Anticipated acquisition by UnitedHealth Group Incorporated of EMIS Group Plc

Summary of provisional findings

Notified: 11 August 2023

Overview of our provisional findings

1. The Competition and Markets Authority (**CMA**) has provisionally found that the anticipated acquisition of EMIS Group Plc (**EMIS**) by UnitedHealth Group Incorporated (**UH**) (the **Merger**) may not be expected to result in a substantial lessening of competition (**SLC**) in relation to the supply of medicines optimisation (**MO**) software or population health management (**PHM**) services in the United Kingdom (**UK**). UH and EMIS are together referred to as the **Parties** and, for statements relating to the future, the **Merged Entity**.

2. This is not our final decision, and we invite any interested parties to make representations to us on these provisional findings by no later than 17:00 BST, on **Friday 1 September 2023**. Please make any response to these findings by email to UnitedHealth.EMIS@cma.gov.uk. We will take all submissions received by this date into account in reaching our final decision.

About the Parties and their products

3. EMIS is a UK-based healthcare software business that supplies, among other things, a primary care electronic patient record (**EPR**) system (**EMIS Web**). Primary care EPR systems allow GPs to manage appointments, conduct patient consultations, and update, store and share patient records. Every GP practice will use a primary care EPR system as it is essential to the running of a practice, and the other software used in GP practices need to interact with it.

4. Primary care EPR systems are the custodians of NHS patient data, although the patient data belongs to the NHS and the GP practices. Any party (including NHS bodies) that requires primary care data relies on these systems for data access and/or extraction. Data protection laws apply, and

there are additional safeguards put in place by the NHS. In order to interact with the primary care EPR system, or to extract data from it, suppliers will integrate using different **APIs** (Application Programming Interfaces). The APIs used can be mandated (ie by the NHS) or customised (ie agreed commercially between two suppliers).

5. EMIS also supplies a data analytics platform and related tools, which customers can use to extract and analyse the data held on EMIS Web (EMIS-X Analytics Explorer, or **EXA**).

6. UH's subsidiary, Optum Health Solutions (UK) Limited (**Optum**), also supplies healthcare solutions. These include:

   (a) MO software (for example ScriptSwitch), which suggests alternative medicines to GPs in order to increase the effectiveness and reduce the cost of prescribing. This software needs to integrate with the primary care EPR system, including to provide prompts to GPs at the appropriate points during their workflow.

   (b) PHM services, both advisory and software/tools, which use data analytics to improve the physical and mental health outcomes across a population. Primary care data is often an important input into the provision of PHM services.

7. Healthcare is a devolved matter, with each UK nation funding and organising its health and care services separately. Generally, GP practices will be part of a local organisation of health and care services (managed by an Integrated Care Board (**ICB**) in England, a Health Board in Wales, an NHS Board in Scotland and the Health and Social Care Board in Northern Ireland (collectively '**ICBs and Health Boards**')). ICBs and Health Boards generally procure the services described above for their local area, although for primary care EPR systems, the individual GP practices will typically have a choice of which supplier they use (from those who have been approved under the relevant procurement framework).

8. In order to be included on the NHS frameworks for primary care EPR systems, a supplier must meet a number of standards, which seek to set out required functionality and pricing, rules around the supplier's commercial behaviour, and principles relating to APIs, access to data, and interoperability (amongst other requirements). NHS England (and the equivalent bodies in each other UK nation) monitors compliance with these standards and can issue new frameworks or update standards as needed.

Our assessment

Why are we examining this Merger?

9. The CMA's primary duty is to seek to promote competition for the benefit of UK consumers, including the investigation of mergers that could raise competition concerns in the UK where it has jurisdiction to do so.

10. In this case, the CMA has jurisdiction over the Merger because the UK turnover of EMIS is in excess of our legal threshold of £70 million for its last business year.

How have we examined this Merger?

11. In deciding whether a merger may be expected to result in an SLC, the question we are required to answer is whether it is more likely than not – a more than 50% chance – that the merger will result in an SLC within a market or markets in the UK.

