State of Wisconsin

Letter Report

BadgerCare Plus Basic Plan

May 2011

Legislative Audit Bureau
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Janice Mueller
State Auditor

May 9, 2011

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

As required by 2009 Wisconsin Act 219, we have completed an evaluation of the BadgerCare Plus Basic Plan administered by the Department of Health Services (DHS). The Basic Plan was established to provide temporary, unsubsidized health insurance for childless adults on a waiting list for the BadgerCare Plus Core Plan, a Medical Assistance program that imposed enrollment caps in October 2009. A total of 5,143 individuals were enrolled in the Basic Plan at some point during the six-month period we reviewed.

Statutes require the Basic Plan's insured benefits and administrative costs to be funded by premiums, although program costs may be subsidized by federal grant funding if it is available. Through December 2010, expenditures exceeded revenues by $140,300, and the deficit would have been larger without $1.1 million in federal State Health Access Program grant funding that may not be available in the future.

We identified numerous concerns that are affecting the Basic Plan's sustainability. Most notably, monthly premiums have been insufficient to cover services and administrative costs, services have been provided to individuals who were not enrolled in the plan, and enrollees have received services that are not covered under the plan. In addition, until recently DHS did little to verify the eligibility of applicants and enrollees. We also found that DHS had charged a total of $878,800 in plan expenditures to two general purpose revenue appropriations, contrary to state law. DHS reversed these transactions when we raised concerns about them during our fieldwork.

DHS has taken recent steps to address the Basic Plan's deficit, including transferring 438 high-cost enrollees with diagnoses of cancer and cardiac conditions to the Core Plan. In addition, DHS suspended enrollment in the Basic Plan in March 2011 and increased the monthly premium from $130 to $200 beginning with June coverage. Despite these recent changes, concerns remain regarding the Basic Plan's sustainability. Therefore, DHS and the Legislature will need to consider how best to address the future of the plan, which is scheduled to sunset on January 1, 2014.

We appreciate the courtesy and cooperation extended to us by DHS in completing this evaluation.

Sincerely,

Janice Mueller
State Auditor

JM/PS/ss

BADGERCARE PLUS BASIC PLAN

BadgerCare Plus Basic was created by 2009 Wisconsin Act 219 to provide temporary, unsubsidized health insurance for childless adults. Individuals who are enrolled in the Basic Plan are required to meet eligibility requirements for BadgerCare Plus Core, which is a Medical Assistance program, but cannot participate in that program because of enrollment caps imposed in October 2009. Both plans are administered by the Department of Health Services (DHS).

Appendix 1 summarizes services covered under the Basic Plan and the Core Plan. By statute, the Basic Plan provides less-comprehensive coverage than the Core Plan, and it was designed to be entirely self-funded with premiums paid by enrollees. Because it is not a Medical Assistance program, the Basic Plan is not bound by federal or state Medical Assistance rules, and its creation did not require federal approval. Under s. 49.67(9m), Wis. Stats., the Basic Plan is scheduled to sunset on January 1, 2014.

Eligibility and Enrollment

DHS began providing coverage under the Basic Plan on July 1, 2010. However, enrollment was suspended on March 19, 2011. At that time, 5,714 individuals were enrolled.

When the program was accepting applications, a prospective enrollee was required to be on the waiting list for the Core Plan and to:

- be a Wisconsin resident and a United States citizen or legal immigrant;
- be between the ages of 19 and 64, and not be pregnant or have dependent children;
- have a family income that did not exceed 200 percent of the federal poverty level, which was $1,805 per month for a single person in 2010;
- be ineligible for any other Medical Assistance program or Medicare;
- have no current coverage under a health insurance policy, and have had no coverage in the 12 months prior to application unless there was a good-cause reason for losing coverage; and
- have no access to health insurance through a current employer in the month of application or the next 3 months, and have had no access to health insurance through a current employer in the 12 months prior to application unless there was a good-cause reason for losing coverage.

