

Institute of Actuaries of India

Subject ST1 – Health and Care Insurance Specialist Technical

May 2015 Examinations

INDICATIVE SOLUTIONS

Introduction

The indicative solution has been written by the Examiners with the aim of helping candidates. The solutions given are only indicative. It is realized that there could be other points as valid answers and examiner have given credit for any alternative approach or interpretation which they consider to be reasonable.

Solution 1:

(i) The points that would be included in the note are

- Propensity to buy versus the need to sell
 - health insurance is typically sold unless it is legal requirement to buy
 - Customers natural tendency is to avoid buying health insurance as the need seems distant or people are simply unaware that the products exist
 - A healthcare insurance product is somewhere between a need and a luxury
 - IP insurance – usually real need but public generally unaware
 - PMI – extent of need depends on level of State provision
 - CI insurance – need is uncertain but provides peace of mind and windfall opportunity, so often bought (desirable luxury)
 - LTCI – extent of need is strongly affected by State provision
- Regulatory and tax regime
 - Govt. may impose restrictions on insurers, usually with the stated aim of protecting policyholder, such as type of products, premium rates, commission to intermediaries etc. These will influence design, sale and profitability.
 - Capital and solvency requirements will have an impact on the design, price (and hence demand for products) and/or profitability of the insurer
 - Tax incentives on premium and/or policy proceeds will make products better value for money and so help sales
 - Different tax treatment for different types of products can make it cheaper to provide benefits in one form of business than another
 - Method and level of taxation of insurers will have impact on profitability and price of the products; for example, I-E method of taxation often produces zero tax for protection products
- Economic and other influences
 - Inflation will erode a policy's benefits in real terms and so the product design may have to allow for this
 - Higher than expected medical inflation will lead to lower profitability for insurers eg. policies that provide indemnity benefits such as PMI
 - Inflation of expenses higher than that allowed for in the premium rates will also erode insurers' profitability
 - Business optimism in general will increase demand for products and thus increase sales
 - Employment security - high security will increase sales;
 - low security will increase claim payouts (eg. IP policies may be seen an alternative source of income in times economic downturn) and hence lower profits
 - Political environment – will affect the economy and hence demand for products; but can significantly affect demand through national policy on promoting State of private healthcare provision

[9]

(ii) Only age as rating factor for Hospital Cash

- Easy to explain and understand – it is generally appreciated and understood by the customers that the cost of insurance increases with age as people fall sick more often as they age
- If it is the market practice to use only age for premium rating then the suggestion makes sense
- In the group platform sometimes only data that is available is age of the members of the group so it is easier to compute premium
- However, there are significant differences between gender when it comes to frequency of hospitalization and in some cases the length of hospitalization (eg. pregnancy, child birth etc.). If the premium rates are not differentiated by gender then there is cross-subsidy between the genders involved. This leads to significant risk particularly if other insurers' rates vary by age and gender.
- The size of the per-day-amount payable is also a significant factor that has influence on the length of hospitalization and so how long the benefits will be paid for a given hospitalization. The higher the per-day-amount the greater the tendency to stay longer in the hospital. Again, there will be significant cross-subsidy risk and you would be more or less attractive in some age and per day benefit bands compared to other insurers who use per day amount payable as one of the rating factors.
- Geography also plays an important role depending upon the access to hospital and availability of hospital beds. Again, not keeping it a rating factor will involve additional risks especially if other insurers use it.
- The longer the premium rate guarantee the higher the risk involved in using only age as the rating factor as there is no ability to adjust the price if actual business mix in terms of gender, per-day-amount, geography etc. differs from that assumed.

[6]**[15 Marks]****Solution 2:****(i)****(a) Linked-claims period**

This refers to the provision in IP insurance contracts where if a claimant returns to work after illness, but falls ill again within the linked-claims period, he/she can start to claim again (rather than having to serve out another deferred period).

The existence of linked-claim period encourages claimant return to work (fully or partially) early without worrying about the risk of having to serve another deferred period if he/she falls sick shortly after returning to work.

For example, under an IP insurance policy with a deferred period of 6 months and a linked-claims period of 3 months, if sickness recurs within 3 months of returning to work, the claim payout starts immediately without the need to serve the deferred period again.

[2]

(b) Over-insurance

Over-insurance refers to a higher than appropriate replacement ratio under IP insurance, where the replacement ratio is the ratio of insurance payout to the pre-disability income. Higher replacement ratio will be a disincentive for claimants to return to work.

