Primary Care Development Corporation

All-Payer Claims Databases & Primary Care Investment Report

Primary Care Investment Network
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Executive Summary

All-Payer Claims Databases (APCDs) play an increasingly important role in advancing primary care investment policy by providing policymakers with the data needed to measure primary care spending, establish investment benchmarks, monitor progress, and inform health system reform. States have adopted a range of approaches to leveraging claims data. Successful state models demonstrate that APCDs are most effective when they are transparent, accessible, and aligned with clearly defined policy goals. Several states have successfully used APCDs to measure primary care spending, support payment reform, inform workforce planning, and strengthen public accountability. The experiences of Nebraska, Texas, and Minnesota illustrate the diverse ways states are developing and utilizing claims data infrastructure to support primary care investment initiatives.

Despite their potential, APCDs face several significant barriers that limit their effectiveness as tools for advancing primary care investment. These challenges include the ERISA data gap, the failure to capture non-claims-based payments, inconsistent data quality, restricted data access, lengthy implementation timelines, and inadequate funding. Collectively, these limitations underscore the importance of strengthening APCD infrastructure while acknowledging that APCDs can be one component of a broader primary care investment policy.

Based on these findings, this report offers six policy recommendations:

1. Prioritize transparency as a core design feature of APCDs.
2. Invest in usability and accessibility of APCD data.
3. Align APCD infrastructure with primary care spending targets and broader policy goals.
4. Incorporate non-claims payment data to capture true primary care investment.
5. Recognize that APCDs are valuable but not strictly necessary for primary care investment policy.
6. Ensure sustainable funding and governance to support long-term APCD effectiveness.

APCDs can serve as powerful tools for informing primary care investment policy when paired with clear policy objectives, stakeholder engagement, and sustained investment. At the same time, states should not delay primary care investment efforts while developing APCD infrastructure, as complementary data collection and reporting strategies can also provide a strong foundation for meaningful policy action.

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Background

An All-Payer Claims Database (APCD) is a market-wide repository of health care claims and encounter data. These databases compile information on health care service utilization and payments, along with contextual data about the individuals served and their diagnosed conditions.[1] APCDs aggregate data from both public and private payers, including claims from programs such as Medicaid [2] As originally conceived, APCDs have the potential to allow the study of utilization, spending, prices, and enrollment across payers, accounting for the vast majority of health care spending in their respective states.[3]

APCDs can be organized into two categories based on their legal and governance structure. “Mandatory or State-Authorized APCDs” are established by state statute or regulation and require covered health insurance carriers, third-party administrators, and public programs to submit claims data. Because submission is compulsory, the goal of these databases is to achieve broad population coverage and produce sufficiently comprehensive data to support rigorous policy analysis, regulatory oversight, and multi-payer benchmarking. “Voluntary APCDs,” by contrast, lack a state mandate compelling payer participation. Instead, they rely on contractual arrangements, purchaser coalitions, or market incentives to attract data submitters.[4] While voluntary APCDs have demonstrated value, their incomplete data coverage, restricted payer participation, and often privately governed structures might make them less suited for population-wide analyses, public transparency reporting, or the establishment of statewide spending benchmarks.

APCDs vary significantly from state to state in their functionality, transparency, and usefulness to researchers and policymakers. These differences shape the extent to which APCDs can support efforts to increase state-level primary care spending. Primary care is the foundation of our health care system and is key to prevention, early detection, and treatment of diseases like diabetes, hypertension, and depression. Despite these benefits, primary care continues to be undervalued and underinvested, with only 5% to 7% of health care expenditures dedicated to primary care, accounting for approximately 35% of health care visits.[5]

APCDs can provide data on cost transparency, utilization insights, and workforce planning, all of which can play a key role in determining the state of primary care in a particular state and developing a primary care investment benchmark. The experiences of different states suggest that while APCDs can be powerful tools, they are not strictly necessary to establish primary care spending targets.

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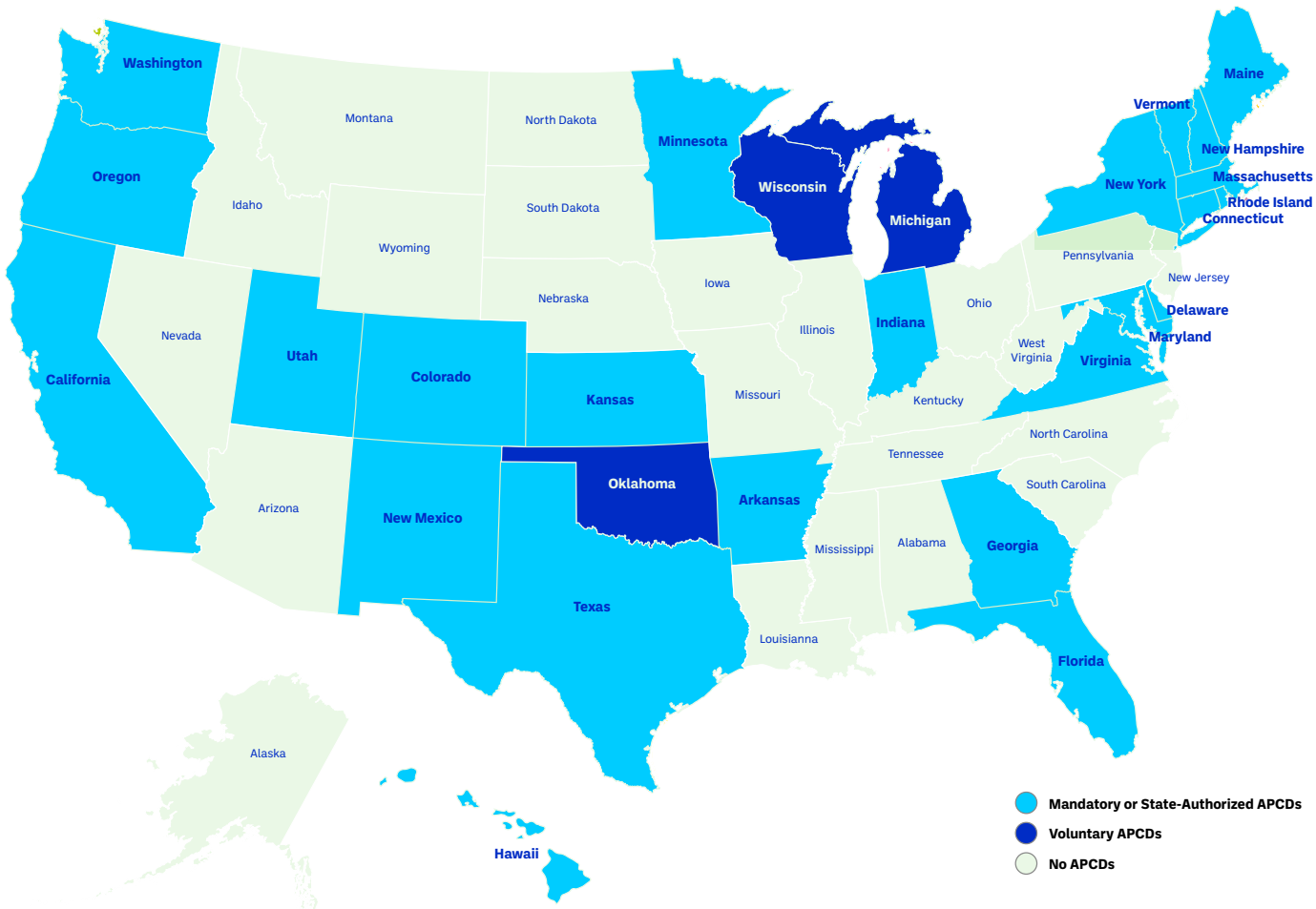
II APCD Utilization for Primary Care Investment & State Profiles