As shown in Table 1, the size of the Core Plan waiting list and the number of individuals enrolled in the Basic Plan increased each month during the period we reviewed. A total of 5,143 individuals were enrolled in the Basic Plan at some point during those six months.

Table 1

Core Plan Waiting List and Basic Plan Enrollment
July 2010 through December 2010

Month	Individuals on the Core Plan Waiting List	Individuals Who Chose to Enroll in the Basic Plan	Percentage of Waiting List Enrolled in the Basic Plan
July	61,778	1,658	2.7%
August	68,128	2,448	3.6
September	74,247	2,965	4.0
October	80,142	3,648	4.6
November	85,200	3,933	4.6
December	89,412	4,384	4.9

As shown in Table 2, the majority of individuals enrolled in the Basic Plan described themselves as white, unemployed U.S. citizens over the age of 50 who live alone, have never been insured, and have no household income; 53.1 percent were female and 46.9 percent were male.

Table 2

Characteristics of Basic Plan Enrollees
July 2010 through December 2010

	Enrollees	Percentage
Race/Ethnicity		
African-American	255	5.0%
American Indian	19	0.4
Asian or Pacific Islander	99	1.9
Hispanic	116	2.2
White	4,363	84.8
Multiple Races or Unknown	291	5.7
Total	**5,143**	**100.0%**
Gender		
Female	2,733	53.1%
Male	2,410	46.9
Total	**5,143**	**100.0%**
Age		
19-29	963	18.7%
30-39	470	9.1
40-49	1,018	19.8
50-59	1,879	36.6
60-64	813	15.8
Total	**5,143**	**100.0%**
Citizenship		
United States Citizen	5,042	98.0%
Legal Immigrant	101	2.0
Total	**5,143**	**100.0%**

	Enrollees	Percentage
Time Uninsured		
Never Insured	5,045	98.2%
Less than 6 Months	22	0.4
6 to 12 Months	32	0.6
More than 12 Months	12	0.2
Unknown	32	0.6
Total	**5,143**	**100.0%**
Household Income[1]		
No Income	2,152	41.9%
1-50 percent	305	5.9
51-100 percent	760	14.8
101-150 percent	947	18.4
151-200 percent	979	19.0
Total	**5,143**	**100.0%**
Employment Status		
Employed	1,352	26.3%
Unemployed	3,791	73.7
Total	**5,143**	**100.0%**
Household Size		
One Person	3,926	76.3%
Two People	1,217	23.7
Total	**5,143**	**100.0%**

[1] As a percentage of the federal poverty level, which was $1,805 per month for a single person in 2010.

As shown in Table 3, Milwaukee County had the largest number of enrollees and accounted for 18.2 percent of all enrollments during the period we reviewed. Appendix 2 shows statewide enrollment data.

Table 3

Basic Plan Enrollment by County
July 2010 through December 2010

County	Enrollees	Percentage
Milwaukee	933	18.2%
Dane	347	6.8
Waukesha	274	5.3
Kenosha	203	4.0
Brown	176	3.4
Racine	165	3.2
Rock	134	2.6
Outagamie	126	2.4
Walworth	122	2.4
Washington	111	2.2
Subtotal	2,591	50.5
All Other Counties	2,552	49.5
Total	**5,143**	**100.0%**

Our analysis of paid claims data indicates that 4,087 Basic Plan enrollees, or 79.5 percent, received professional and other health care services during the six-month period we reviewed, as shown in Table 4. By statute, only certified Medical Assistance providers may receive payments for services provided under the Basic Plan, at rates that are no less than Medical Assistance rates.

Table 4

Use of Health Care Services Available Under the Basic Plan
July 2010 through December 2010

	Enrollees	Percentage
Enrollees Who Received Services[1]	**4,087**	**79.5%**
Types of Service		
Professional Services	3,680	71.6
Pharmacy Services	2,954	57.4
Outpatient Services	1,650	32.1
Inpatient Services[2]	184	3.6
Dental Services	146	2.8
Enrollees Who Did Not Receive Services	**1,056**	**20.5**
Total	**5,143**	**100.0%**

[1] Enrollees may have received more than one type of service.

