

Reinsurance in Insurance M&A and Insurance-Linked Securities

by John Dembeck

Reinsurance has an important role in the ordinary course running of an insurer. Reinsurance may take the form of both proportional and non-proportional reinsurance – coinsurance and yearly renewable term reinsurance for life insurers and quota share and excess of loss reinsurance for non-life insurers. Reinsurance also plays a key role in certain insurance merger and acquisition transactions and the structure of insurance-linked securities. This article describes the uses of reinsurance in insurance M&A and insurance-linked securities and then outlines major corporate and regulatory issues relating to these kinds of transactions.

Reinsurance in Insurance M&A Transactions

Acquisition of Direct Life or Annuity Block of Business

While a block of direct life or annuity business can always be acquired by acquiring the insurer that wrote the business, a buyer can limit its acquisition to the block of business by means of reinsurance. Historically, these kinds of transactions were done by means of assumption reinsurance – reinsurance that purported to transfer (assign) the underlying policies from the selling insurer to the acquiring insurer. However, since the policyholder was not usually a party to the assumption reinsurance agreement, issues were raised about whether the selling insurer could be released from the liability under the

transferred policies without the consent of the policyholder. Since the mid-1980s, many U.S. courts have held that there is no novation under an assumption reinsurance agreement where the policyholder has not consented to the policy transfer – the selling (ceding) insurer remains liable under the policy. In addition, beginning in the 1990s, a number of states enacted laws regulating assumption reinsurance based on the NAIC Assumption Reinsurance Model Act (which included required policyholder notice and deemed consent if the policyholder did not object to the policy transfer). While the acquiring insurer can agree to indemnify the selling insurer against this liability, this is problematic when the acquiring insurer subsequently fails and cannot honor any such indemnity. Under assumption reinsurance, the selling insurer will generally transfer assets to the acquiring insurer equal to policy reserves less a ceding commission representing the present value of future profits for the block of business being transferred. If the acquiring insurer fails and the selling insurer is held liable, the selling insurer will have to fund the obligations from its remaining assets.

Assumption reinsurance of life and annuity blocks of business fell out of favor in the U.S. in the late 1980s and early 1990s due to the need for policyholder consent to release the selling insurer from future policy liability. While assumption reinsurance is not widely

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Letter from the Editor

This second issue of the *Debevoise & Plimpton Financial Institutions Report* goes to press as subprime mortgage problems and risk reassessment affect the credit markets as a whole and as financial institutions seek to complete transactions in challenging market circumstances.

In this issue we present articles on insurance transactional basics: the use of reinsurance to implement transactions. We also report on legislative and regulatory developments in the U.S., the U.K. and India that will affect transactions in the financial sector, and case-law developments in England. The articles, contributed by Debevoise lawyers in New York, London and Hong Kong, underscore the global nature of the insurance industry.

Regulators and commissions in the United States are exploring the advantages and disadvantages of moving to a more principles-based regulatory model, with less reliance on detailed rules. One of this issue's articles discusses the lessons that can be learned from the approach of the U.K. Financial Services Authority.

We will monitor developments in the implementation of the European Commission's Solvency II directive proposal, published in July. Solvency II will make major revisions in the way that European regulators supervise the financial strength of European insurance companies, in light of all the risks they face. Timing of full implementation remains to be seen. And its implications for M&A transactions should be watched with interest. Will larger companies be better able to diversify their risks, giving them an advantage in capital requirements? Will such an advantage propel consolidation for smaller European insurers?

We will monitor these and other developments and will continue to report on them in the *Debevoise & Plimpton Financial Institutions Report* and in Client Updates.