Claims data can help answer many questions for policymakers, employers, health systems, researchers, and consumers, including what types of care are being used and how much that costs within a state.[6] APCDs are intended to provide the data needed to find gaps in coverage, expand access to care, and compare current costs for services like primary care across different providers.

Several limitations can reduce the effectiveness of APCDs in supporting primary care investment efforts. These include missing data for key populations and services, inconsistent data collection and access requirements, and the need for sustainable and adequate funding for state health data capacity.[7]

Three states in the early stages of considering primary care investment policy, Nebraska, Texas, and Minnesota, illustrate different approaches to how APCDs are perceived and utilized in primary care policy development. The authors of this report have developed unique insights into these states' efforts to leverage claims data to inform primary care investment policy through their direct technical assistance to the policy advocates in the Primary Care Investment Network advancing these initiatives.



Nebraska

Nebraska demonstrates that primary care investment efforts can move forward without an APCD, though with limitations.

In February 2014, the Nebraska legislature passed the Health Care Transparency Act, which established an advisory committee to evaluate the ability and need for the state to create an APCD.[8] In December 2014, the committee issued a report where they recommended against Nebraska establishing an APCD but suggested that a more formal study should be completed by the Department of Insurance.[9] No formal study has taken place, and the state remains without an APCD. However, the Primary Care Investment Council was established in 2022 to study spending data for primary care and specialty care including, "the current amount of health care spending on primary care in Nebraska," among other stated goals related to primary care access and investment.[10]

While a mandated 2023 report[11] issued by the Council recommended a definition of primary care and a primary care spending target, it outlined eight vacancies, many of which persist as of 2026.[12] Independent advocates have continued to push Nebraska's governor to fill these empty seats while working towards establishing an APCD in order to measure primary care spend and subsequent primary care spending increases.

Nebraska demonstrates that primary care investment efforts can move forward without an APCD, though with limitations.

Texas

Texas illustrates how an APCD can exist but still be underutilized due to implementation capacity, access pathways, and funding challenges that do not initially match the policy vision.

Texas's APCD was predated by two initiatives, which included a voluntary claims data collection effort through the University of Texas Center for Healthcare Data that collected claims for 65% of the state's population. In 2011, the Texas Institute of Health Care Quality and Efficiency at the Health and Human Services Commission (HHSC) was established to create a state plan with the goal of improving the quality and efficiency of health care delivery and making policy recommendations.[13]

The institute was dissolved in 2015 but in 2021, Texas's APCD was formally, with implementation and administrative authority vested in the University of Texas Health Science Center at Houston Center for Health Care Data.[14] The database is designed to support transparency, research, and policymaking by producing reports on cost, quality, utilization, and population health, and by enabling access for qualified research entities.[15] A 2023 law was intended to expand pathways for qualified researchers to access and publish analyses from the database.

While the APCD has been able to collect and store claims, researchers' access to the database remains constrained due to insufficient funding.[16] However, The Texas Legislature appropriated $9 million for the 2025–27 biennium to support APCD implementation and

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appropriated $9 million for the 2025–27 biennium to support APCD implementation and operations. And while the state has not established a primary care investment benchmark the APCD is due to submit its legislatively mandated report on September 1, 2026, which is expected to provide a statewide picture of health care costs, utilization, outcomes, and quality.

There have been various efforts by independent advocates to support primary care investment. This includes the Texas Primary Care Consortium. Led by the Texas Health Institute and the Texas Medical Home Initiative, the Consortium is a group of statewide advocates from different sectors dedicated to advancing high-quality primary care.[17] These independent cross-sector efforts have reinforced the importance of more actionable statewide data to inform system improvement and accountability. Texas's APCD does not just underscore delayed utilization but is also a case study in how policy infrastructure, stakeholder demand, and public investment must align before an APCD can meaningfully support primary care strategy and broader health system improvement.

Minnesota

Minnesota represents a more mature and transparent APCD model, though not all intended uses have been fully realized.

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Since 2009, Minnesota's APCD has collected enrollment, encounter, and pricing data from all public payers, including all data submitted to the Centers for Medicare and Medicaid Services. The Minnesota Department of Health (MDH) maintains the APCD and makes data available for individuals or organizations conducting research on improving health care outcomes, access, quality, addressing health disparities or health care spending.[18] The state is also in the process of establishing an Office of Healthcare Affordability, which may help further develop an APCD structure.

Notably, the APCD commissioned MDH to study payments made for primary care services as part of a one-time report on the volume and distribution of health care spending across payment models, with the report being due in February 2024.[19] One of the more transparent APCDs in the country, Minnesota publicly releases APCD public use files,[20] publishes analyses,[21] and a dashboard[22] but has yet to release the report on primary care, two years past its mandated timeline.

While Minnesota has enacted legislation requiring state agencies to study and publicly report on primary care spending,[23] it has not yet established a formal primary care investment benchmark tied to the APCD. Spearheading primary care advocacy in the state is the Minnesota Primary Care Stakeholder Group. Established in 2020 by the Minnesota Academy of Family Physicians, and the Minnesota Department of Health's Health Care Homes Program and Office of Rural Health and Primary Care, this group includes stakeholders from health care professional associations, providers, payers, employers, consumers, and government agencies. The group collaborates in defining goals, objectives, strategies, and recommendations to increase primary care investment.[24]

III State-by-State Landscape

The summaries that follow profile the states identified as having active, operational APCDs, organized into two categories, "Mandatory or State-Authorized APCDs" and "Voluntary APCDs," as defined in a previous section.

A. Mandatory or State-Authorized APCDs

Arkansas

The Arkansas APCD became operational in 2016 through legislation and authorized the Arkansas Insurance Department to issue rules for collecting medical, dental, and pharmaceutical claims.[25] The Arkansas Center for Health Improvement serves as the statutorily designated administrator. The APCD collects medical, pharmacy, and dental claims as well as enrollment data and provider files from a broad range of submitters, including commercial insurers, Medicaid, Medicare, third-party administrators, pharmacy benefit managers, the state employee plan, and managed care organizations. In a notable expansion beyond traditional claims data, the APCD also collects supplemental non-claims data including vital records, disease registry information, hospital discharges for uninsured patients, and medical marijuana.[26] The data is used to support consumer transparency, quality improvement, and health policy research.