There are several ways in which over-insurance can occur:

- Over-insurance from outset
- Over-insurance arising due to salary increases not keeping pace with the increase in scale of benefits which may happen due to change in jobs
- Reduction in tax applied on claim payouts and hence increase in net benefits payable to the insured
- Multiple policies or receipt of some undisclosed sources of income

Regular reviews on appropriateness of cover and unambiguous policy conditions on likely action in event of over insurance at claim stage can help reduce risk of over insurance under IP Policies

[2]

(ii) Age-at-entry pricing with guaranteed renewability for life

- ‘Age-at-entry’ pricing refers to calculating premiums in PMI Products with allowance for increasing probability of claims as the age of the policyholder increases over the prospective period of cover
- Therefore, such policyholders are not subject to age related increases and their premium is fixed at the time of taking out the insurance
- The proposal here is that the premiums fixed should not be changed throughout the life of the policyholder as long as the policyholder continues to renew the contract every year
- It provides the policyholder with great deal of certainty as to what premiums are payable for his/her entire life – an attractive proposition
- On the other hand, the premium will be significantly heavier initially compared to a PMI product where the premium increases every year with age, due to
 - o Difficult for insurers’ to predict medical inflation (both frequency of sickness and cost of treatment) long term into the future and so will have to make more cautious pricing assumptions

- Stringent regulatory reserving requirements (due to longer and significant guarantee) to ensure the insurer has enough money set aside to meet future claims outgo
- There is also added uncertainty around persistency – policyholders may lapse and re-enter if the price falls or stick around if they are sick and/or price rises – again, the need to be cautious in pricing
- However, the level and type of cover bought now may not be appropriate in the future especially when policy is taken out at a young age. Difficult to predict if the cover bought today would be adequate in the long run. Additional cover may need to be bought in the future at currently unknown premium rates.
- From regulatory perspective, this is in the interest of the policyholders as there is certainty as to the premium outgo and guaranteed renewability for life provides protection against insurers' sharply rising rates or through stringent underwriting try to avoid older and sick lives being continually insured
- On the other hand, such a guarantee comes with significant cost and the policyholders may not be able to weigh the cost vs the benefits of long term guarantee and so reduced propensity to buy the cover
- There is also increased risk of insolvency for insurers due to greater level of uncertainty surrounding future morbidity incidence and cost of healthcare
- The onerousness of this provision may also put off some insurers from offering the product at all leading to reduced business for insurers and reduced choice for customers
- If the pricing of the product turns out to be inadequate, insurers may resort to stringent claim underwriting leading to lot of claim disputes; reducing public confidence in the insurance industry which is the last thing that the regulator would like to happen
- Alternatively, the insurers would try to pass on the additional claim burden from the existing policyholders onto new policyholders by charging them more either explicitly or implicitly – new generation cross-subsidizing the old. This will affect sales and would likely not be permitted by the regulator from the point of view of treating customers fairly.
- The insurer will also have to set paid-up /surrender values as there will be significant reserves building up in the early years. It will be tricky and challenging to set values so as to maintain equity amongst leaving and staying policyholders.
- Significant exposure to such long term guarantee business will be seen negatively by rating agencies and public and so could impact the share price of the insurer – something that the shareholders will not be happy about
- With significant reserves building up and long-term liabilities, the product will be more sensitive to investment returns and ALM; so, need to strengthen investment department

- Reinsurers may not be willing to offer such guarantees and so limiting the ability for the insurer to transfer/share risk
 - For intermediaries, the guarantee and premium certainty will be a great sales pitch and thus boost sales; on the other hand, depending upon the commission structure, the intermediaries might prefer to have yearly churning and selling new type and level of cover from time to time
- [8]

