43.6
Never married	73.6	68.6, 78.0	26.4	22.0, 31.4
Sexual orientation				
Straight/heterosexual	74.1	71.4, 76.6	25.9	23.4, 28.6
Bisexual	88.8	82.5, 93.1	11.2	6.9, 17.5
Race-ethnicity (detailed)				
White, non-Hispanic	85.8	82.4, 88.6	14.2	11.4, 17.6
Latino/a or Hispanic	70.9	67.0, 74.5	29.1	25.5, 33.0
Asian, non-Hispanic	75.1	68.4, 80.7	24.9	19.3, 31.6
Black, non-Hispanic	49.3	31.1, 67.7	50.7	32.3, 68.9
Any other race alone, or more than one race	75.7	62.8, 85.1	24.3	14.9, 37.2
Race-ethnicity (two-group)				
White, non-Hispanic	85.8	82.4, 88.6	14.2	11.4, 17.6
All other racial-ethic groups	70.8	67.6, 73.8	29.2	26.2, 32.4
Language spoken at home				
English only	78.8	75.3, 81.9	21.2	18.1, 24.7
Spanish only	73.5	61.9, 82.5	26.5	17.5, 38.1
English & Spanish	68.8	63.1, 74.0	31.2	26.0, 36.9
English & Asian languages	72.4	61.4, 81.2	27.6	18.8, 38.6
Other language(s)	79.6	72.3, 85.3	20.4	14.7, 27.7
Citizenship status				
US-born	77.0	74.1, 79.6	23.0	20.4, 25.9
Naturalized	67.8	60.8, 74.0	32.2	26.0, 39.2
Non-citizen	73.5	66.1, 79.8	26.5	20.2, 33.9

	Any contraception n=1,767		No contraception n=515	
	%	95% CI	%	95% CI
Urbanicity				
Urban	75.7	72.9, 78.3	24.3	21.7, 27.1
Rural	72.1	63.5, 79.3	27.9	20.7, 36.5
Education				
High school or less	73.8	67.5, 79.3	26.2	20.7, 32.5
Associates or some college	69.7	63.7, 75.1	30.3	24.9, 36.3
Bachelor's or more	78.6	75.5, 81.4	21.4	18.6, 24.5
Poverty				
<100% federal poverty level (FPL)	67.7	60.3, 74.3	32.3	25.7, 39.7
100%-199% FPL	68.5	60.8, 75.3	31.5	24.7, 39.2
200%-299% FPL	66.8	59.0, 73.8	33.2	26.2, 41.0
300%-399% FPL	83.7	76.9, 88.8	16.3	11.2, 23.1
≥ 400% FPL	80.9	77.8, 83.7	19.1	16.3, 22.2
Health & Health Service Characteristics				
Health insurance type				
Uninsured	62.9	50.6, 73.7	37.1	26.3, 49.4
Medicaid (Medi-Cal)	68.7	63.4, 73.5	31.3	26.5, 36.6
Employment-based	79.8	76.9, 82.4	20.2	17.6, 23.1
Other	74.4	58.4, 85.8	25.6	14.2, 41.6
Self-reported health				
Poor/fair	80.1	69.0, 87.9	19.9	12.1, 31.0
Good/very good/excellent	74.9	72.2, 77.4	25.1	22.6, 27.8
Has usual source of health care				
Yes (doctor's office/HMO/Kaiser/community or government clinic/ community hospital/other/multiple)	77.1	74.7, 79.3	22.9	20.7, 25.3
No (None/emergency room/urgent care)	68.5	61.6, 74.6	31.5	25.4, 38.4
Had trouble finding general doctor in the past 12 months				
Yes	80.5	70.9, 87.5	19.5	12.5, 29.1
No	74.9	72.3, 77.4	25.1	22.6, 27.7
Delay or never obtain needed medical care in the past 12 months				
Yes	82.5	77.6, 86.5	17.5	13.5, 22.4
No	73.6	70.8, 76.2	26.4	23.8, 29.2
Delay or never obtained needed prescription in the past 12 months				
Yes	74.7	65.5, 82.1	25.3	17.9, 34.5
No	75.4	72.8, 77.9	24.6	22.1, 27.2
Received birth control counseling or information from doctor or medical provider in the past 12 months				
No	73.2	70.1, 76.1	26.8	23.9, 29.9
Yes	78.7	75.1, 82.1	21.2	17.9, 24.9