[2] Typically includes overnight hospitalization.

Verifying Eligibility

The BadgerCare Plus Core and Basic plans did not require prospective enrollees to apply in person, as Medical Assistance programs generally do, and eligibility was not determined by county social services staff. Instead, applicants answered a series of questions either online or by telephone, and their responses were evaluated by staff at the DHS Enrollment Services Center located in Madison, which was created in December 2008 to address the increased workload associated with the expansion of BadgerCare Plus to adults without dependent children. Applicants who reported that they met eligibility requirements for the Core Plan were given the option of enrolling in the Basic Plan by paying a monthly premium, which was initially $130.

Section 49.67(3)(am), Wis. Stats., requires DHS to verify the eligibility of individuals enrolled in the Basic Plan each month. However, some eligibility criteria, including Wisconsin residency, have not been verified, and other eligibility verification activity has been limited. For example, DHS did not begin verifying enrollees' income and access to insurance through automated data matches with state wage and insurance liability data systems until December 2010. At that time, it identified 100 enrollees whose incomes appeared to exceed program limits, and 299 enrollees who were potentially ineligible for the Basic Plan because they had access to private insurance or Medicare. At the time of our review, DHS was in the process of following up with these individuals to determine whether they should be disenrolled.

Revenues and Expenditures

Table 5 shows revenues and expenditures for the Basic Plan from its inception through December 2010, when it had a net deficit of $140,300. Revenues included $3.9 million in premiums paid by enrollees and $1.1 million in federal funding received under a State Health Access Program grant. Section 49.67(2), Wis. Stats., requires administrative costs and the costs of services provided under the Basic Plan to be funded by enrollees' premium payments, but statutes also specify that DHS may subsidize program costs with federal grant funding if it is available.

Table 5

Basic Plan Revenues and Expenditures[1]
May 2010 through December 2010

	FY 2009-10 (May-June)	FY 2010-11 (July-December)	Total	Percentage
Revenues				
Premium Payments	$290,100	$3,560,500	$3,850,600	78.1%
Federal Grant	–	1,077,700	1,077,700	21.9
Total Revenues	$290,100	$4,638,200	$4,928,300	100.0%
Expenditures	$477,300	$4,591,300	$5,068,600	100.0%
Net Surplus/(Deficit)	**$(187,200)**	**$ 46,900**	**$ (140,300)**	–

[1] Includes paid claims and administrative expenditures for the 8-month period.

When we reviewed financial transactions, we found that $878,800, primarily in Basic Plan administrative expenditures, had been inappropriately charged to two different general purpose revenue (GPR) appropriations: $849,000 had been charged to an appropriation that funds administration for Medical Assistance, Food Stamps, and BadgerCare programs, and $29,800 had been charged to an appropriation that funds Medical Assistance benefits. We raised concerns in February 2011, and DHS corrected its accounting records to transfer $477,300 in fiscal year (FY) 2009-10 expenditures and $401,500 in FY 2010-11 expenditures to the Basic Plan.

As shown in Table 6, paid claims for services accounted for more than three-quarters of Basic Plan expenditures, while administrative and start-up costs accounted for 21.4 percent.

Table 6

Basic Plan Expenditures by Type
May 2010 through December 2010

	Amount	Percentage
Paid Claims for Services	$3,983,800	78.6%
Administrative Costs		
Contractual and Professional Services	1,033,800	20.4
Credit/Debit Card Processing Fees	19,500	0.4
Salaries and Fringe Benefits	17,200	0.3
Transfers	10,800	0.2
Supplies and Services	3,500	0.1
Subtotal, Administrative Costs	1,084,800	21.4
Total Expenditures	**$5,068,600**	**100.0%**

Through December 2010, administrative costs charged to the Basic Plan included:

- $880,600 paid to Deloitte LLP, a private firm under contract to provide data processing and database management services;
- $153,200 paid to Hewlett-Packard Co., a private firm under contract to provide enrollment services, claims processing, and the services of a nurse case manager;
- $19,500 for credit and debit card processing fees;
- $17,200 for the salary and benefit costs of seven DHS staff who spent a portion of their time working directly on the Basic Plan from July through September 2010;
- $10,800 paid to UW-Oshkosh and the Department of Workforce Development for income maintenance activities; and
- $3,500 for supplies and services.