Arkansas has used APCD data to conduct analysis of the primary care workforce, and the state's 2025 Primary Care Payment Working Group is tasked with defining, measuring, and reporting primary care spending and recommending payment targets, drawing on the state's administrative health data infrastructure.[27] Arkansas does not yet have a legislated primary care spending benchmark tied specifically to its APCD, but the database provides the foundational claims data infrastructure that would support such reporting going forward. As of the time of writing, the Working Group has submitted its report to the legislature which will review this summer. The report has not been released to the public.

California

The California APCD was established was established by a 2020 legislation requiring the Department of Health Care Access and Information (HCAI) to create and administer the Healthcare Payments Data (HPD) Program, which collects comprehensive health care claims, and encounters data from health services plans, and the California state Medicaid agency to improve cost transparency and support policy decisions.[28] As of 2025, the HPD contains enrollment information, and medical, pharmacy, and dental claims and encounters.[29] In 2026, the HPD anticipates implementing collection of non-claims payment data, including total amount paid for primary care and behavioral health, using the National Association of Health Data Organizations' NCP Data Layout.[30] California's Office of Health Care Affordability (OHCA), also within HACAI, was established in 2022 to slow health care spending growth, promote high value health care system performance, and assess market consolidation. OHCA is statutorily mandated to measure primary care spending and set primary care investment benchmarks.[31] In 2024, California's Health Care Affordability Board approved a statewide investment benchmark of 15% of total medical expense allocated to primary care for all payers by performance year 2034.[32]

Separate from the HPD, OHCA collects data to measure primary care spending through both claims and non-claims payments and will publicly report on primary care spending in 2026.[33] OHCA partners with HPD to conduct analyses using HPD data that can answer policy questions related to OHCA's measurement and benchmark setting mandates and provide insights into cost drivers and

utilization that further OHCA's work to promote affordable, high value care.[34] As an example, in 2026 OHCA is using HPD to analyze the utilization of primary care services using the OHCA measurement definition.

Colorado

The Colorado APCD was established by legislation in 2010 and launched in 2012.[35] Colorado's Department of Health Care Polic and Financing named the nonprofit Center for Improving Value in Health Care (CIVHC) as administrator. The CO APCD Advisory Committee, comprised of experts from across the Colorado health care ecosystem, helps advise CIVHC regarding policies and standards for maintenance an enhancement of the CO APCD, as well as development of meaningful and actionable public reports. The APCD now contains over 1.3 billion claims from Medicaid, Medicare, Medicare Advantage, and 33 commercial health plans, representing over 70% of insured Coloradans.[36] Data collected includes medical and pharmacy claims, enrollment files, and provider files. The database also collects non-claims payment data, such as alternative payment model files capturing payments made to providers outside of traditional fee-for-service, including capitation and shared savings arrangements.[37] The data is used for public price and quality reporting, custom data requests for researchers and state agencies, and policy analysis.

Colorado has passed legislation specifically tracking the percentage of medical spending dedicated to primary care.[38] Colorado required commercial insurers to increase their primary care investment by 1% annually in calendar years 2022 and 2023.[39] The CO APCD's payment arrangement files, which capture alternative payment methodology data, make it particularly well-suited to tracking not just primary care claims but also non-claims-based primary care payments such as care coordination and capitation, a level of granularity most other APCDs cannot yet match.

Connecticut

The Connecticut APCD was created in 2012 by legislation as a program to receive, store, and analyze health insurance claims data, requiring health insurers to submit medical and pharmacy claims data as well as provider and eligibility information.[40] The APCD is administered by the Connecticut Office of Health Strategy (OHS), and effective July 1, 2026, by the Office of Policy Management. The APCD collects medical, pharmacy, and dental claims and provider data from commercial health insurers, Medicaid, and Medicare. It currently contains over 2.3 billion claims representing approximately 86% of insured Connecticut residents.[41] The data supports healthcare cost growth benchmarking, affordability analyses, regulatory oversight, and research. A notable ongoing challenge is that although the APCD collects Medicaid and Medicare data, these are not permitted for public release under the state's agreements with the federal government.[42]

Connecticut's 10% primary care spending target for commercial health plans, Medicare, and Medicaid was established in 2020 through an executive order and later codified in legislation.[43] Connecticut was also a participant in the New England States' joint all-payer report on primary care payments, which used standardized APCD data to identify each state's percentage of all-payer primary care spending relative to overall healthcare spending.[44] The OHS uses data from payer submissions to monitor insurer progress toward the primary care target as part of its broader cost growth benchmark program.

Delaware

The Delaware APCD was created via legislation in 2016 and is formally called the Health Care Claims Database (HCCD). The HCCD was created within the existing framework of the Delaware Health Information Network (DHIN).[45] DHIN is authorized to serve as administrator and data governance is overseen by a Health Care Claims Database Committee.[46] The HCCD collects healthcare claims, enrollment, and provider data from Medicare, Medicaid, and the seven largest commercial health insurers.[47] The data is used to support Delaware's health reform agenda and consumer transparency tools.

In 2021, Delaware established primary care spending target, which required all insurers to reach 11.5% primary care spend by 2025, and match Medicare reimbursement rates for primary care.[48] Delaware's HCCD provides the foundational claims data used to monitor insurer compliance with these targets, making it a direct instrument of primary care investment policy.

Florida

Florida's APCD was created by legislation in 2016. The Florida Agency for Health Care Administration maintains the system, with the Health Care Cost Institute.[49] The claims focus primarily on employer-sponsored group and individual market plans and do not contain Medicare fee-for-service, Medicaid, VA, or TRICARE claims. The data powers AHCA's Florida Health Price Finder consumer website, supported by more than 88 million lines of insurance claim data and displaying costs for specific medical conditions.[50]

Florida's APCD is notably narrower in scope than most peer states, focused predominantly on commercial price transparency. The state does not have a primary care investment benchmark tied to its APCD. The absence of Medicaid and Medicare data from the database limits its utility for the kind of multi-payer primary care spending analysis.

Georgia

Georgia's APCD was established by legislation in 2020. The Office of Health Strategy and Coordination is responsible for creating and implementing the APCD, with the Georgia Tech Research Institute's Center for Health Analytics and Informatics serving as administrator.[51] Insurance companies who cover at least 1,000 people are required to submit data, along with the Department of Community Health, Medicaid Care Management Organizations, and the State Health Benefit Plan.[52] The APCD primarily contains medical, dental, and pharmacy insurance claims, with common data elements including visit, procedure, diagnosis, medication dispensing, costs of care, and demographics.[53] The data is used for public dashboards on chronic disease, telehealth, urban-rural access, and pediatric mental health.