12. To determine whether this is the case, we have built on the information collected during the Phase 1 investigation and gathered further evidence from a wide variety of sources, using our statutory powers where necessary, to understand the potential impact of this Merger on competition in the UK.

13. During Phase 2, we held site visits, formal hearings and calls with UH and EMIS to gather evidence from their senior business leaders, as well as through written submissions and requests for information. We reviewed a significant volume of internal business documents from each of UH and EMIS, which set out views on the relevant products and markets, future commercial strategies, and the rationale for the Merger. We held calls and sent requests for information to (current and potential) competitors in primary care EPR systems, MO software and PHM services, as well as customers and representative user groups of these products. We also obtained extensive evidence from NHS England to help us understand the relevant products and the NHS's role in shaping these markets.

14. Based on this evidence, we focused on two ways, or theories of harm, in which the Merger could give rise to an SLC. Both of these centred on whether the Merged Entity could use EMIS's position as a supplier of primary care EPR systems to harm the competitiveness of rivals supplying MO software or PHM services through partial foreclosure. We assessed these theories of harm by looking at whether the Merged Entity would have the ability to do so (eg through worsening integration with, or data access from, EMIS's primary

care EPR system, or through raising costs for rivals), whether it would have the incentive to do so (ie is it financially beneficial to do so) and finally what the impact of such a strategy would be on competition in each of the MO software and PHM services markets.

What did the evidence tell us about EMIS's position as a primary care EPR supplier?

15. EMIS's position as a primary care EPR system supplier is relevant to assess its ability to harm the competitiveness of rivals in both theories of harm. Based on evidence from the Parties, competitors and NHS customers and stakeholders, we have provisionally concluded that EMIS has market power in the supply of primary care EPR systems. This is because:

    (a) EMIS's market share in the supply of primary care EPR systems in the UK is 50-60%, with a similar share in each UK nation, and this has been stable over the last five years.

    (b) Evidence (in particular from customers) shows switching supplier is considered a complex and risky process and can involve a large financial cost.

    (c) These high switching costs are reflected in very low levels of customers switching to or from EMIS's primary care EPR system in the last five years. This low level of switching is supported by the fact that the average customer has been procuring EMIS's system for a long time.

16. NHS England told us that the existing suppliers (ie EMIS and its main rival) have an entrenched market position and that it is actively looking to stimulate new market entry. Whilst evidence suggests there will be some entry into the market in the near future, we do not currently consider this will be at a sufficient scale to deprive EMIS of its market power.

What did the evidence tell us about our first concern: harm to competition in the MO software market?

17. Evidence from the Parties and third parties shows that MO software requires customised integration with primary care EPR systems to compete because certain features and functionalities of the MO software would not be supported by the NHS's open APIs. Both Optum and its only current MO software rival have customised integration with EMIS Web for their products.

18. We considered a number of potential mechanisms through which the Merged Entity might be able to harm Optum's rival. These include worsening the

quality of the rival's customised integration with EMIS Web, raising the cost to the rival of the customised integration, and/or worsening the rival's MO software's user interface on EMIS Web. Evidence suggests the impact of any of these available strategies on Optum's rival would be to significantly impair its ability to compete including by reducing the quality of its software, slowing product development, and raising costs.

19. We also considered whether the Merged Entity could use any commercially sensitive information shared with EMIS by Optum's MO software rival to improve its own MO offering to the detriment of the rival. We have found that some proprietary information is shared with EMIS but consider, based on the available evidence relating to the nature of this information, that its disclosure would not be capable of harming the competitiveness of the rival. For example, some of the information shared with EMIS is likely to be very specific to the individual supplier, and so not of use to Optum, and the extent of information made available in relation to new products appears to be limited in practice.

20. EMIS, as a primary care EPR system supplier on the NHS frameworks, is subject to a number of provisions regarding its general behaviour as a supplier, although the evidence we gathered was mixed on the extent to which the NHS would be able to intervene under specific provisions of its frameworks to prevent the Merged Entity pursuing the potential mechanisms we investigated. This is partly because the custom integration currently used for MO software sits outside some of the NHS standards and so is subject to less oversight. Whilst the NHS is therefore likely to have some ability and motivation to detect and prevent certain behaviour, we provisionally conclude that this would not be sufficient to remove the ability of the Merged Entity to harm the competitiveness of Optum's MO rival.