Adequacy of Monthly Premiums

Statutes require DHS to set Basic Plan premiums at the level necessary to pay for services provided and to maintain the plan's fiscal soundness. To assess financial sustainability, we analyzed the methodology used to develop monthly premiums and the actions taken by DHS to address the plan's deficit.

The premium for the Basic Plan was developed by DHS in conjunction with an actuarial firm. It was based on the costs of services for adults enrolled in BadgerCare in 2006 and 2007, adjusted by 1.0 percent to reflect professional provider rate increases. To date, however, the Basic Plan premium has not accurately reflected plan costs. The reason appears to be largely that adverse selection, or disproportionate enrollment by individuals with higher health care needs, was greater than anticipated. In addition, the 6.2 percent allowance for administrative costs, such as enrollment, eligibility verification, and data processing costs, was less than the 10.0 percent administrative cost allowance in the Core Plan, although both plans serve the same population.

The monthly Basic Plan premium of $130 consists of two parts: $121.95 per member per month for services, and $8.05 for administration. We analyzed data on service and administrative costs and found that both of these costs exceeded premium revenues in each month from July through December 2010. As shown in Table 7, average monthly costs per enrollee totaled $273, or $143 more than the $130 monthly premium. In addition, it should be noted that some claims—particularly those for services provided near the end of our review period—were not yet submitted or paid by the time of our review, which are likely to increase per member per month costs.

Table 7

Average Monthly Costs and Premium Amounts for the Basic Plan
July 2010 through December 2010

	Average Costs per Enrollee	Monthly Premium	Difference
Services	$241.00	$121.95	$119.05
Administration	32.00	8.05	23.95
Total	**$273.00**	**$130.00**	**$143.00**

In an attempt to reduce Basic Plan costs, DHS sought federal approval to permit Basic Plan enrollees diagnosed with most cancers to instead participate in the Core Plan, which operates under the terms of a federal waiver. In December 2010, with federal approval, DHS also permitted Basic Plan enrollees with certain cardiac conditions to transfer to the Core Plan. As of February 2011, 438 individuals had been transferred from the Basic Plan to the Core Plan, including 129 who qualified for transfer because of a cancer diagnosis and 309 who qualified because of a cardiac condition. DHS subsequently suspended such transfers after determining that the strategy was not financially sustainable.

We note that under DHS policy, Basic Plan enrollees who were eligible for transfer were enrolled in the Core Plan on the first or fifteenth day of the following month, and federal program rules prohibit retroactive enrollment in the Core Plan. During our review of financial transactions, we identified a revenue transfer of $103,023 from the Core Plan appropriation to the Basic Plan appropriation that DHS staff indicated was for expenditures associated with the retroactive enrollment of an unspecified number of individuals who were transferred from the Basic Plan to the Core Plan. When we questioned DHS regarding the appropriateness of this transaction, they reversed it.

In another effort to contain Basic Plan costs, DHS in January 2011 reduced the number of emergency room visits covered by the plan from five to two each year and increased copayments for brand name prescriptions, radiology services, and vaccinations. Additionally, when DHS suspended enrollment in the Basic Plan in March 2011, monthly premiums were increased from $130 to $200, beginning with the payment for June coverage. This represents a 53.8 percent increase and is likely to raise concerns about affordability for enrollees.