While the APCD collects the broad claims data needed to identify primary care utilization and spending as a share of total spending, the state has not yet legislated a primary care spending target or produced annual primary care spending reports. The infrastructure is now in place for Georgia to begin such analysis, and the APCD's data on chronic conditions and care access provides useful context for future primary care investment discussions.

Hawaii

Hawaii's APCD was established by legislation in 2016 and designated by the State Health Planning and Development Agency (SHPDA) as the lead agency. SHPDA designated the Pacific Health Informatics and Data Center (PHIDC) as the data center, responsible for collecting, cleansing, storing, validating, and matching data, and for analysis and reporting. The law mandates submission of Medicaid, Hawaii Employer-Union Health Benefits Trust Fund, Medicare, and state employees and retiree health care claims data. Additional privately insured data is submitted voluntarily. Intended uses include identifying variation across market segments, improving quality, lowering costs, increasing pricing transparency, and supporting insurance rate review.[54] Hawaii's APCD has been among the slowest in the country to achieve full operational status. The database began operational standup in 2025, with full reporting maturity still developing through 2026, supported in part by the state's AHEAD funding.[55]

At the time of the writing, the Hawaii APCD had not yet produced primary care spending reports, and no primary care spending benchmark has been established through the database. The state legislature is considering legislation that would require commercial carriers to incrementally increase the share of total medical expenditures directed to primary care providers, with the APCDC intended to serve as the measurement tool.[56]

Indiana

The Indiana APCD was created by legislation in 2020,[57] and a consumer-facing website was launched in 2024.[58] The APCD collects medical claims, pharmacy claims, eligibility data, and provider information from both private and public payers. Dental claims are specifically excluded under Indiana statute. As of early 2025, the database covers over 1.27 billion total claims from 38 submitters, including 37 commercial health plans and the Indiana Family and Social Services Administration for Medicaid.[59]

The Indiana APCD, while technically capable of identifying primary care utilization and spending from claims data, has not produced primary care spending reports. Notably, however, Indiana is set to begin implementing hospital price caps across its commercial market in 2027[60], reflecting a broader interest in cost containment that the APCD will be positioned to support.

Kansas

The Kansas APCD was created by legislation in 2008. The Kansas legislature's purpose in creating the database was to provide health care consumers, third-party payers, providers, and health care planners with information regarding trends in use and cost of health care services for improved decision-making.[61] Since July 2011, Kansas has integrated Medicaid claims into its data warehouse, which also includes the state employee health plan and commercial claims from the Kansas Health Insurance Information System, with all data maintained on a rolling five-year cycle.[62] Data is used for analyses of cost, efficiency, quality, system utilization, episodes of care, and geographic and racial differences.

The Kansas APCD, while capable of identifying primary care utilization and spending from claims data, has not produced primary care spending reports.

Maine

The Maine APCD was created by legislation and began collecting health insurance claims information in its APCD in 2003, making it the nation's first operational statewide APCD. The database is administered by the Maine Health Data Organization (MHDO), an independent state agency. The APCD holds claims from commercial insurance carriers, third-party administrators, pharmacy benefit managers, dental benefit administrators, Medicaid, and Medicare, with mandatory monthly submissions covering eligibility, medical claims, pharmacy claims, and dental claims.[63] MHDO is funded through a state-mandated annual assessment on health care providers and health plans.

The state requires the Maine Quality Forum to develop an annual report on primary care spending using claims data from the MHDO, with reporting having begun in January 2020.[64] These reports use MHDO's all-payer claims data for claims-based payments, supplemented by non-claims-based payment data collected under another authority,[65] giving Maine a relatively comprehensive picture of primary care spending. The most recent report is from June 2026.[66]

Maryland

Established by the Maryland Legislature in 1993, the Medical Care Data Base (MCDB), Maryland's APCD, is one of the nation's first.[67] The MCDB is administered by the Maryland Health Care Commission (MHCC). The MHCC collects privately insured claims, encounters, and eligibility data quarterly from private payers and reporting entities, including life and health insurance carriers, HMOs, third-party administrators, managed care behavioral health organizations, pharmacy benefit managers licensed in Maryland, and claims from public payers including Medicare and Medicaid.[68] A 2026 analysis the MCDB conducted by the MHCC also found that the database can be used to ensure that services are not overvalued, which can lead to the undervaluation of other services and implications for access to primary care.[69]

The MCDB supports cost and utilization estimates, policy analyses, and evaluations of demonstration programs, and serves as a decision-support tool for the Health Services Cost Review Commission, Maryland Insurance Administration, Maryland Health Benefit Exchange,

Prescription Affordability Board, and the Maryland Department of Health.[70] Maryland has published primary care spending estimates using its APCD data, reporting both narrow and broad definitions of primary care.[71] Maryland's long-running APCD makes it well-positioned to track primary care spending trends longitudinally and can be used to support better access to primary care.

Massachusetts

The Massachusetts APCD was created by legislation in 2008. In 2009, the Division of Health Care Finance and Policy began formally collecting detailed claims data from payers.[72] Responsibility for the APCD was transferred to the Center for Health Information and Analysis (CHIA) in November 2012.[73] The APCD's explicit legislative purpose is administrative simplification, making it the central resource for state agencies needing claims-level data. The database covers medical, pharmacy, dental, vision, behavioral health, and specialty services for fully insured members. CHIA works with approximately 60 payer organizations for monthly submissions.[74]

CHIA additionally collects aggregate data and reports on payments made by health plans to primary care and behavioral health service providers, including payer-paid and member cost-sharing amounts, as part of its efforts to inform policy initiatives, investments, and delivery system reforms.[75] Massachusetts participated in the six-state New England joint all-payer report on primary care payments.[76]

Minnesota

See Section II.

New Hampshire

The New Hampshire APCD was created by legislation in 2005. Formally called the Comprehensive Healthcare Information System (CHIS), the database began accepting claims submissions in 2005. CHIS' primary purpose is to serve as a resource for continuous review of health care utilization, expenditures, and performance data by insurers, purchasers, employers, providers, and state agencies.[77] The database is jointly administered by the New Hampshire Insurance Department (NHID) and the NH Department of Health and Human Services. Data collected includes medical, pharmacy, and dental claims from commercial insurers, Medicaid, and Medicare. The HealthCost website, developed by NHID in 2007, provides price information for consumers and employers by insurance plan and procedure, updated quarterly.[78]

New Hampshire participated in the six-state New England joint all-payer primary care spending report, released in 2020[79], which used standardized APCD data to measure primary care spending as a share of total healthcare spending across all six New England states. New Hampshire has not enacted a legislated primary care spending target or benchmark, distinguishing it from the other New England states.

