employer groups and individual consumers across the country. United and DMG both offer managed care provider organization (''MCPO'') services to health insurers. The merger is therefore both horizontal in nature—because it combines two competing MCPO service providers—and vertical, as it combines MCPO and insurance assets.

Staff spent more than a year and a half investigating the competitive effects of this acquisition, which involves assets in several states, including Colorado, Florida, New Mexico, Nevada, and Washington. Based on the findings from that investigation, the Commission has accepted a proposed consent agreement requiring United to divest DMG's healthcare provider organization (its MCPO) in the Las Vegas, Nevada, area to Intermountain Healthcare, a non-profit healthcare provider system without a presence in the market. We join Commissioners Slaughter and Chopra in supporting this remedy and in thanking staff for their exceptional effort and diligence through this long investigation.

Our colleagues write separately, stating they would have asked a federal judge to block United's acquisition of DMG based on their belief that the vertical integration of United's health insurance business and DMG's MCPOs and physicians in Colorado would harm consumers. In our view, the evidence in support of likely harm in Colorado was not compelling, and therefore a federal judge was unlikely to grant that relief.

As Commissioners Slaughter and Chopra point out, the acquisition in Colorado is purely vertical. In other words, in that state the transaction combines firms that operate at different levels of the supply chain and do not compete with one another. Specifically, DMG's MCPO services and physicians serve as ''inputs'' to the MA insurance plans that United and other health insurers sell to employers and individuals. The putative theory of harm in Colorado involved raising rivals' costs (''RRC''). It posited that, after acquiring DMG, United would find it profitable to raise DMG's prices to rival MA insurance plans, because doing so would reduce these plans' benefits and induce some customers to switch to United's MA products. The more business United recaptures in the market for MA plans, the greater its incentive to raise DMG's prices to rivals.

We do not rule out the possibility that vertical mergers can harm competition under a RRC theory. We both voted to issue the complaint, which alleges a similar vertical theory of harm in Nevada. And given both substantially stronger facts and the significant horizontal overlap in that state, that was the right call.

But vertical mergers often generate procompetitive benefits that must also factor into the antitrust analysis.[1] A major source of these benefits is the elimination of double-marginalization, which places downward pressure on prices in the output market. We conclude that the evidence in Colorado, quantitative and qualitative, reflected both dynamics, with mixed results. In our view, taken together, the evidence would not have convinced a judge that the proposed acquisition was likely, on balance, to harm consumers in Colorado.

As our colleagues note, a lawsuit based upon this evidence posed significant litigation risk. Among other things, the law on vertical mergers is relatively underdeveloped, and an adverse decision can impact enforcement in later cases that present clearer harm. Of course, all litigation presents risks, and sometimes the risks are worth taking. But, faced with a body of evidence of harm that was ambiguous in the first place, we cannot agree with our colleagues that this was a case on which to roll the dice.

Statement of Commissioners Rebecca Kelly Slaughter and Rohit Chopra

UnitedHealth Group, Inc. (''United'') proposes to acquire DaVita Medical Group (''DMG''), which provides healthcare services in Nevada and Colorado, among other states. Today, the Commission voted to accept a proposed consent agreement that requires a divestiture of the DMG business serving Clark and Nye counties in Nevada to maintain competition. We agree with the proposed remedy for Nevada, but we disagree with the Commission's decision to not pursue an enforcement action in Colorado.

We believe the evidence uncovered by Commission staff demonstrates that the vertical merger of United's health insurance and DMG's healthcare services businesses would likely result in actionable harm to competition in Colorado. We were prepared to challenge the transaction in court, given the likelihood of harm. We acknowledge that Commission action involving Colorado would have borne significant litigation risks, but we believe such risks were worth taking.

Fortunately, the Attorney General of Colorado has taken action in an effort to address some of the harmful effects of the merger in a separate action. We hope all state attorneys general actively enforce the antitrust laws to protect their residents from harmful mergers and anticompetitive practices.

We thank Commission staff for their tireless work on a complex and very resource-intensive matter. While we would have preferred a different outcome, staff put the Commission in a very strong position to make a well-informed decision and serve the public interest.