Additional Concerns with Sustainability

We identified a number of other issues that are affecting the Basic Plan's sustainability:

- The recently approved premium increase to $200 per month remains less than average monthly service and administrative costs per enrollee.
- A "claims lag" of several months means that reported expenditures for services are likely to understate the actual cost of services provided under the plan.
- Services have been provided to individuals who were not enrolled in the plan, and enrollees received services that were not covered under the plan provisions; we identified 107 inappropriately paid claims for services that totaled $14,600.
- Continued federal grant funding under the State Health Access Program grant is uncertain, which is challenging because these funds have increasingly been used to supplement program revenues. In addition to the $1.1 million in federal funds used to subsidize costs through December 2010, $2.9 million was used for the period from January through March 2011.

Given the relatively small size of the Basic Plan, a small number of enrollees and high-cost claims can also have a disproportionate effect on expenditures. For example, 92 enrollees who each had 50 or more claims during our review period accounted for 19.5 percent of the total claims amount, as shown in Table 8. Six of those individuals had 100 or more claims each.

Table 8

Claims Incurred by Basic Plan Enrollees
July 2010 through December 2010

	Enrollees		Claims	
Number of Claims	Number	Percentage	Cost of Services[1]	Percentage
0	1,056	20.5%	$ 0	0.0%
1 to 24	3,513	68.3	2,107,700	45.9
25 to 49	482	9.4	1,591,700	34.6
50 or more	92	1.8	897,300	19.5
Total	**5,143**	**100.0%**	**$4,596,700**	**100.0%**

[1] Reflects all services provided through December 2010, although some claims have not yet been paid.

Further, a small number of higher-cost claims accounted for a disproportionately large share of the total cost of services, as shown in Table 9. For example, claims of $5,000 or more represented only 0.2 percent of claims under the Basic Plan through December 2010 but accounted for nearly one-quarter of the total cost of services.

Table 9

Claim Size and Service Costs
July 2010 through December 2010

Claim Size	Number	Percentage	Cost of Services[1]	Percentage
$25 or Less	26,801	51.6%	$ 228,000	5.0%
$25 to $99	18,048	34.7	930,100	20.2
$100 to $199	3,566	6.9	497,600	10.8
$200 to $499	2,507	4.8	750,500	16.3
$500 to $999	589	1.1	387,800	8.4
$1,000 to $4,999	376	0.7	711,700	15.5
$5,000 or More	108	0.2	1,091,000	23.8
Total	**51,995**	**100.0%**	**$4,596,700**	**100.0%**

[1] Reflects all services provided through December 2010, although some claims have not yet been paid.

Future Considerations

Trends in Basic Plan enrollment and the waiting list for the Core Plan indicate that there is demand for low-cost health care coverage for childless adults who are not eligible for other Medical Assistance or entitlement programs. However, it does not appear that the Basic Plan can be financially sustainable without additional changes to premium levels, covered services, eligibility requirements, or the plan's funding structure. One possible alternative to the Basic Plan is the State Health Insurance Risk-Sharing Plan (HIRSP), which provides health care coverage to individuals who are either unable to find adequate health insurance in the private market because of their medical conditions or who have lost their employer-sponsored health insurance. However, even subsidized HIRSP premiums may be cost-prohibitive for some individuals who are enrolled in the Basic Plan.

Given the State's budget deficit and the rising costs of health care, DHS and the Legislature will need to determine the future of the Basic Plan, including the extent to which providing health care coverage for low-income childless adults remains a priority. In doing so, it will be important to carefully consider the obstacles to providing health care coverage to this population, as well as the monetary and other costs associated with not providing it.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by September 1, 2011, on:

- *the effects on enrollment of the monthly premium increase from $130 to $200;*
- *the extent of any disparity between monthly premiums and actual expenditures;*
- *the current financial status of the plan, including the amount and sources of all funds used to address plan deficits;*
- *the steps it has taken to improve eligibility verification for individuals already enrolled in the plan; and*
- *the steps it has taken to identify and recover payments for services either not covered under the plan or provided to ineligible individuals.*