New Mexico

The New Mexico APCD was established via legislation in 2015 and is operated through the New Mexico Department of Health's Epidemiology and Response Division. The APCD collects medical, dental, and pharmaceutical claims data from insured patients who receive care in New Mexico, as well as claims data from public insurers like Medicare and Medicaid, patient eligibility information, and health care provider information. It was completed in 2024, and a consumer-facing health care transparency website launched the same year, allowing New Mexicans to compare cost and quality data that is used to promote health care cost transparency.[80] For primary care, the APCD is a data resource that policymakers, researchers, payers, providers, employers, public health practitioners, and health system leaders can use to inform future policy, planning, and investment decision and better understand patterns in cost, utilization, access, quality, and spending across New Mexico's health care system.

New Mexico has taken substantial action to strengthen primary care through its Primary Care Council, established in 2021. The Council serves as a collaborative advisory body that brings together stakeholders from across the health care system to develop policy and

legislative recommendations to strengthen New Mexico's primary care system. In addition to monitoring statewide primary care spending, the PCC develops a five-year plan to advance primary care access, quality workforce development, and value-based investment, with the goal of improving health outcomes, expanding access to care and helping reduce overall health care costs across New Mexico.[81]

New York

The New York APCD was created by legislation in 2011. It is formally called the New York All Payer Database, and the Department of Health secured an analytics vendor and issued regulations in 2016.[82] The database is administered by the New York State Department of Health through its Bureau of All Payer Systems and Informatics. State regulations require third-party health care payers to submit complete, accurate, and timely APCD data to the Department monthly.[83] The public-facing NYS Health Connector launched in May 2018, with research files anticipated for release in late 2026.[84]

New York's APCD is not yet sufficiently mature or data-accessible to have been used for primary care investment benchmarking. Its data is still not available to external researchers and has not been deployed for multi-payer primary care spending analysis. The scale of New York's database, if fully operationalized and accessible, would make it a powerful tool for tracking primary care utilization and investment across the state's diverse payer mix and geographic regions. The state legislature is considering a primary care investment measurement and benchmark law for which the APCD could serve as a central tool.

Oregon

The Oregon All Payer All Claims (APAC) Reporting Program has been integral to Oregon's health system transformation since it was established via legislation in 2009. It contains administrative health care data on insurance coverage, health service cost, and utilization for Oregon's insured populations.[85] APAC collects data from most major public and private payers. Since 2017, APAC has also collected payment arrangement files at the service contract level, which include payment methodologies and amounts related to primary care.[86]

Oregon is the national leader in integrating primary care investment measurement into its APCD. The state's Primary Care Spending Report is built using APAC claims payment, non-claims payment, and enrollment data, representing at least 90% of Oregonians.[87] Oregon required coordinated care organizations and commercial carriers to allocate 12% of their medical spending to primary care by 2023, and the state tracks progress through annual reports built directly from APAC data.[88] Oregon found that a one-dollar increase in primary care spending was associated with $13 in savings for other health services[89], a finding made possible by APAC's comprehensive multi-payer data.

Rhode Island

The Rhode Island APCD was created by legislation in 2008, with first-year data collected in 2010.[90] The APCD, known as HealthFacts RI, is administered by the Rhode Island Department of Health. The HealthFacts RI Database includes information on over one million people, covering health status and demographics, emergency room visits, medical services, healthcare providers, pharmacy services, and member enrollment.[91]

Rhode Island established a primary care expenditure target for commercial health insurers in 2010, mandating annual increases to reach a target of 10.7% of total medical expenses by 2014.[92] HealthFacts RI data has been a tool for monitoring insurer compliance with this benchmark, and Rhode Island participated in the New England States' joint all-payer primary care spending report.[93]

Texas

See Section II.

Utah

Utah established its APCD through legislation passed in 2006. The APCD is administered by the Utah Health Care Information and Analysis Program within the Utah Department of Health & Human Services, with oversight from a Health Data Committee appointed by the governor. Utah's APCD contains data from health insurance carriers, Medicaid, and third-party administrators, consisting of medical, pharmacy, and dental claims as well as insurance enrollment and health care provider data.[94] The database is estimated to capture data covering approximately 90% of the state's commercially insured, 35% of the Medicaid, 100% of the Child Health Insurance Program, and 92% of its Medicare populations.[95]

Utah has published primary care spending estimates using APCD data.[96] Utah has used APCD data to conduct analysis of the primary care workforce.[97] The APCD's comprehensive data coverage makes it well-suited to such benchmarking if the state chooses to pursue it.

Vermont

The Vermont APCD, known as the Vermont Healthcare Claims Uniform Reporting and Evaluation System or VHCURES, was created by legislation in 2009.[98] The APCD is administered by the Vermont Department of Financial Regulation and the Green Mountain Care Board, Vermont's independent healthcare regulator. Vermont collects medical, pharmacy, and dental claims from commercial insurers, Medicaid, and Medicare. Vermont's APCD is particularly well-integrated into the state's broader health reform efforts, including health resource allocation planning and the evaluation of patient-centered medical home programs. Vermont used APCD funds to investigate how its multi-payer claims database could inform the rate review process, including medical trend analyses and generating comparative benchmarks.[99]

Vermont has passed legislation specifically tracking the percentage of medical spending dedicated to primary care.[100] Vermont participated in the New England States' joint all-payer report on primary care payments,[101] and the Green Mountain Care Board and Agency of Human Services actively uses APCD data to monitor progress toward primary care investment goals.

Virginia

Virginia's APCD is administered by Virginia Health Information (VHI), a multi-stakeholder nonprofit operating under authority of the Virginia Department of Health.[102] Virginia initially operated a voluntary APCD but later mandated claims submission. The APCD became fully mandatory in 2019.[103] Virginia collects medical, pharmacy, and dental claims from commercial insurers, Medicaid, and Medicare.

The Virginia Center for Health Innovation, which staffs the Virginia Task Force on Primary Care, has published primary care spending estimates and developed a primary care scorecard using APCD data.[104] Using these reports, the task force successfully advocated for $151 million in increased primary care spending within the state's Medicaid program and secured a state financial commitment to support the ongoing work of the task force.[105] Additionally, Virginia has used APCD data to conduct analysis of the primary care workforce[106] and the impact of several primary care pilot payment models.[107]

Washington

The Washington APCD was established by legislation in 2014, with data submissions beginning in 2017.[108] The APCD is administered by the Washington Health Care Authority (HCA). The database collects medical, pharmacy, and dental claims from commercial insurers, Medicaid, and Medicare. Washington's APCD contains claims for over 70% of the state's covered lives.[109]

Washington state has passed legislation specifically tracking the percentage of medical spending dedicated to primary care.[110] It has also published primary care spending estimates using APCD data.[111]

B. Voluntary APCDs

Michigan

Established in 2005, the Michigan Data Collaborative (MDC) is a data infrastructure organization that aggregates, manages and analyzes claims and clinical data. The collaborative began multi-payer claims data aggregation in 2010.[112] Historically, Michigan has had some experience with voluntary multi-payer data reporting and dashboards. From 2012 to 2017, the MDC produced multi-payer dashboards for the state's participation in the CMMI Multi-payer Advanced Primary Care Practice (MAPCP), which covered over a tenth of the Michigan population.[113] The multi-payer database and dashboards were sunset at the end of the demonstration.