(iii) Setting morbidity assumptions for IP

- Morbidity assumptions required for IP are – claim inception and claim termination rates
- No past IP experience in the market; however, there is lot of experience both within the company and in the market for PMI and hospital cash that can be leveraged
- Starting point would be to look at the past experience of PMI and hospital cash products – recent industry and internal studies
- Industry study might only give results at a high level (eg. age groups) and there could be data quality and data aggregation issues; further, there will likely product, underwriting, target market etc. differences amongst different companies participated in the study
- Need to look at internal study for finer data cuts and make sensible adjustments to the industry experience
- PMI and hospital cash experience will give incidences of sickness and length of treatment/hospitalization
- Particular focus would be to map the target market for the IP product – white collar salaried employees – Employer-employee group products experience from white collar industries will be a close match; individual products experience where the occupation data field available could be used as well
- Need to map that experience that lasted beyond 60 days
- However, people may be away from work recuperating post hospitalization/ treatment where IP claim payment would continue that needs to be allowed (for example, musculoskeletal issues); this would involve identifying incidence of such illness from the PMI and hospital cash data and working with medical experts as to how long they would prevent people from returning to work; Given the low income replacement ratio of 20%, there is significant incentive for claimants to return to work as soon as they are physically able to
- Particular care needs to be taken in estimating the claim termination rates – termination can occur due to death or recovery from illness – any disabled lives mortality experience available could be used for termination due to death;

- Experience needs adjustment for medical trend from the mid-point of the period to which the experience relates to the mid-point of the future period to which the derived rates would apply
- Level of underwriting for individual IP would be more stringent than that of yearly renewable PMI and hospital cash products; a sensible adjustment to this effect in consultation with the underwriters will need to be made
- Claim inception and termination rates so derived from relevant PMI and hospital cash experience and adjusted for product specifics would then need to be compared with rates from other markets where there is product specific experience for reasonableness
- Consultants and reinsurers would have experience in other markets and views on how the local experience would differ – so, it is another independent source to check reasonableness of the rates derived

[8]

[20 Marks]

Solution 3:**(i) Considerations for including an illness under CI insurance**

- It is a condition perceived by the public to be serious, either life threatening or lifestyle threatening, and to occur frequently.
- Market research has shown that some diseases are feared by public out of proportion to their actual incidence – this may reflect active awareness campaigns are high profile in the press
- Insurers do add such conditions to the list of covered conditions that are very low in frequency but feared by the public – it adds little to the cost but increases the perceived value of the CI product or its comprehensiveness significantly
- Ideally illnesses should not be so rare that there is very negligible chance of occurrence, so that each add value in their own right
- Each condition covered can be defined clearly so that there is no ambiguity at the time of claim
- Avoiding ambiguity is not easy as the nature of the benefit structure leads to complex medical terminology – so, for example, cancers are usually restricted to those where malignant tumors have invaded adjacent tissue
- Sufficient data are available to price the benefit – any condition included must be capable of being priced as accurately as possible both now and in the future
- Another desirable feature of a critical illness is the ability to avoid anti-selection; an analysis of early claims would help identify the propensity of a particular condition to anti-selection

[3]

(ii) Product design features and their implications for stakeholders

- The severity can be defined either in terms of well defined stages of the cancer or the site of the cancer (for example, blood cancer is more serious than skin cancer) or a combination of both
- The design may not quite fit within the typical critical illness characteristics covered in part (i) above – it can be positioned to cover just about the cost of treatment of different types of cancer and in that case acting more like a medical expenses for cancer cover; it depends upon the sum assured restrictions and how the customers perceive and so how much cover they buy
- The product can be seen to be better aligned to the customer need as the consequence of cancer depends on its severity
- The design to some extent alleviates the concern of claim disputes and high repudiation rates associated with typical late stage critical illness products – claim not paid despite someone is diagnosed having cancer but does not quite meet the policy definition of cancer
- Difficult to define early stages of Cancer unless there are well established protocols for the illnesses; there may not be standard industry definitions if this is a new design for the market and so lot of effort will have to go into defining the severity
- The product will be complex and so would require trained intermediaries to sell the product, however, arguably this design is less prone to mis-selling than the traditional one lump sum on severe cancer or CI product
- Availability of claim payouts at early less severe stages of the cancer would increase the popularity of the product and also facilitate cash for early treatment and thus possibly preventing the disease from advancing to later and more severe stages
- It is complex to price due to lack of data – need to estimate incidence of different stages of cancer and their probabilities or progression into late stages
- If it is a new design to the market, it could help differentiate the insurer in terms of innovative protection solutions and hence help build reputation and boost sales
- The product will be more expensive than a late stage cancer only product and so there will be some amount of education and effort required to make the customers see the value of the product
- Claim underwriting will be more intensive and administration systems need to be modified appropriately as there will be more than one payout under the contract [7]

[10 Marks]