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Editor-in-Chief

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Special Purpose Financial Captive Insurance Securitizations: Newly Enacted Legislation in Vermont

by Thomas M. Kelly and Alexander R. Cochran

Vermont recently enacted legislation regulating special purpose financial captive insurance companies (the "Vermont SPFC Act") which became effective on July 1, 2007. The Vermont SPFC Act was drafted by the Vermont Department of Banking, Insurance, Securities & Health Care Administration (the "Vermont Department of Insurance") and it adds provisions to Vermont's existing captive insurance law to allow for a securitization transaction involving a special purpose financial captive insurance company. Our firm submitted comments on the Vermont SPFC Act to the staff of the Vermont Department of Insurance as part of the public comment process.

Vermont is currently the on-shore leader by number in captive insurers – following only Bermuda and the Cayman Islands in the number of captive insurers licensed globally. To date though, on-shore insurance securitizations have predominantly been organized using South Carolina captive insurers, at least in part due to the existence of South Carolina's special purpose financial captive act (the "South Carolina SPFC Act"), which was enacted to facilitate such transactions. The Vermont SPFC Act will likely promote Vermont as a potential alternative to South Carolina for insurance securitization transactions.

The Vermont SPFC Act is modeled after the South Carolina SPFC Act and, like the South Carolina SPFC Act, the Vermont legislation generally provides for: the organization and licensing of special purpose financial captives; securities to be issued by special purpose financial captives; permitted reinsurance; regulation of assets to be held

by special purpose financial captives; and annual reports by special purpose financial captives.

More specifically, some of the notable similarities to the South Carolina SPFC Act include:

- *Plan of operations and amendments thereto.* The Vermont legislation includes a requirement that a plan of operations including a complete description of the proposed transactions be submitted to and approved by the Vermont Department of Insurance and that any amendments to the plan of operations be approved as well.
- *The ability of the regulator to exempt a special purpose financial captive from statutory and regulatory provisions.* The Vermont SPFC Act allows the Vermont Department of Insurance to exempt a special purpose financial captive from provisions determined to be inappropriate based on the captive's plan of operations.
- *The standard for amending orders of the Vermont Department of Insurance.* An order issued to a special purpose financial captive in Vermont can generally only be amended or modified with the consent of the captive insurer or upon a showing of clear and convincing evidence by the Vermont Department of Insurance that such an amendment or modification is necessary to avoid irreparable harm to the captive or the ceding insurer.
- *Rules for licensing sponsored captive insurance companies as special purpose financial captives.* The Vermont SPFC Act specifically provides that its

provisions will apply to a sponsored captive insurance company (a protected cell company) and sets forth rules regarding the licensing of a sponsored captive insurance company as a special purpose financial captive insurance company.

In addition to Vermont, Delaware and the District of Columbia are in the process of drafting or have recently passed special purpose financial captive legislation that could further expand the choices in terms of on-shore jurisdictions for insurance securitizations

There are also some important differences between the Vermont and South Carolina SPFC Acts, including:

- *Pre-approval of payment formulas.* Like the South Carolina SPFC Act, the Vermont SPFC Act provides that a special purpose financial captive can make periodic written requests for the payments of interest and principal on surplus notes and other debt obligations. However, unlike South Carolina, Vermont also allows the

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Vermont SPFC Act

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Department of Insurance to approve a formula or plan, included in the plan of operations, for the payment of interest and principal with respect to surplus notes and other debt obligations (in South Carolina, the Director of Insurance may approve such a formula or plan simply "to provide guidance in connection with his ongoing review of requests to approve the payments on and principal repayments of surplus notes"). Although it is unclear the extent to which the Vermont Department of Insurance will "hard-wire" a payment formula for debt repayment into an order (which as discussed above, can only be modified in limited circumstances), this provision could potentially give greater certainty to a monoline or purchaser of debt obligations as to the terms of repayment.

- **Potentially broader applicability of the Vermont SPFC Act.** The South Carolina SPFC Act expressly contemplates only reinsurance agreements secured by a reinsurance trust and while, in our

experience, the South Carolina Department of Insurance has authorized other arrangements such as funds withheld reinsurance transactions, the Vermont legislation does not contain such an express limitation and generally contemplates a wider range of transactions.