* Row percentages total 100%; CI: Confidence Interval

Table 3. Odds of no contraceptive use vs. any contraceptive use by sociodemographic, health, and related characteristics of cisgender heterosexual and bisexual California women ages 18-44 who do not intend to get pregnant in the next 12 months (N=2,282), 2020 California Health Interview Survey

	All N=2,282	
	Odds ratio	95% CI
Demographic Characteristics		
Age		
18-25	0.6	0.4, 0.9
26-29	0.5	0.3, 0.7
30-34	0.6	0.4, 0.9
35-39	0.8	0.5, 1.3
40-44	1.0	
Marital status		
Married	1.0	
Living with partner	0.7	0.5, 1.1
Widow/separated/divorced	1.4	0.8, 2.4
Never married	1.1	0.8, 1.5
Sexual orientation		
Straight/heterosexual	1.0	
Bisexual	0.4	0.2, 0.6
Race-ethnicity (detailed)		
White, non-Hispanic	1.0	
Latino/a or Hispanic	2.5	1.8, 3.4
Asian, non-Hispanic	2.0	1.3, 3.0
Black, non-Hispanic	6.2	2.8, 13.7
Any other race alone, or more than one race	1.9	1.0, 3.8
Race-ethnicity (two-group)		
White, non-Hispanic	1.0	
All other racial-ethic groups	2.5	1.9, 3.3
Language spoken at home		
English only	1.0	
Spanish only	1.3	0.8, 2.4
English & Spanish	1.7	1.2, 2.3
English & Asian languages	1.4	0.8, 2.5
Other language(s)	1.0	0.6, 1.5
Citizenship status		
US-born	1.0	
Naturalized	1.6	1.2, 2.2
Non-citizen	1.2	0.8, 1.8

	All N=2,282	
	Odds ratio	**95% CI**
Urbanicity		
Urban	1.0	
Rural	1.2	0.8, 1.9
Education		
High school or less	1.3	0.9, 1.9
Associates or some college	1.6	1.2, 2.2
Bachelor's or more	1.0	
Poverty		
<100% federal poverty level (FPL)	2.0	1.4, 2.9
100%-199% FPL	2.0	1.4, 2.8
200%-299% FPL	2.1	1.5, 3.1
300%-399% FPL	0.8	0.5, 1.3
≥ 400% FPL	1.0	
Health & Health Service Characteristics		
Health insurance type		
Uninsured	2.3	1.4, 4.0
Medicaid (Medi-Cal)	1.8	1.3, 2.4
Employment-based	1.0	
Other	1.4	0.6, 3.0
Self-reported health		
Poor/fair	0.7	0.4, 1.4
Good/very good/excellent	1.0	
Has usual source of health care		
Yes (doctor's office/HMO/Kaiser/community or government clinic/community hospital/ other/multiple)	1.0	
No (None/emergency room/urgent care)	1.6	1.1, 2.1
Had trouble finding general doctor in the past 12 months		
Yes	0.7	0.4, 1.3
No	1.0	
Delay or never obtain needed medical care in the past 12 months		
Yes	0.6	0.4, 0.8
No	1.0	
Delay or never obtained needed prescription in the past 12 months		
Yes	1.0	0.7, 1.7
No	1.0	
Received birth control counseling or information from doctor or medical provider in the past 12 months		
Yes	0.7	0.6, 0.9
No	1.0	

CI: Confidence Interval