Solution 4:**(i) key risks and monitoring**

- Main risk for IP business relates to claim inception rates being higher than expected and/or claim termination rates being lower than expected
- This can be monitored through regular actual to expected experience studies as well as monitoring actual to expected business mix in terms of target market characteristics build into the pricing
- Associated with this is the risk of significant anti-selection under individual contracts and a minor such risk under group contracts
- Monitoring will be through early claims analysis and feed back into the underwriting process
- There is also, in the case of individual contracts, the risk of selective lapse – good lives leaving and sick lives staying on;
- monitor through regular lapse studies split by distribution channel and duration
- There is a risk of lack of diversification writing only IP business – IP claims experience moves with economic cycle; Monitor economic downturn, changes to State provision for disabilities, any trend in legal interpretation of disability definitions and changes to taxation that might lead to over-insurance risk

[3]**(ii) Operational risk monitoring**

- Operational risk usually arises due to inadequate controls over processes, people and systems or from external events. This is the risk of loss due to fraud or mismanagement etc.
- The argument by the COO has some merit in the sense that the company writes only one line of business (IP) and so relatively simple operation than other insurers who write different lines of businesses.
- The company will be using counter parties that give rise to credit risk – risk of default by the counter party; however, there is also associated operational risk due to lack of direct control and additional administrative aspects involved. So, there are two distinct elements of risk that need to be looked at separately in order to pin point the problem area and address them
- There are some risks categorized under Operational risk which can be accounted for in the measurement of other risks. For example, risk of wrong excessive claim pay outs due to admin lapses will reflect in the morbidity risk.
- There are others, however, categorized under Operational risk, that do not get accounted for in the measurement of other risk. For example, Regulatory fines, fraud, adverse publicity etc.

- It is, therefore, preferable to monitor operational risk separately while recognizing overlap with other risk.
- Separating monitoring also helps the Operations department to set goals to work on areas for improvement and not mislead by having what is essentially operational risk masked in other risks and thus not getting effectively addressed.

[4]

(iii) Response to falling interest rates

Impact of falling interest rates

- Proceeds from the short-term assets can no longer be reinvested at the rates needed to meet the liabilities – this is more of an issue for Individual IP than the group version
- If the term of the assets is shorter than that of the liabilities, then the fall in interest rates would increase the value of the liabilities by more than the value of the assets – this will then increase the reserve and capital requirements.
- On the asset side, low yield curve results in increased market value of bond assets (fixed interest backing assets) both g-sec and corporate bonds.
- Reduces return to shareholders on their invested capital
- Impact depends on how matched the assets are to the liabilities. The closer the matching the lower the impact of movement in interest rates

Possible response by the company

- First of all, the reason of interest rate cut should be analyzed; Is this some sort of market correction? Or, is this cut is expected to revert back in future years?
- Check how competitors' react to this; but, recognize the unique 'IP' only portfolio would mean your exposure to interest rate movements will likely be different from others
- If this is a temporary cut, then re-pricing is not advisable, especially when competitors are not re-pricing, to avoid risk of selective lapses due to increase premium
- Individual IP pricing is sensitive to interest rates, group IP is to a much lesser extent
- What are the market long term expectations about interest rate? If the long term interest rate expectations have changed then products should be re-priced to ensure expected return to shareholders on their capital
- If the current prevailing interest rates are still higher than best estimate interest rates used in the pricing model then re-pricing is not required.
- Since the Company is writing Individual Income Protection business and these are long term contracts, the company needs to re-look at investment strategy in the economic scenario where interest rates are falling.
- Hence, the extent of assets and liabilities matching is very important. This might results in revised investment strategy to reduce ALM risk.

- Making changes to investment strategy also involves additional expense and this needs to be weighed against the risk as well. The level of available free assets will drive this thinking.
- Company's free assets should be considered before deciding upon any new investment strategy. If the Company has sufficient amount of free assets and has appetite to take risk, then riskier investment strategy can be adopted.
- If hedging is permitted by regulator, then some insurer might opt for hedge further reduction in yield curve. However, this could result in increase in counterparty risk.
- The insurer could consider investing any free assets in higher yielding assets, such as equities, in order to generate higher expected returns for shareholders.