- **Greater flexibility in drafting transaction documents.** Unlike the South Carolina SPFC Act, the Vermont SPFC Act does not broadly prescribe required provisions for reinsurance and trust agreements. This is useful, because the requirements of the South Carolina SPFC Act sometimes conflict with reinsurance credit rules of the ceding insurer's state of domicile.

One additional item of note is that the Vermont SPFC Act will apply not only to new special purpose financial captives, but also to captive insurers previously licensed by Vermont that are engaged in or will be engaged in insurance securitizations. Accordingly, the Vermont Department of Insurance may require existing captive

insurers to take "any action that the commissioner determines is reasonably necessary to bring such captive insurance company into compliance with [the Vermont SPFC Act]".

Finally, in addition to Vermont, Delaware and the District of Columbia are in the process of drafting or have recently passed special purpose financial captive legislation that could further expand the choices in terms of on-shore jurisdictions for insurance securitizations and it would not be surprising if additional states updated their existing captive insurance acts to specifically provide for securitization transactions as well. ■

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Principles-Based Regulation: Lessons from the U.K. Financial Services Authority

by *Jeremy Hill and Elizabeth K. Brill*

Principles-based regulation of financial services firms has been attracting increased attention and support in both the United States and Europe. In the U.K., the Financial Services Authority's ("FSA") 2007-2008 Business Plan includes a move toward a "more" principles-based regulatory approach, emphasizing increased flexibility in the way authorized firms deliver to customers the desired quality of service, eliminating redundant processes, reducing costs and encouraging authorized firms to take increased responsibility. In the United States, the Committee on Capital Markets Regulation, an independent, bipartisan committee including various leaders from the investor community, business, finance, law, accounting, and academia, studied the continuing competitiveness of U.S. capital markets. Among other conclusions, its November 2006 Interim Report recommended a principles-based regime for the U.S. Securities and Exchange Commission and self-regulatory organizations. Similarly, in January 2007, the McKinsey Report, commissioned by New York City Mayor Michael Bloomberg and New York Senator Charles Schumer to develop a comprehensive perspective on the competitiveness of the overall U.S. financial services sector, with particular emphasis on New York's contribution, was released. This report recommended that federal regulators develop a principles-based approach "to eliminate duplication and inefficiencies in our regulatory system".

Within the U.S. insurance industry, the National Association of Insurance Commissioners continues to work on its principles-based reserving and capital initiative, which emphasizes the principles of risk management, asset adequacy analysis, and stochastic modeling in setting reserves

Four Regulatory Objectives Underpinning the FSA¹

1. **Market Confidence:** "[M]aintaining confidence in the [UK] financial system", including "financial markets and exchanges".
2. **Public Awareness:** "[P]romotion of public understanding of the [UK] financial system", including "promoting awareness of benefits and risks associated with different kinds of investment or other financial dealing" and "the provision of appropriate information and advice".
3. **Consumer Protection:** "[S]ecuring the appropriate degree of protection for consumers". In determining the appropriate degree of protection for consumers, the FSA is obliged to consider the spectrum of risk presented by different transactions, consumers' need for advice and the range of experience and expertise that different consumers are likely to have.
4. **Reduction of Financial Crime:** "[R]educing the extent to which it is possible for a business carried on [by entities approved by the FSA] to be used [knowingly or unwittingly] for a purpose connected with financial crime".

¹*Financial Services and Markets Act 2000, c. 8, §§ 3-6.*

and determining capital adequacy. More generally, New York Insurance Superintendent Eric R. Dinallo has spoken in recent months about the benefits of a principles-based approach to insurance regulation, focusing in particular on the FSA regime.

What Is Principles-Based Regulation?

The precise contours of a "principles-based" regulatory regime depend on the specific industry and context. However, certain common themes characterize a principles-based approach:

- Regulation focused on broad principles of conduct rather than detailed and prescriptive rules and regulations.
- Performance against the principles measured primarily by the outcome of business conduct.