Michigan has not enacted a primary care spending benchmark or APCD legislation.

Oklahoma

Established in 2009, Oklahoma's APCD is voluntarily administered by MyHealth Access Network, a coalition of health care industry stakeholders. It collects commercial payer claims, covering approximately 1 million lives or about 25% of the state's total population.[114] The database is used primarily for provider performance and cost analyses.

Although Oklahoma has enacted legislation requiring Medicaid managed care programs to report how much they spend on primary care and to raise the share of total spending devoted to primary care,[115] this Medicaid-focused primary care requirement is not tracked through Oklahoma's voluntary commercial APCD but through Medicaid managed care reporting.

Wisconsin

Wisconsin's APCD was created through legislation in 2008 as a public-private partnership to improve healthcare transparency, quality, and efficiency.[116] The Wisconsin Health Information Organization (WHIO) administers the database on behalf of the Wisconsin Department of Health Services.[117] The database consists of claims that represent commercial, self-funded employer, Medicare Advantage and Medicaid plans, as well as other data files.[118] The data is used by state agencies, universities, health plans, employers, consultants, and others.[119]

Wisconsin has not enacted a primary care spending benchmark. However, WHIO has completed state level primary care spend rate trend that is expected to be released soon.

IV Best Practices & Successful Models

Each APCD operates differently, has various stated missions, and pursues its own research and reporting priorities using the data it collects.[120] States with the most effective APCDs tend to share several key characteristics, including transparency, usability, and alignment with policy goals.

Multi-state collaborators, like the New England States Consortium Systems Organization, have also demonstrated the value of standardized methodologies. This work group comprised of all six New England states issued the "All-Payer Report on Primary Care Payments," that found how much is being spent across all payer types[121] in the region by focusing on how states incentivize and measure primary care payments as a percentage of total health care expenditures.

The efforts of several state APCDs are notable for their effectiveness, their existing impact on primary care investment policy, and potential for the same. Washington's APCD is paired with a public-facing tool that allows users to directly search prices and quality metrics for healthcare services, making complex claims data usable for consumers and stakeholders. The database is another model framework because it emphasizes true transparency and usability, by ensuring APCD data actively informs consumer decisions and policy rather than remaining siloed in technical dataset.[122] Colorado's APCD is notable for incorporating data on alternative payment models and other non-claims elements, which are directly tied to value-based care and primary care investment strategies.[123] This makes it a model framework because it enables policymakers to track spending on primary care and evaluate payment reform efforts, supporting targeted policies that shift resources toward high-value, primary care-focused systems.[124]

V Challenges and Gaps

While state APCDs hold significant promise as tools for measuring and advancing primary care investment, a range of structural, legal, and technical barriers can sometimes limit their effectiveness in this role. These challenges are compounded by the fact that nearly half of the U.S. population lives in a state without an APCD.[125] As a result, any national effort to benchmark primary care investment through APCD data is fundamentally constrained. Additionally, existing state efforts to develop and maintain APCDs also face several challenges.

The ERISA Data Gap

The most structurally significant barrier is the exclusion of private-sector self-insured employer plans from mandatory APCD submission requirements. As of 2020, an estimated 67% of workers covered by employer-sponsored health insurance were enrolled in self-insured plans.[126] The 2016 U.S. Supreme Court decision in Gobeille v. Liberty Mutual Insurance Co. further constrains all APCDs by exempting private-sector self-insured employer plans governed by ERISA from state data submission requirements. For primary care benchmarking purposes, this gap is particularly consequential. Employer-sponsored insurance is the dominant payer for working-age adults, and excluding these enrollees from primary care spending calculations produces estimates that may be incomplete.

As of 2020, an estimated **67%** of workers covered by employer-sponsored health insurance were enrolled in self-insured plans.

Failure to Capture Non-Claims-Based Primary Care Payments

As the health care system shifts toward value-based payment models, often with the goal of increasing primary care investment, APCD data rooted in traditional fee-for-service claims increasingly misses a growing share of primary care investment. Carriers routinely reimburse providers outside of claims in a multitude of ways including capitation, care coordination payments, pay-for-performance bonuses, and shared savings. Most APCDs do not currently capture these transactions and costs, leaving states with an incomplete picture of the total costs and pricing.[127] For states trying to assess whether payers are meeting primary care investment benchmarks that include value-based payments, relying solely on claims data will systematically undercount true primary care spending.

As the health care system shifts toward value-based payment models, APCD data rooted in traditional fee-for-service claims increasingly misses a growing share of primary care investment.

Inconsistent Data Quality and Completeness

APCD data quality varies across states and even across payers within a single state. In terms of the recency of data available, while APCDs in a few states include close to real-time data, most lag by three to four years.[128] For primary care investment monitoring, multi-year data lags can make APCD-based benchmarking a retrospective exercise rather than a timely policy tool. Additionally, demographic information such as race and ethnicity is often incomplete or absent in APCD data, as payers rarely collect this information in their regular administrative processes,[129] limiting the ability to assess primary care investment disparities.

Demographic information such as race and ethnicity is often incomplete or absent in APCD data.

Restricted Access and Prohibitive Costs

Even where high-quality APCD data exists, access barriers can prevent policymakers, advocates, and researchers from using it effectively for primary care investment analysis. There are significant differences in data access policies across databases. Even when data access is permitted to external researchers, there are various indirect barriers to access in the form of complex application procedures, fees, and data management requirements.[130] Each state has its own application process, its own restrictions on how data can be used, and its own fees for data access, meaning that accessing multiple states' databases may require a substantial investment of both time and funds.[131] For primary care advocates and researchers trying to conduct cross-state benchmarking analyses, these barriers can be prohibitive.

There are significant differences in data access policies across databases.

Legislative Delays of Establishing an APCD

For states that do not have an APCD, establishing a database is a substantial legislative and operational undertaking. Waiting to build that infrastructure before pursuing primary care investment benchmarks could delay urgently needed action by years or even decades. Similar to primary care investment efforts, successful APCD implementation requires engaging with stakeholders, establishing salient use cases, determining a suitable governance structure, securing sustainable funding, setting realistic implementation goals and timeframes, and ensuring data quality and analytic rigor while protecting data privacy.[132] In practice, this process is rarely swift. According to a Commonwealth Fund report, developing and implementing the APCDs it studied required from one to three years before the database was even technically operational, and that timeline does not account for the additional years typically needed after launch to refine data quality, onboard all submitters, build analytic capacity, and produce reliable public reporting.

