od were in the database; among those excluded were women whose records were inaccessible because of incompatible billing methods and women enrolled in health maintenance organizations.

The characteristics of women in the database were representative of those of all Colorado Medicaid-eligible women. Their mean age was 24 years, their median age was 22 and their modal age was 20. The age distribution was weighted toward young women in their late teens and early 20s. One limitation of the data set was its inability to distinguish between AFDC clients and Medicaid-only clients; there were also no data on race or marital status.

Each record in the database included the age of the woman and the date of the baseline Medicaid-eligible birth and any subsequent births over the study period. For purposes of analysis, birth order pertains only to the information in the database, not necessarily to the woman’s true birth experience. A woman’s “first” birth, for example, is her first birth that was entered into the Medicaid database. However, since an estimated 85% of all births in the Medicaid database are first births, the birth-order designations for the most part accurately reflect birth order. Although we could not predict the probability of a repeat birth not covered by Medicaid, that likelihood is probably small, since a young woman is unlikely to be able to cover the cost of a second delivery.

The dates that a woman elected to have the implant inserted (and subsequently removed) or to have a contraceptive injection (available after January 1993) were also in the database. (We did not analyze the impact of the contraceptive injection on fertility, however.) The basic criterion for inclusion was Medicaid coverage, so any repeat pregnancies or deliveries not paid for by Medicaid, or any contraceptive methods obtained outside the Medicaid program, are not reflected in the data.

Life tables were constructed for the 11,544 women in the database whose first Medicaid-eligible birth occurred between January 1, 1991, and December 31, 1991; these women made up the 1991 cohort. The 13,624 women who first delivered between January 1, 1992, and December 31, 1992, comprised the 1992 cohort. Each annual cohort was also separated by age into subsets of women who first gave birth as teenagers (N=2,815 in the 1991 cohort and N=3,561 in the 1992 cohort) and all women.

Life-table analysis was used to determine the probability of a subsequent Medicaid-eligible birth by April 30, 1994—a maximum period of 40 months for the women whose first Medicaid-eligible birth occurred in January of 1991. Each woman’s experience was followed for as long as there were relevant data available for her; if she had not had a second delivery by the end of the study period, she was considered lost to follow-up at that time.

### Results

#### Subsequent Fertility

According to life-table analysis, 1.6% of the women whose first delivery was paid for by Medicaid in 1991 had another birth within 12 months, 8.1% gave birth again within 18 months, 14.1% delivered again within 24 months and 21.3% did so within 36 months (see Figure 1). By the end of the maximum interval of 40 months, 23.0% had had a subsequent Medicaid-eligible delivery.

Among women whose first Medicaid-eligible delivery took place in 1992, 1.3% had a second Medicaid-eligible birth within 12 months, 6.3% had one within 18 months and 10.6% within 24 months. This 24-month repeat fertility rate for the 1992 cohort is 25% lower than that calculated for the 1991 cohort, and the difference is statistically significant (p<.001). The repeat delivery rate among women in the 1992 cohort reached 12.3% at 28 months, the maximum length of time in which this cohort could be followed.

When we examined the adolescent mothers in each cohort, the proportions who went on to have a second Medicaid-financed birth were consistently higher (see Figure 2, page 280). For example, 2.9% of women in the 1991 cohort who were 19 or younger at their first Medicaid birth had delivered again within 12 months, 13.1% had done so within 18 months, 22.3% within 24 months and 34.1% within 36 months.

For the 1992 cohort, the rate of repeat births among women who were teenagers at their first Medicaid-eligible birth was 1.9% within 12 months, 9.3% within 18 months and 15.9% within 24 months. The 29% decrease in the 24-month repeat delivery rate between cohorts of teenage mothers—22.3% in the 1991 cohort vs. 15.9% in the 1992 cohort—was statistically significant (p<.001).

### Impact of the Implant

Among the women who first delivered in 1992, 20% chose to have a Medicaid-financed implant insertion within six months of delivery and a total of 23% eventually got an implant; we do not know, however, what proportion of the remaining women chose another effective method or were using no method. At least 7% of the 2,739 women who had an implant insertion after a 1992 delivery had the implant removed within 12 months, and 14% had their implant removed within 24 months. These data reflect only known removals paid for by Medicaid; women who were not entitled to coverage beyond the 60-day postpartum period would have had to turn to other sources, such as family planning clinics, for removal. Thus, these incomplete removal rates probably underestimate the level of implant discontinuation in this population.

As expected, the probability of an early repeat birth among Medicaid-eligible women using the implant was very low: Just 2.5% of these women went on to have a Medicaid-financed delivery within two years (see Table 1, page 280). Among those in the 1992 first-birth cohort who did not choose an implant within six months of delivery, 12.6% went on to have another Medicaid-financed birth within 24 months, a rate five times higher than that among implant users in the same cohort. The repeat delivery rate at 24 months for mem-