21. We then considered a range of both quantitative and qualitative evidence in order to determine whether the Merged Entity would have the incentive to engage in this type of strategy.

22. We considered the profits which would be gained by the Merged Entity from customers switching to Optum's MO software relative to the profits which would be lost from any customers who choose to switch away from EMIS, as well as any wider benefits or costs to foreclosure.

23. The MO software market is small, although it is expected to grow moderately over the next five years as a result of the uptake of new products. Our analysis indicates that even if a relatively high proportion of the customers who use EMIS Web and Optum's rival's MO software switch to Optum, any gains in profit would be very small. These gains would need to be set against

any losses from switching away from EMIS Web, although given the low switching by primary care EPR system customers, we consider that these losses would be relatively small.

24. Our provisional view is that the position of the NHS in this market, including its ability to influence market outcomes (such as by updating frameworks and standards) and it seeking (or the threat of it seeking) to take a broad approach to interpreting and enforcing the existing frameworks and standards would be likely to negate any potential gains and reduce the incentive of the Merged Entity to engage in partial foreclosure. This is because, although evidence was mixed on whether the NHS could intervene under the standards (on their face), we saw evidence of effective action by the NHS in areas not strictly covered by its frameworks or standards.

25. We have not seen any evidence (including in our review of UH's internal documents related to the Merger) that Optum expected broader strategic benefits (ie beyond those considered in our assessment of lost profits) from restricting MO software rivals' access to EMIS's EPR system.

26. We also note that engaging in partial foreclosure could potentially have wider costs, such as damaging the Merged Entity's relationship and reputation with the NHS.

27. Overall, we provisionally conclude that the Merged Entity would not have the incentive to engage in partial foreclosure in the supply of MO software.

What did the evidence tell us about our second concern: harm to competition in the PHM services market?

28. Evidence from the Parties and third parties shows that primary care data held by EMIS is an important input for PHM services providers. In particular, PHM service providers' feedback indicates that this data is the most complete source of health information for PHM.

29. Evidence from the Parties and PHM services rivals shows that there are various ways to access the primary care data held by EMIS, including directly from EMIS through NHS mandated APIs or customised integration, through EXA, or indirectly through third parties such as NHS Commissioning Support Units (**CSUs**).

30. We considered a number of potential mechanisms through which the Merged Entity might be able to harm Optum's PHM services rivals. These include worsening rivals' access to data where the NHS mandated APIs are used,

degrading customised integration with EMIS, and increasing the cost of EXA. The evidence we assessed on these potential mechanisms showed:

(a) While the Merged Entity would be technically able (at least to some extent) to worsen Optum's rivals' access to data where the NHS's mandated APIs are used, evidence also suggests rivals would be likely to report this behaviour to NHS England or other bodies. NHS England told us that it would investigate all such complaints and is active in resolving any breaches of its standards. Moreover, PHM services providers had mixed views on whether the Merged Entity would engage in this behaviour in practice.

(b) We found limited evidence indicating that customised integration is currently used by PHM services providers to access data held by EMIS. Optum's rivals' views were mixed on whether customised integration is likely to be used in the future, but EMIS has only received one request to set up a customised integration in the last three years from a PHM services provider.

(c) We found that only one PHM services provider (excluding the CSUs) currently uses EXA to access data held by EMIS. While several third parties raised concerns about the pricing and strategy in relation to EXA, some of these concerns were not related to the Merger. We found that at least some customers would be protected from price increases because EXA is included on certain NHS frameworks, and NHS England would monitor and react to complaints related to price increases of EXA. NHS England also told us that it has plans to modernise its frameworks including the mandated APIs, which could further mitigate any risks associated with data access through EXA for PHM services providers.

31. Overall, we provisionally conclude that the Merged Entity would not have the ability to partially foreclose Optum's PHM services rivals.

Provisional conclusion

32. Our provisional conclusion is that the Merger would result in the creation of a relevant merger situation, but that it may not be expected to result in an SLC in relation to the supply of either MO software or PHM services in the UK.