(3) Collect appropriate information relating to health care costs, utilization, or resources from payors and governmental agencies.

[(c)] (D) (1) The Commission shall adopt regulations governing the access and retrieval of all medical claims data and other information collected and stored in the medical care data base and any claims clearinghouse licensed by the Commission and may set reasonable fees covering the costs of accessing and retrieving the stored data.

(2) These regulations shall ensure that confidential or privileged patient information is kept confidential.

(3) Records or information protected by the privilege between a health care practitioner and a patient, or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the person protected.

[(d)] (E) (1) To the extent practicable, when collecting the data required under subsection [(b)] (C) of this section, the Commission shall utilize any standardized claim form or electronic transfer system being used by health care practitioners, office facilities, and payors.

(2) The Commission shall develop appropriate methods for collecting the data required under subsection [(b)] (C) of this section on subscribers or enrollees of health maintenance organizations.

[(e)] (F) Until the provisions of § 19–135 of this subtitle are fully implemented, where appropriate, the Commission may limit the data collection under this section.

[(f)] (G) (1) By October 1, 1995 and each year thereafter, the Commission shall publish an annual report on those health care services selected by the Commission that:

[(1)] (I) Describes the variation in fees charged by health care practitioners and office facilities on a statewide basis and in each health service area for those health care services; and

[(2)] (II) Describes the geographic variation in the utilization of those health care services.

(2) (I) ON AN ANNUAL BASIS, THE COMMISSION SHALL PUBLISH:

1. THE TOTAL REIMBURSEMENT FOR ALL HEALTH CARE SERVICES OVER A 12–MONTH PERIOD;

2. THE TOTAL REIMBURSEMENT FOR EACH HEALTH CARE SPECIALITY OVER A 12–MONTH PERIOD;

3. THE TOTAL REIMBURSEMENT FOR EACH CODE OVER A 12–MONTH PERIOD; AND

4. THE ANNUAL RATE OF CHANGE IN REIMBURSEMENT FOR HEALTH SERVICES BY HEALTH CARE SPECIALTIES AND BY CODE.