Establishing a database is a substantial legislative and operational undertaking.

Inadequate and Unstable Funding

Underlying many of these barriers is the chronic underfunding of state APCD programs. Most APCD agencies are funded through states' general funds, meaning their budgets shift annually and restrict their long-term planning capabilities.[133] A Commonwealth Fund report has similarly noted that state APCDs are generally considered underfunded and under-resourced relative to the tasks states have set for them, with many APCD leaders describing themselves as "scratching the surface" of what their databases could accomplish.[134] Underfunding directly impairs the analytical and staffing capacity needed to produce meaningful primary care spending reports, monitor benchmark compliance, and respond to data requests from stakeholders.

Demographic information such as race and ethnicity is often incomplete or absent in APCD data.

VI Policy Recommendations and Lessons Learned

Drawing on the state experiences and challenges outlined in this report, several key policy recommendations and lessons learned emerge for states both with and without APCDs:

1 Prioritize transparency as a core design feature of APCDs.

States should ensure that APCDs produce publicly available reports, dashboards, and summary datasets that allow policymakers, researchers, and consumers to understand health care spending patterns. Transparent models demonstrate that APCDs are most effective when data is not only collected but actively shared in accessible formats that inform decision-making and accountability.

2 Invest in usability and accessibility of APCD data.

Beyond transparency, APCDs must be usable. States should reduce administrative, financial, and technical barriers to data access and prioritize user-friendly tools, such as public price comparison platforms and standardized research files. Even robust data collection is insufficient if researchers and policymakers cannot meaningfully access or analyze the data.

3 Align APCD infrastructure with primary care spending targets and broader policy goals.

States pursuing primary care investment benchmarks should explicitly align APCD data collection and reporting with those goals. APCDs are most impactful when they are designed to track primary care spending, including non-claims payments, and directly support enforcement or evaluation of spending targets.

4 Incorporate non-claims payment data to capture true primary care investment.

As payment models shift toward value-based care, states should expand APCDs (or complementary reporting systems) to include capitation, care coordination payments, and other non-claims expenditures. Without this, states risk systematically undercounting primary care investment and misinforming policy decisions tied to spending benchmarks. A more wholistic measure of primary care spending, which includes non-claims expenditures, may also inform a policy shift to increase the investment benchmark.

5 Recognize that APCDs are valuable but not strictly necessary for primary care investment policy.

States without APCDs should not treat database development as a prerequisite for action. Primary care spending targets and reporting requirements can be pursued through payer reporting and other mechanisms, even in the absence of a comprehensive APCD. While APCDs can significantly enhance data-driven policymaking, they are not essential for establishing or advancing primary care investment goals. States should weigh the costs, timelines, and data limitations of APCDs against alternative approaches. One example of an alternative approach might be to require payers to report primary care spending and utilization to capture the data necessary to inform primary care investment policy.

6 Ensure sustainable funding and governance to support long-term APCD effectiveness.

States should establish stable funding mechanisms, such as payer assessments or dedicated appropriations, and clear governance structures to maintain data quality, timeliness, and analytic capacity. Without sustained investment, APCDs risk becoming underutilized assets that cannot effectively support primary care investment or broader health system reforms.

VII Conclusion

All-Payer Claims Databases have emerged as powerful, though imperfect, tools for understanding health care utilization, spending, and system performance across states. As this report demonstrates, APCDs can play a central role in informing and operationalizing primary care investment policies by enabling multi-payer analysis, benchmarking, and longitudinal tracking. Leading states have shown that when APCDs are transparent, accessible, and aligned with policy goals, they can move beyond passive data repositories to become active instruments of health system reform.

At the same time, the wide variation in APCD design, functionality, and use underscores that data infrastructure alone does not guarantee policy success. Persistent challenges, including incomplete data due to ERISA limitations, insufficient capture of non-claims payments, delayed reporting, and restricted access, can significantly limit their effectiveness. Moreover, state experiences make clear that meaningful progress on primary care investment does not depend solely on APCDs. States without fully developed databases have still advanced policy through alternative data collection strategies, while some states with robust APCDs have yet to translate data into actionable benchmarks.

Ultimately, the most important lesson is that APCDs should be viewed as tools in service of policy, not prerequisites for it. States seeking to strengthen primary care investment should focus on clear policy goals, stakeholder alignment, and sustainable implementation strategies leveraging APCDs where they add value but not delaying action in their absence. By prioritizing transparency, usability, and alignment with broader health system reforms, states can ensure that whether through APCDs or other mechanisms, their efforts meaningfully advance a more equitable, efficient, and primary care-centered health system.