- Risk-based approach to regulation and continuous rather than episodic supervision by regulators.
- General principles supplemented with specific rules where necessary to provide clarity and direction.

According to advocates of a principles-based approach, such an approach should increase flexibility for both companies and regulators and result in a more efficient and effective regulatory environment.

The FSA

The FSA is often cited as an example of effective principles-based regulation of financial services firms, particularly by regulators and others in the U.S. advocating principles-based regulation. The FSA is an independent non-governmental body created by the Financial Services & Markets Act 2000 ("FSMA") to consolidate regulation

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of the U.K. financial services sector in the hands of one super-regulator.¹ The FSA, which regulates over 29,000 firms, was granted rule-making, investigatory and enforcement powers under the FSMA and replaced all existing principal regulators, including the Securities and Investments Board (SIB), Investment Management Regulatory Organisation (IMRO), Life Assurance and Unit Trust Regulatory Organisation (LAUTRO), Personal Investment Authority (PIA), and Financial Intermediaries, Managers and Brokers Regulatory Association (FIMBRA). Additionally, the FSA regulates some remaining regulators, such as Lloyd's, which have remaining authority for direct regulation of their own markets and has inherited functions from other departments of H.M. Government, assuming for example the regulatory role over the insurance industry once carried on by Department of Trade & Industry. Consequently, the FSA regulates a broad array of financial services firms – retail banks, investment banks, insurance companies, both life insurers and general insurers, insurance brokers and intermediaries, stockbrokers, consumer finance advisers and lenders, mortgage lenders, deposit takers, building societies (thrifts), financial advisers, friendly societies – and also acts as regulator of stock and commodity markets and as the listing authority for the London Stock Exchange.

Principles and Handbook

FSA regulation is based on a set of eleven basic principles (inherited to a large extent from SIB). These principles, which set out in simple terms the high level standards that all authorized firms must meet, are as follows:

1. Integrity – A firm must conduct its business with integrity.
2. Skill, Care and Diligence – A firm must conduct its business with due skill, care and diligence.

3. Management and Control – A firm must take reasonable care to organize and control its affairs responsibly and effectively, with adequate risk management systems.
4. Financial Prudence – A firm must maintain adequate financial resources.
5. Market Conduct – A firm must observe proper standards of market conduct.
6. Customer's Interests – A firm must pay due regard to the interests of its customers and treat them fairly.
7. Communications with Clients – A firm must pay due regard to the information needs of its clients and communicate information to them in a way which is clear, fair and not misleading.
8. Conflicts of Interest – A firm must manage conflicts of interest fairly, both between itself and its customers and between a customer and another client.
9. Customers: Relationships of Trust – A firm must take reasonable care to ensure the

suitability of its advice and discretionary decisions for any customer who is entitled to rely upon its judgment.

10. Clients' Assets – A firm must arrange adequate protection for clients' assets when it is responsible for them.
11. Relations with Regulators – A firm must deal with its regulators in an open and co-operative way and must disclose to the FSA anything relating to the firm of which the FSA would reasonably expect notice.

In addition to these eleven principles, the FSA also maintains a lengthy and detailed handbook, containing extensive rules and other guidance applicable to authorized firms.² Including over 8,000 printed pages, the handbook brings together a legacy of rules from previous regulators as well as new material reflecting the FSA's increased scope of responsibilities, including for example, materials related to the mortgage and general insurance business. In addition to the main handbook, the FSA produces

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New York State Commission to Modernize the Regulation of Financial Services

New York Governor Eliot Spitzer issued an executive order on May 29, 2007 establishing the New York State Commission to Modernize the Regulation of Financial Services to review New York's financial services statutes, regulations, rules and policies.