[8]

[15 Marks]

Solution 5:**(i) Reasons for analysis of surplus**

- To show the financial effect of divergences between the valuation assumptions and the actual experience
- To expose which assumptions are more financially significant
- To show the financial effect of writing new business
- To provide a check on the valuation data and process, if carried out independently
- To identify non-recurring components of surplus, thus enabling appropriate decisions to be made about the distribution of surplus
- To provide information on trends in the experience of the company

[3]

(ii) Data required for the experience study

- Worse than expected morbidity experience means one or more of the following
 - o More than expected number of insured getting disabled
 - o Recovery from disability taking longer than expected
 - o Disabled lives living longer than expected
 - o Depending upon the age at disability, higher or lower than expected number of people qualifying for total and permanent disability
- Expected basis (pricing assumptions) for each of the above
- For exposed-to-risk calculation, the following would be required:
 - o Policy number
 - o Date of birth or age at entry
 - o Gender

- Smoker status
- Underwriting status (standard or sub-standard)
- Deferred period chosen by the policy holder
- Policy status (inforce/lapse/paidup/in-claim)
- Occupation
- Industry
- Residence
- Distribution channel
- Policy commencement date (or duration from entry)
- Date(s) of lapse/disability/recovery/death, if applicable
- Policy original face value
- Policy paidup value, if applicable
- For claims, the following will be required:
 - Policy number (to link the corresponding exposure record)
 - Date of claim event
 - Status of claim (during deferred period or in-payment or TPD)
 - Date of notification (to enable IBNR to be calculated)
 - Cause of claim
 - Date of claim termination, if applicable
 - Cause of claim termination (recovery/death/TPD)
- Additionally, the consultant would require any changes to the underwriting or claim processes over time to be able to explain any trends over time

[5]

(iii) Actions that the company can take

- Change product design features
 - introduce linked-claims period
 - not offer '3 months' deferred period
 - strengthen benefit triggers ('Own occ' to 'Any occ', '2 out of 6' to '3 out of 6' ADLs)
 - observation period for TPD increased from 6 months to, say, 24 months
- Review and select more appropriate distribution channels/sales methods
- Revise wording and format of sales literature to minimise risk of anti-selection
- Review and strengthen underwriting processes
- Review and strengthen claim processes
- Introduce or strengthen claim counselling to encourage faster return to work
- Review reinsurance arrangements

- Stop selling to unprofitable segments and or increase sales to, for example, certain age groups, industries, occupations, distribution channels
- Revise the mechanics of commission/clawback and other incentives to improve persistency experience of good quality business

[5]

[13 Marks]

Solution 6:**(i) Types of reserves**

- Unearned Premium Reserves - the balance of premiums received in respect of periods of insurance not yet expired
- Unexpired Risk Reserves - reserve in respect of the above unexpired insurance premium where it is felt that the premium basis is inadequate. This is important given the 3-year premium rate guarantee
- Outstanding Claim Reserves - reserve in respect of claims notified to the insurer but not yet fully settled
- Incurred but not reported (IBNR) Reserves - reserve in respect of claims that have arisen but that have yet to be notified to the insurer
- Incurred but not enough reported Reserves - as above but where it is felt that not all detail has yet been submitted and a provision needs to be established for the remainder
- Equalization or catastrophe reserves - reserves where it is felt that the current year is atypical and amounts will have to be held back for abnormal events – this helps smoothen premium rate increases
- Claim In Transit - reserve in respect of claims reported but not assessed, or not recorded.
- Since the product offers guaranteed renewability for life, there may be a requirement to set aside a premium deficiency reserve if there are limitations in terms of rate increases, especially, for elderly lives and mitigate reputation/selective withdrawals risk for any large jump in premium rates from one year to another

[4]

(ii) a) Case estimates are suitable when

- Claims are unusual
- Portfolio is insufficiently large
- Claims are unstable

Objective : To calculate IBNR

[2]

b) Statistical estimates are suitable when

- Particular types of homogeneous claims
- Portfolio is large
- Claims are stable
- Objective : To calculate IBNR

[2]

(iii) Factors to be considered in Case estimate basis:

- Procedure type
- Procedure Cost
- Hospital (medical centre) to be used
- name of surgeon, consultant or other medical principal
- Inpatient duration and associated costs
- Age
- Gender
- Past claims history of claimant
- Policy coverage (Excess limits, limits etc.)
- Recuperation benefits
- Current level of medical inflation
- Anticipated level of medical inflation
- Medical outlook (advancement etc.)