[1] *See, e.g., United States* v. *AT&T,* 310 F.Supp.3d 161, 192–94 (D.D.C. 2018).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–19–0573]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled National HIV Surveillance System (NHSS), to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on April 23rd, 2019 to obtain comments from the public and affected agencies. CDC did not receive comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other

technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

National HIV Surveillance System (NHSS) (OMB No. 0920–0573, Expiration 06/30/2019)—Revision—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Collected with authorization under Sections 304 and 306 of the Public Health Service Act (42 U.S.C. 242b and 242k) the National HIV Surveillance System (NHSS) data are the primary data used to monitor the extent and characteristics of the HIV burden in the United States. HIV surveillance data are used to describe trends in HIV incidence, prevalence and characteristics of infected persons and used widely at the federal, state, and local levels for planning and evaluating prevention programs and healthcare services, and to allocate funding for prevention and care.

As science, technology, and our understanding of HIV have evolved, the NHSS has been updated periodically. CDC in collaboration with health departments in the 50 states, the District of Columbia, and U.S. dependent areas, conducts national surveillance for cases of HIV infection that includes critical data across the spectrum of HIV disease from HIV diagnosis, to stage 3 (AIDS), the end stage disease caused by infection with HIV, and death. In addition, this national system provides essential data to estimate HIV incidence, monitor patterns in HIV drug resistance and genetic diversity, identify and respond to clusters of recent and rapid transmission, as well as provide information on perinatal exposure to HIV in the United States. The CDC surveillance case definition has been modified periodically to accurately monitor disease in adults, adolescents and children and reflect use of new testing technologies and changes in HIV treatment. Information is then updated in the case report forms and reporting software as needed.

In 2018, CDC implemented activities under a new cooperative agreement PS18–1802: Integrated HIV Surveillance and Prevention Programs for Health Departments. The purpose of PS18–1802 is to implement a comprehensive HIV surveillance and prevention program to prevent new HIV infections and achieve viral suppression among persons living with HIV. These goals are in accordance with the CDC's and national prevention goals, including the President's new initiative to End the HIV Epidemic in America. This information collection request revision includes activities to continue national surveillance program activities and align with program priorities under the new cooperative agreement (PS18–1802).

The revisions requested in this extension include minor modifications to currently collected data elements and forms (including the Adult Case Report Form (ACRF) and the Pediatric Case Report Form (PCRF)), modifications to data system variables used to summarize geocoded address data collected as part of the geocoding and data linkage activities, addition of new cluster report forms for health departments to report on progress for HIV cluster response activities and addition of investigation reporting and evaluation activities to account for additional data reported as part of these activities. No changes are being requested to data elements collected on the Perinatal HIV Exposure Reporting (PHER) form, but the number of jurisdictions (respondents) completing the form has been reduced. Minor changes to the information collected in the standards evaluation report form (SER) are also requested to align with changes in program activities under PS18–1802. Finally, we have updated our burden estimates to more accurately reflect current data collection practices that are summarized in the table below.

CDC provides funding for 59 jurisdictions to provide adult and pediatric HIV case reports. Health department staff compile information from laboratories, physicians, hospitals, clinics and other health care providers to complete the HIV adult and pediatric case reports. CDC estimates that on average, approximately 854 adult HIV case reports and three pediatric case reports are processed by each health department annually.

These data are recorded using standard case report forms either on paper or electronically and entered into the electronic reporting system. Updates to case reports are also entered into the reporting system by health departments as additional information may be received from laboratories, vital statistics, or additional providers. Evaluations are also conducted by health departments on a subset of case reports (*e.g.,* re-abstraction, validation). CDC estimates that on average approximately 86 evaluations of case reports, 2353 updates to case reports and 9410 updates of electronic laboratory test data will be processed by each of the 59 health departments annually. In addition, all 59 health departments will conduct routine deduplication activities for new diagnoses and cumulative case reports. CDC estimates that health departments on average will follow-up on 2741 reports as part of deduplication activities annually. Case report information compiled over time by health departments is then de-identified and forwarded to CDC on a monthly basis to become part of the national HIV surveillance database.

When necessary additional information may be reported by health departments for monitoring and evaluation of health department investigations including activities identifying persons who are not in HIV medical care and linking them to HIV medical care (*e.g.,* Data-to-Care activities) and other services and identifying and responding to clusters. CDC estimates health departments will on average process 901 responses related to investigation reporting and monitoring annually.