The Commission will reexamine New York State's regulation of financial services firms, including insurance companies, banks and securities firms, with a view toward enhancing New York's role as a leading financial center in an increasingly competitive global marketplace and rationalizing and coordinating regulation of various types of financial institutions. In particular, the Commission is charged with: (a) identifying ways in which regulatory powers may be integrated, rationalized, and changed in order to promote economic innovation and protect consumers; (b) recommending specific changes in statutes and regulations to promote competition and the growth of business, while effectively protecting consumers and businesses from unfair or unethical practices; and (c) ensuring that all statutes and regulations serve a beneficial purpose with benefits in excess of the costs imposed.

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fourteen sector-specific tailored handbooks of rules and guidance for small firms.

Enforcement

Typically enforcement actions are based on violations of both principles and rules. The FSA's Enforcement Division investigates when firms breach the rules or the provisions of the FSMA. The FSMA allows the FSA to take actions that include withdrawing a firm's authorization, disciplining authorized firms and people approved by the FSA to work in those firms, imposing penalties for market abuse, applying to the Court for injunction and restitution orders, and prosecuting various offenses. The FSA's enforcement staff prepare and recommend action in individual cases. These are then considered by the Regulatory Decisions Committee, a separate committee of the FSA. In addition, the Financial Services and Markets Tribunal provides a forum for the independent review of certain decisions made by the FSA. In some instances there could also be judicial review by the courts of FSA decisions.

More Principles and Fewer Rules

In January 2007 the FSA published its Business Plan for 2007-2008, which sets out its priorities for the current year. Notably, the plan focuses on the organization's move towards more principles-based regulation, i.e., increased reliance on the eleven principles and decreased reliance on the detailed handbook rules. This move will require the FSA to make significant changes in the scope and content of the handbook and will require increased investment in employee training and recruitment in order to augment the skills and capabilities of the FSA staff. Under the new approach, the FSA says it will give greater deference to companies' own management and controls if companies engage openly with FSA officials. In an April 2007 report on principles-based regulation, the FSA suggests that well

managed firms should see real benefits from the move toward more principles-based regulation, including "relatively lower levels of regulatory capital, less frequent risk assessments, greater reliance on firms' senior management or a less intensive risk mitigation programme".³

Benefits of Principles-Based Regulation vs. Rules-Based Regulation

Principles-based regulation of financial services firms offers several important benefits. By using a risk-based approach, it makes more efficient use of limited regulatory resources. Because it focuses on broad principles rather than detailed prescriptive rules, it increases flexibility for companies to develop effective compliance systems. It reduces incentives to identify and exploit "loop holes" and arguably reduces barriers-to-entry and enhances competition. Additionally, proponents of principles-based regulation argue that it reduces the cost and burden of regulation for regulators and companies. However, there are also benefits to rules-based regulation. Detailed rules increase predictability and certainty for regulated companies and are simpler for regulators to oversee and enforce. While a principles-based system allows each regulated entity to craft a compliance system based on the entity's business and risk profile, larger entities likely would develop a set of detailed compliance rules to ensure uniform compliance throughout the organization. Such entities would bear not only the burden of creating these compliances rules but also the risk that a regulator might later determine that its compliance system is in breach of the underlying principles. Rules also encourage more consistent practices among companies and allow a regulator to specify required disclosure to unsophisticated consumers. Under either regime, the burden of

regulation, and the associated cost of compliance, will be an important consideration. In its 2007 Insurance Banana Skins survey of over 100 insurance practitioners, brokers, regulators and analysts from over 21 countries, the Centre for the Study of Financial Innovation, an independent financial services industry think tank based in the U.K., listed the "burden of too much regulation" as the greatest risk facing the insurance industry. However, "too little regulation" also made the list – at number thirty-two. Ultimately, there is a place for both principles-based and rules-based regulation of financial institutions. The difficulty lies in finding the optimal balance. As the U.S. begins to look at principles-based regulation as an alternative to the prescriptive rules, a keen eye should be kept on how this approach continues to play out in the U.K. ■

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¹ The FMSA can be found at <http://www.opsi.gov.uk/acts/acts2000/20000008.htm>.