Appendix: State-by-State Landscape

State APCD Summary: Primary Care Investment Landscape

State	Year Established	Administrator(s)	Data Sources	Data Collected	Primary Care Spending Report Produced?	APCD Data Used for PC Spending Report?	Primary Care Investment Benchmark Established?
Arkansas	**2016**	Arkansas Center for Health Improvement (ACHI)	Commercial insurers, Medicaid, Medicare, third-party administrators, pharmacy benefit managers, state employee plan, managed care organizations	Medical, pharmacy, and dental claims; enrollment data; provider files; supplemental non-claims data (vital records, disease registry, hospital discharges for uninsured, medical marijuana data)	**In Progress**	**Yes** (pending)	**No** (in development)
California	**2020**	Department of Health Care Access and Information (HCAI); Office of Health Care Affordability (OHCA)	Commercial health plans, insurers, Medicaid, Medicare fee-for-service, Medicare Advantage	Medical, pharmacy, and dental claims; enrollment data; provider data; non-claims payment data	**In Progress** (public reporting expected 2026)	**Yes**	**Yes;** 15% by 2034
Colorado	**2010**	Center for Improving Value in Health Care (CIVHC); advisory committee appointed by state Medicaid agency	Medicaid, Medicare, Medicare Advantage, 21 largest commercial health plans	Medical and pharmacy claims; enrollment files; provider files; alternative payment model (APM) files capturing non-fee-for-service payments (capitation, shared savings)	**Yes**	**Yes**	**No** set target, year-by-year determination.
Connecticut	**2012**	Connecticut Office of Health Strategy (OHS)	Commercial health insurers, Medicaid, Medicare	Medical, pharmacy, and dental claims; provider data; eligibility/ enrollment data	**Yes**	**Yes**	**Yes;** 10% by 2025
Delaware	**2016**	Delaware Health Information Network (DHIN); Health Care Claims Database Committee	Medicare, Medicaid, seven largest commercial health insurers	Healthcare claims, enrollment data, provider data	**Yes** (via insurer compliance reporting)	**Yes**	**Yes;** 7% by 2022, 8.5% by 2023, 10% by 2024, 11.5% by 2025
Florida	**2016**	Florida Agency for Health Care Administration (AHCA); Health Care Cost Institute (HCCI)	Employer-sponsored group and individual market commercial plans only	Medical claims for commercial employer-sponsored and individual market plans only	**No**	**No**	**No**
Georgia	**2020**	Office of Health Strategy and Coordination (OHSC); Georgia Tech Research Institute's Center for Health Analytics and Informatic	Insurance companies with 1,000+ covered lives; Department of Community Health; Medicaid Care Management Organizations; State Health Benefit Plan	Medical, dental, and pharmacy insurance claims; visit, procedure, diagnosis, medication dispensing, cost, and demographic data	**No**	**No**	**No**
Hawaii	**2016** (operational standup 2025)	Pacific Health Informatics and Data Center (PHIDC)	Medicaid, Hawaii Employer-Union Health Benefits Trust Fund, Medicare, state employees and retiree health care claims (mandatory); privately insured data (voluntary)	Medical claims data; mandated submissions from public payers/plans noted above; voluntary commercial claims data	**No**	**No**	**No**
Indiana	**2020**	Indiana Department of Insurance (IDOI); Onpoint Health Data	37 commercial health plans, Indiana Family and Social Services Administration (Medicaid)	Medical and pharmacy claims; eligibility data; provider data (dental claims explicitly excluded by statute)	**No**	**No**	**No**
Kansas	**2008**	Kansas Insurance Department; Department of Health and Environment	Medicaid, state employee health plan, commercial insurers (Kansas Health Insurance Information System)	Medical claims; pharmacy claims; Medicaid claims; state employee health plan claims; rolling five-year data cycle	**No**	**No**	**No**
Maine	**2003**	Maine Health Data Organization (MHDO)	Commercial insurance carriers, third-party administrators, pharmacy benefit managers, dental benefit administrators, Medicaid, Medicare	Medical, pharmacy, and dental claims; eligibility data; non-claims-based payment data (collected under separate authority)	**Yes**	**Yes**	**No**
Maryland	**1995**	Maryland Health Care Commission (MHCC)	Life and health insurance carriers, HMOs, third-party administrators, pharmacy benefit managers, Medicaid, Medicare	Medical claims and membership data; professional, institutional, and pharmacy claims (excludes private self-insured ERISA plan data post-Gobeille)	**Yes**	**Yes**	**No**
Massachusetts	**2008**	Center for Health Information and Analysis (CHIA), an independent state agency	Approximately 60 payer organizations (commercial insurers, Medicaid, Medicare, managed care organizations)	Medical, pharmacy, dental, vision, behavioral health, and specialty services claims; enrollment data; provider data; primary care and behavioral health payment data	**Yes**	**Yes**	**No**

State APCD Summary: Primary Care Investment Landscape

State	Year Established	Administrator(s)	Data Sources	Data Collected	Primary Care Spending Report Produced?	APCD Data Used for PC Spending Report?	Primary Care Investment Benchmark Established?
Michigan	**2005** (MDC established); voluntary multi-payer claims aggregation began 2010	Voluntary, no authorizing legislation	Michigan Data Collaborative (MDC)	Multi-payer claims and clinical data	**No**	**No**	**No**
Minnesota	**2009**	Minnesota Department of Health (MDH)	Commercial insurers, Medicaid, Medicare; all sources submitting over $3M in MN claims/year	Medical, pharmacy, and enrollment data	**Pending** (mandated report on primary care spending due February 2024; not yet released as of 2026)	**Pending**	**No**
New Hampshire	**2005**	NH Insurance Department (NHID); NH Dept. of Health and Human Services (DHHS)	Commercial insurers, Medicaid, Medicare	Medical, pharmacy, and dental claims; enrollment data	**Yes** (via New England 6-state joint report, 2020)	**Yes**	**No**
New Mexico	**2015** (completed 2024)	New Mexico Department of Health, Epidemiology and Response Division	Insured patients receiving care in New Mexico; public insurers including Medicare and Medicaid	Medical, dental, and pharmaceutical claims data; patient eligibility information; health care provider information	**No**	**No**	**No**
New York	**2011**	NYS Department of Health, Bureau of All Payer Systems and Informatics	All third-party health care payers (mandatory monthly submission)	Medical, pharmacy, and enrollment claims; provider data	**No**	**No**	**No** (legislation pending)
Oklahoma	**2009**	MyHealth Access Network (coalition of health care industry stakeholders)	Commercial payers (voluntary participation)	Commercial payer claims, covering approximately 1 million lives (~25% of state population)	**No**	**No** (Medicaid primary care spending tracked separately, not through the APCD)	**No** (via APCD); Yes for Medicaid managed care (separate reporting requirement)
Oregon	**2009**	Oregon Health Authority (OHA)	All major public and private payers: commercial carriers, licensed TPAs, pharmacy benefit managers, Medicaid managed care organizations, Medicaid fee-for-service, Medicare Parts C and D	Medical claims; pharmacy claims; dental claims; payment arrangement files capturing alternative payment methodology data	**Yes**	**Yes**	**Yes;** 12% by 2023
Rhode Island	**2008**	Rhode Island Department of Health	Commercial health insurers, Medicaid, Medicare	Medical claims; pharmacy claims; enrollment data; health status and demographic data; emergency department, medical services, Medical, pharmacy, and dental claims; eligibility data; provider data	**Yes**	**Yes**	**Yes;** 10% by 2028
Texas	**2021**	University of Texas Health Science Center at Houston (UTHealth), Center for Health Care Data	Public and private payers		**No**	**No**	**No**
Utah	**2006**	Office of Health Care Statistics (OHCS), Utah Department of Health; Health Data Committee	Health insurance carriers, Medicaid, third-party administrators	Medical, pharmacy, and dental claims; insurance enrollment data; health care provider data	**Yes**	**Yes**	**No**
Vermont	**2009**	Vermont Department of Financial Regulation; Green Mountain Care Board	Commercial insurers, Medicaid, Medicare	Medical, pharmacy, and dental claims	**Yes** (via New England 6-state joint report and ongoing Green Mountain Care Board monitoring)	**Yes**	**No**
Virginia	**2019**	Virginia Health Information (VHI)	Commercial insurers, Medicaid, Medicare	Medical, pharmacy, and dental claims	**Yes**	**Yes**	**No**
Washington	**2014**	Washington Health Care Authority (HCA)	Commercial insurers, Medicaid, Medicare	Medical, pharmacy, and dental claims	**Yes**	**Yes**	**Yes**; 12%, no fixed deadline
Wisconsin	**2008**	Wisconsin Health Information Organization (WHIO)	Commercial, self-funded employer, Medicare Advantage, and Medicaid plans	Claims representing commercial, self-funded employer, Medicare Advantage, and Medicaid plans; other data files	In Progress (state-level primary care spend rate trend completed by WHIO, expected to be released soon)	**Yes**	**No**

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