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Appendix 1

Comparison of Core Plan and Basic Plan Services

January 2011

Service	Core Plan	Basic Plan
Ambulance Transportation	Coverage limited to emergencies. No copayment.	Coverage limited to emergencies. No copayment.
Ambulatory Services	Coverage of certain surgical procedures and related lab services. $3 copayment per service.	Coverage of certain surgical procedures and related lab services, limited to 5 visits per enrollment year. $60 copayment per visit.
Dental	Coverage limited to certain emergency services only. Emergency dental care is defined as an immediate service that must be provided to relieve the enrollee from pain, an acute infection, swelling, trismus, fever, or trauma. No copayment.	Coverage limited to certain emergency services only. Emergency dental care is defined as an immediate service that must be provided to relieve the enrollee from pain, an acute infection, swelling, trismus, fever, or trauma. $10 copayment per visit.
Disposable Medical Supplies	Coverage of diabetic supplies, ostomy supplies, and supplies that are required with the use of a durable medical equipment item. $0.50 to $3 copayment per service. $0.50 copayment for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and supplies that are required with the use of a durable medical equipment item. Up to $5 copayment per priced unit for most disposable medical supplies. $0.50 per prescription for diabetic supplies. (These prescriptions do not count towards an enrollee's 10 per month limit.)
Durable Medical Equipment	Full coverage up to $2,500 per enrollment year. $0.50 to $3 copayment per item.	Full coverage up to $500 per enrollment year. Up to $10 copayment per item.
Emergency Room Services	Full coverage. No copayment for members with income up to 100 percent of the federal poverty level. $60 copayment per visit for members with incomes from 100 to 200 percent of the federal poverty level (waived if the enrollee is admitted to a hospital).	Full coverage limited to 2 visits per enrollment year. $60 copayment per visit (waived if the enrollee is admitted to a hospital).

Service	Core Plan	Basic Plan
End Stage Renal Disease	Full coverage. No copayment.	Full coverage. $10 copayment per visit.
Home Care	Coverage for 30 days following an inpatient hospital stay if required as part of discharge instructions. Coverage limited to 100 visits post-hospitalization. No copayment.	No coverage.
Hospice Care	Full coverage. No copayment.	Full coverage. No copayment.
Inpatient Hospital	Full coverage (not including inpatient psychiatric stays or inpatient substance abuse treatment). $3 copayment per day for enrollees with incomes up to 100 percent of the federal poverty level with a $75 cap per stay. $100 copayment per stay for members with income from 100 to 200 percent of the federal poverty level. There is a $300 total copayment cap per enrollment year for inpatient and outpatient hospital services.	Full coverage for the first stay with authorization (not including inpatient psychiatric stays or inpatient substance abuse treatment). $7,500 deductible for additional inpatient and outpatient hospital stays (excluding emergency room). $100 copayment per stay after the deductible has been met.
Mental Health and Substance Abuse Treatment	Coverage limited to mental health services provided by a psychiatrist. $0.50 to $3 copayment per service; the maximum copayment is $30 per provider, per enrollment year.	Coverage limited to mental health services provided by a psychiatrist.
Outpatient Hospital	Full coverage, excluding mental health and substance abuse treatment services. $3 copayment per visit for members with incomes up to 100 percent of the federal poverty level. $15 copayment per visit for members with incomes from 100 to 200 percent of the federal poverty level. $300 total copayment cap per enrollment year for inpatient and outpatient hospital services for all income levels.	Full coverage for first 5 authorized non-emergency visits, excluding mental health and substance abuse treatment services. $60 copayment per visit for nondeductible visits. $7,500 deductible for additional inpatient and outpatient hospital stays (excluding emergency room).