² The FSA Handbook can be found at <http://fsahandbook.info/FSA/html/handbook/>.

³ The Financial Services Authority, *Principles-based regulation – Focusing on the outcomes that matter* (April 2007).

Change of Control of U.S. Specialty Insurers

by John Dembeck

While it is well known in the U.S. (and perhaps worldwide) insurance community that a person that seeks to acquire control of a U.S. stock insurer must first obtain the consent of the insurer's domestic state insurance regulator, there are other kinds of U.S. insurance or risk-assuming entities for which an acquisition will also require prior state insurance regulatory consent.

U.S. Insurance Holding Company Acts

The insurance holding company acts of the various states often define an "insurer" whose acquisition requires prior consent in different ways. California, for example, defines an insurer for purposes of its insurance holding company act as "every organization organized for purposes of assuming the risk of loss under contracts of insurance or reinsurance". This is a very broad definition that may sweep up all kinds of risk-assuming entities other than stock insurers. Similarly, Texas defines an "insurer" subject to its insurance holding company act to include various mutual companies, a fraternal benefit society, a Lloyd's plan, a reciprocal insurer and a group hospital service corporation. It is important in any acquisition of U.S. risk-assuming entities to determine whether the entity's domestic state insurance holding company act includes the entity as an "insurer" and thus will require a prior consent for its acquisition.

Florida Specialty Insurers

The Florida insurance law has a special change of control law applicable to "specialty insurers". "Specialty insurers" are defined to mean any one of 11 risk-assuming entities that are licensed to do business in Florida. These include a motor vehicle service agreement company, a home warranty association, a service warranty

association, certain health maintenance organizations and a premium finance company. Significantly, this change of control law applies to any specialty insurer that is licensed to do business in the state, not just those domiciled (organized) in the state.

It is important in any acquisition of U.S. risk-assuming entities to determine whether the entity's domestic state insurance holding company act includes the entity as an "insurer" and thus will require a prior consent for its acquisition.

Unlike state insurance holding company acts, the Florida specialty insurer change of control law requires that the acquiring person file a letter of notification regarding the transaction or proposed transaction no later than 5 days after the acquisition of the securities or ownership interest. Thereafter, an application to acquire control of a specialty insurer must be filed within 30 days after the acquisition of the securities or ownership interest. In the case of an acquisition to be made pursuant to a stock purchase agreement that contemplates a subsequent acquisition closing, the Florida

Office of Insurance Regulation has indicated that each of these time periods commence with the signing of the purchase agreement. Late filings are subject to monetary penalties so it is important to identify any Florida specialty insurers early on in the due diligence process to be sure that the acquiring person has the required Florida filings ready for timely submission.

Also, unlike state insurance holding company acts, the Florida consent to a change of control of a specialty insurer need not be obtained before the acquisition closing date. However, if the consent is to be obtained after the acquisition closing date, then any material change to the operation of the specialty insurer after closing will require prior Florida regulatory consent and any material change in the management of the specialty insurer will require notice to the Florida regulator and the material change in management is subject to disapproval by the Florida regulator.

U.S. Health Maintenance Organizations

An insurance group being acquired may include one or more health maintenance organizations ("HMOs"). HMOs tend to be incorporated and authorized to do business in a single state, although an HMO may be authorized to do business in states other than its state of domicile. While most states regulate HMOs under the insurance law, other states regulate HMOs under other laws such as the corporation law or public health law.