[3]

[11 Marks]

Solution 7:

(i) The process of determining purchase price

- Purchase price (Appraisal Value) = Embedded Value + Good Will
- Embedded Value = Shareholders Net worth (SNW) + Value of future profits
- SNW is calculated as Market Value of assets less Market value of liabilities
- SNW includes any expense overruns
- Value of future profits is calculated as discounted value of future profits. In other words, this is release of MAD built in reserves.
- Appropriate assumptions need to be used to calculate Appraisal value. This includes termination assumptions, expense assumptions, mortality and morbidity assumptions, risk discount rates, interest rate assumptions and inflation assumptions.
- The company has to choose model points on which business projections will be made.
- The risk discount rate will be based on the purchaser's required rate of return on the transaction allowing for the inherent risks and uncertainty within the cashflows.

- As the company is being valued by the purchaser, more prudent assumptions will be used for sensitivity calculations.
- Assumptions made will be based on those for equivalent items in the purchasing company where relevant (life insurer) and based on information in the statutory returns of the target company and also may be compared to those in the statutory returns of similar health and care insurers and other publicly available information such as industry experience surveys
- Mortality/morbidity assumptions need to be based on the policyholders of the target company
- Should allow for costs and recoveries of any reinsurance arrangements allowing for any treaty renegotiations
- Allow for commission on current structure for existing business
- Allow for own expected post takeover policy expenses taking into account expense inflation
- Allow for potentially reduced costs due to synergies between the businesses e.g. expenses, reserving capital, tax
- Persistency will need to take into account the profile of business and any effects brought about by the takeover. For example, there may be policyholders who are unhappy about the takeover and therefore lapse
- Use own methodology and assumptions for statutory reserving and allow for the effects of combining the business into own existing solvency position, e.g. on any minimum reserving requirements
- Investment return will be consistent with risk discount rate and expense inflation taking into account the post takeover investment strategy
- Tax will need to incorporate any changes as a result of combining the businesses and taking account of any differences between the taxation of the life and health insurance business
- Also need to allow for non policy-related costs of takeover e.g. redundancies, costs of policyholder communications, potential relocation costs etc.
- The goodwill component, which reflects the value of expected future new business, should also be added.
- This will be based on current new business volumes and expectations of potential future market performance of the target company e.g. based on their business plans, if available.
- The value of this new business should be estimated e.g. based on new business disclosures, if available.
- Assumptions used should be as for the existing business, allowing for any known differences e.g. changes to the commission structure post integration. Any planned changes to marketing strategy should be taken into account.

(ii) Other factors

- How willing is the target company to sell
- Does it meet all of the takeover objectives?
- History of industrial relations
- Internal controls e.g. fraud prevention, risk management
- Customer base compared to its existing customers e.g. potential to cross sell its current products
- Range of products
- Range and quality of distribution channels
- Ease of administering existing business
- Any possible legacy issues
- Regulatory constraints
- Quality of systems, Quality of illustration and alteration systems
- Quality of policy records, literature
- Claims and underwriting processes
- Complaints history and outstanding complaints
- Any potential mis-selling issues and any other outstanding reputational/legal issues
- Location of the target company
- Plans for the workforce, offices
- Fit with existing distribution channels
- Integration/migration plan
- Any additional costs of the takeover (e.g. advisors, legal, stamp duty etc.)
- Payment method e.g. cash only and availability of sufficient existing capital to fund the purchase or, if not, ability to raise it and the related cost of capital
- Credit rating of target and likely impact on own credit rating
- Capital structure of target
- Quality of data
- Quality of any assets being purchased and how well matched they are
- Any high risk investments e.g. derivatives
- General economic outlook
- Whether a process can be put in place for some repayment if the quality of business/ accuracy of takeover information is not as good as expected
- similarly if systems, data etc not as good as expected
- Quality of any third party arrangements and will they still be available e.g. Reinsurance arrangements, Third party administration, Medical providers e.g. hospitals
- Potential level of management distraction and whether it would have a negative impact on other key projects
- Margins in any key assumptions used to determine the price

- Market reaction if purchase goes ahead
- Shareholder reaction if purchase goes ahead
- Whether it is a competitive bid
- Other recent similar deals (their price, lessons learned etc)
- Need to treat customers (of both companies) fairly throughout and after the process

[7]

[16 Marks]