Clusters of HIV are groups of persons related by recent, rapid transmission, for which rapid response is needed in order to interrupt ongoing transmission and prevent further HIV infections. Health departments may detect clusters through multiple means, including through routine analyses of Surveillance data and other data reported to the NHSS. Data on clusters of recent and rapid HIV transmission in the United States will be collected to monitor situations necessitating public health intervention, assess health department response, and evaluate outcomes of intervention activities. These summary data will be collected through quarterly cluster report forms that will be completed by health departments for clusters that they have identified and for which they are actively conducting response activities. Health departments will complete an initial cluster report form when a cluster is first identified, a cluster follow-up form for each quarter in which the cluster response remains

active and a cluster close-out form when cluster response activities are closed or at annual intervals while a cluster response remains active. Completion of forms will be determined by the number of clusters detected. Health departments that do not identify recent and rapid clusters of HIV transmission will not complete any cluster report forms, while some jurisdictions will detect multiple recent and rapid clusters of HIV transmission, necessitating the completion of multiple cluster report forms. CDC estimates on average health departments will provide information for 2.5 initial cluster reports, five Cluster Follow-up reports, and 2.5 Cluster Close-out reports annually.

Perinatal HIV surveillance and prevention activities with HIV exposure reporting and perinatal services coordination is an integrated approach to advancing the progress toward perinatal HIV elimination goals. A subset of 16 health departments in the most affected jurisdictions will be reporting using the Perinatal Exposure Reporting (PHER) form to monitor and evaluate perinatal HIV prevention efforts. An estimated 197 reports containing perinatal exposure data elements will be processed on average annually by each of the 16 health departments reporting data collected as part of PHER. These supplemental data are also reported monthly to CDC.

The Standards Evaluation Report (SER) is used by CDC and Health Departments to improve data quality, interpretation, usefulness, and surveillance system efficiency, as well as to monitor progress toward meeting surveillance program objectives. The information collected for the SER includes a brief set of questions about evaluation outcomes and the collection of laboratory data that will be reported one time a year by each 59 health departments. The total estimated annual burden hours are 58,131.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Health Departments	Adult HIV Case Report	59	854	20/60
Health Departments	Pediatric HIV Case Report	59	3	20/60
Health Departments	Case Report Evaluations	59	86	20/60
Health Departments	Case Report Updates	59	2,353	2/60
Health Departments	Laboratory Updates	59	9,410	0.5/60
Health Departments	Deduplication Activities	59	2,741	10/60
Health Departments	Investigation Reporting and Evaluation	59	901	1/60
Health Departments	Initial Cluster Report Form	59	2.5	1
Health Departments	Cluster Follow-up Form	59	5	30/60
Health Departments	Cluster Close-out Form	59	2.5	1
Health Departments	Perinatal HIV Exposure Reporting (PHER)	16	197	30/60
Health Departments	Annual Reporting: Standards Evaluation Report (SER).	59	1	8

Jeffrey M. Zirger,

Lead, Information Collection Review Office, Office of Scientific Integrity, Office of Science, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–19–18AMQ]

Agency Forms Undergoing Paperwork Reduction Act Review

In accordance with the Paperwork Reduction Act of 1995, the Centers for Disease Control and Prevention (CDC) has submitted the information collection request titled *Assessing impact of the NIOSH research* to the Office of Management and Budget (OMB) for review and approval. CDC previously published a ''Proposed Data Collection Submitted for Public Comment and Recommendations'' notice on July 20, 2018 to obtain comments from the public and affected agencies. CDC received two comments related to the previous notice. This notice serves to allow an additional 30 days for public and affected agency comments.

CDC will accept all comments for this proposed information collection project. The Office of Management and Budget is particularly interested in comments that:

(a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;

(b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

(c) Enhance the quality, utility, and clarity of the information to be collected;

(d) Minimize the burden of the collection of information on those who are to respond, including, through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, *e.g.,* permitting electronic submission of responses; and

(e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639–7570 or send an email to *omb@cdc.gov.* Direct written comments and/or suggestions regarding the items contained in this notice to the Attention: CDC Desk Officer, Office of Management and Budget, 725 17th Street, NW, Washington, DC 20503 or by fax to (202) 395–5806. Provide written comments within 30 days of notice publication.

Proposed Project

Assessing impact of the NIOSH research—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Institute for Occupational Safety and Health (NIOSH) is responsible for conducting research and making recommendations