Acquisition of control of an HMO may require prior regulatory consent under the domestic state's insurance holding company act (see above). Other states have laws regulating HMOs that subject an acquisition of control of an HMO to portions of the state's insurance holding company act. Still

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other states have laws that include provisions governing the approval or notice of modifications to the information contained in the applications for a certificate of authority submitted by the HMOs. In general, these laws and regulations set forth the information required to be included in the certificate of authority application, and then provide either that any "material modification" (or, in some states "significant modification" or even "any modification") to

that information must be approved in advance by the relevant regulator, or that the regulator must be given notice of any such modification after it has become effective. These laws typically include a 30 or 60-day "deemer" provision, meaning that if the regulator does not object to a proposed modification within the stated time period, the modification will be deemed approved. In an acquisition involving HMOs, each of these kinds of laws must be evaluated in

order to determine the regulatory requirements applicable to the acquisition of control of an HMO in a given state. ■

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NAIC Military Sales Practices Model Regulation

by Michael K. McDonnell

Concluding a drafting and comment process of several months, the National Association of Insurance Commissioners ("NAIC") adopted a Military Sales Model Regulation at its June 2007 national meeting. The NAIC created its Military Sales Working Group on December 10, 2006 to begin work on this issue in response to the federal Military Personnel Financial Services Protection Act, enacted in September 2006. This Act, which could be considered an indication of the federal government's increasing willingness to become involved in the regulation of insurance, includes a statement of intent by Congress that the states should work collectively with the Secretary of Defense to "ensure implementation of appropriate standards to protect members of the armed forces from dishonest and predatory insurance sales practices while on a military installation." The Act recommends that the NAIC report back to Congress on the extent

to which the states have fulfilled this mandate by September 29, 2007.

The model regulation provides that certain sales practices of life insurers and life insurance producers in connection with sales to members of the armed services will be considered false, misleading, deceptive or unfair for purposes of an adopting state's unfair trade practices laws. Sales practices declared to be false, misleading, deceptive or unfair under the model include, among others:

- (1) knowingly soliciting the purchase of life insurance products "door-to-door" on a military installation or without first making an appointment;
- (2) soliciting the purchase of insurance during normal duty hours, during gatherings where attendance is not optional, or in barracks or other areas prohibited by an installation commander;

(3) soliciting purchases without first obtaining the permission of the installation commander or the commander's designee;

(4) soliciting the purchase of insurance products from service members without making certain specified disclosures; and

(5) soliciting the purchase of certain life insurance products that include "side fund" features from junior service members, unless a life insurer reasonably believes that the life insurance death benefit is suitable for the service member. ■

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Possible Increase in the Foreign Investment Ceiling in the Insurance Sector in India

by *Thomas M. Britt III and Sidharth Bhasin*

The privatization of the life insurance sector in India in the 1990s generated considerable interest from non-Indian insurance companies that wanted to invest in the Indian insurance sector. However, the foreign direct investment ("FDI") policy of India limited the amount of equity that a foreign investor can own in an Indian insurance company, without having to obtain approval from the Indian government, to 26%. Recently there has been discussion to increase the FDI ceiling in the insurance sector from 26% to 49%. One of the main reasons for increasing the present FDI ceiling is to allow new capital to be introduced into the insurance sector. Increasing the FDI ceiling will allow increased foreign investment, one of the most likely sources of such new capital.

Background

Private life insurance companies in India were nationalized in 1956 when they were taken over by the Life Insurance Corporation, a government-owned corporation. They remained nationalized until the 1990s when the government of India began a privatization process, including the enactment of the Insurance Regulatory and Development Authority Act of 1999 (the "IRDA Act"), which also amended the Insurance Act of 1938 (the "Insurance Act"), and the establishment of the Insurance Regulatory and Development Authority (the "IRDA"). The IRDA is the principal insurance regulatory body in India and all insurance companies in India have to be licensed by, and comply with the regulations of, the IRDA.

Proposal to Increase the FDI Ceiling

In addition to constraining new capital injections, the current 26% foreign investment cap is a cause of concern to many foreign investors who are expected to bring expertise and know-how to India, in addition to capital, in return for their equity stake in an Indian joint venture. Many non-Indian partners in Indian life insurance joint ventures feel it is unfair that they are limited to only a 26% ownership stake when they are making significant contributions to the operating efficiencies of the business and accordingly would welcome an increase in the FDI ceiling to 49%.