Service	Core Plan	Basic Plan
Physical Therapy, Occupational Therapy and Speech Therapy	Full coverage, limited to 20 visits per therapy discipline per enrollment year. $0.50 to $3 copayment per service. Copayment obligation limited to the first 30 hours or $1,500, per discipline per enrollment year.	Full coverage, limited to 10 visits per therapy discipline per enrollment year. $10 copayment per visit.
Physician Services *(includes Physicians, Psychiatrists, Ophthalmologists, Nurse Practitioners, Physician Assistants, Chiropractors, Podiatrists, and Optometrists)*	Full coverage, includes laboratory and radiology. $0.50 to $3 copayment per service. The maximum copayment is $30 per provider per enrollment year for physicians, psychiatrists, and podiatrists. No copayment for emergency services, preventive care, anesthesia, or clozapine for managing schizophrenia.	Full coverage, includes laboratory and radiology. 10 visit limit applies to: ▪ chiropractors; ▪ nurse practitioners; ▪ physicians; ▪ physician assistants; and ▪ podiatrists. $10 copayment per visit. Vaccination copayments of $10. $5 to $20 copayments for radiology.
Prescription Drugs	Generic-only formulary drug benefit with a few generic over-the-counter drugs. Minimal brand name drug coverage. Up to $4 copayment for generic drugs and up to $8 for brand name drugs with a $24 copayment limit per month, per provider.	Generic-only formulary drug benefit with a few generic over-the-counter drugs, limited to 10 per calendar month. $5 copayment for generic drugs and $10 copayment for brand name drugs.

Appendix 2

Statewide Basic Plan Enrollment

July 2010 through December 2010

County/Tribe	Number of Enrollees	Percentage of Total
Adams County	35	0.7%
Ashland County	26	0.5
Barron County	53	1.0
Bayfield County	26	0.5
Brown County	176	3.4
Buffalo County	18	0.3
Burnett County	36	0.7
Calumet County	28	0.5
Chippewa County	53	1.0
Clark County	37	0.7
Columbia County	64	1.2
Crawford County	19	0.4
Dane County	347	6.8
Dodge County	80	1.6
Door County	42	0.8
Douglas County	23	0.4
Dunn County	38	0.7
Eau Claire County	71	1.4
Florence County	13	0.3
Fond du Lac County	82	1.6
Forest County	12	0.2
Grant County	51	1.0
Green County	26	0.5
Green Lake County	13	0.3
Iowa County	28	0.5
Iron County	15	0.3
Jackson County	16	0.3
Jefferson County	82	1.6
Juneau County	47	0.9
Kenosha County	203	4.0
Kewaunee County	16	0.3
La Crosse County	70	1.4
Lac du Flambeau Tribe	2	0.0
Lafayette County	19	0.4
Langlade County	37	0.7
Lincoln County	34	0.7
Manitowoc County	76	1.5

County/Tribe	Number of Enrollees	Percentage of Total
Marathon County	88	1.7
Marinette County	67	1.3
Marquette County	25	0.5
Menominee County	1	<0.1
Milwaukee County	933	18.2
Monroe County	30	0.6
Oconto County	64	1.2
Oneida County	47	0.9
Outagamie County	126	2.4
Ozaukee County	65	1.3
Pepin County	7	0.1
Pierce County	23	0.4
Polk County	61	1.2
Portage County	64	1.2
Potawatomi Tribe	1	<0.1
Price County	27	0.5
Racine County	165	3.2
Red Cliff Tribe	1	<0.1
Richland County	14	0.3
Rock County	134	2.6
Rusk County	15	0.3
Sauk County	56	1.1
Sawyer County	19	0.4
Shawano County	43	0.8
Sheboygan County	93	1.8
St. Croix County	54	1.0
Taylor County	30	0.6
Trempealeau County	21	0.4
Vernon County	36	0.7
Vilas County	49	1.0
Walworth County	122	2.4
Washburn County	21	0.4
Washington County	111	2.2
Waukesha County	274	5.3
Waupaca County	44	0.9
Waushara County	32	0.6
Winnebago County	94	1.8
Wood County	72	1.4
Total	**5,143**	**100.0%**