Recently there has been discussion to increase the foreign direct investment ceiling in the insurance sector from 26% to 49%.

However, some private Indian insurance companies involved in joint ventures with foreign partners are apprehensive about the proposed increase in the FDI ceiling. This is due in part to the divestment provisions under the current regulatory framework. At present, it is mandatory under the Insurance Act (as amended by the IRDA Act) for Indian promoters to

reduce their ownership interest in an insurance company from 74% to 26% before the completion of 10 years of operations of the insurance company. The IRDA Act did not contemplate the foreign shareholding limit would rise from the current 26% cap to 49% and, accordingly, does not impose similar divestment requirements on foreign investors. As such, if the FDI ceiling were increased to 49% without amendment to the divestment provisions, after the expiry of the 10-year period, Indian promoters would be restricted to a 26% stake, whereas their foreign counterparts could have up to a 49% stake.

Further, private insurance companies in India are relatively new and most of these companies have been incurring losses. Since Indian promoters necessarily hold, in the early years, at least 74% in any joint venture insurance company with a foreign partner, the Indian promoters have been absorbing the larger portion of these losses. As the businesses of these companies grow over time and the companies become profitable, the Indian promoters would be required to divest their ownership interest to 26%, whereas the foreign partners would still be allowed to hold 49%. Thus, even though a larger share of the losses in the initial years of operation of the insurance company were borne by the Indian promoters, it would be the foreign partners who would receive the larger portion of the profits of such insurance company in later years.

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Possible Solutions

It is still uncertain whether or not the Indian government will increase the FDI ceiling to 49%. However, if the government does decide to increase the FDI limit, then it is likely that local partners will insist upon the amendment of the divestment provisions under the Insurance Act and the IRDA Act.

The simplest solution would be to eliminate the mandatory divestment concept altogether and allow both Indian promoters and foreign investors to make free market choices about whether and when to divest. Another possible solution would be to amend the Insurance Act and the IRDA Act to make the divestment provisions applicable to both foreign investors as well as Indian promoters. That is, both the foreign investors and the Indian promoters would be obligated to divest their respective ownership interests to 26% before completion of 10 years of operations.

Alternatively, the government could amend the divestment mechanism in a manner such that, after divestment of the

shareholding to the public, the residual shareholding of the Indian promoter and the foreign partner would be in the ratio of 51:49, in favor of the Indian promoter. Thus, since the Indian promoters are required to divest their ownership to 26%, the foreign investors would, under the revised provision, be obligated to divest their ownership to 24.9%, in order to maintain the 51:49 ratio in favor of the Indian promoter.

Any one of the above amendments to the divestment provisions under the Insurance Act and the IRDA Act would likely ease the apprehensions of Indian promoters and would make it easier to garner additional support for the proposal to increase the FDI ceiling in the insurance sector to 49%.

Conclusion

The proposal to increase the FDI ceiling in the insurance sector in India is still being debated by the legislature. Given the strong opposition from certain political constituencies in India, it is uncertain whether or not the proposal will be adopted. It would likely help if the proposal were also to include a proposed

amendment to the divestment provisions under the Insurance Act and the IRDA Act (such as the amendments suggested above). However, until a final decision is taken by the Indian government on raising the FDI cap in the insurance sector, many of the existing joint ventures will come under continuing financial pressure due to the inability of non-Indian shareholders to inject additional capital into the company. ■

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National Insurance Act of 2007

Senators Sununu (R-NH) and Johnson (D-SD) introduced S.40, the National Insurance Act of 2007 ("NIA"), on May 24, 2007 and Representatives Bean (D-IL) and Royce (R-CA) introduced a nearly identical bill, H.R.3200, on July 25, 2007. The NIA is a comprehensive bill that would establish a federal insurance regulator to supervise the activities of federally chartered insurers, federally chartered insurance agencies and federally licensed insurance producers. All aspects of regulation would be subject to federal standards – organization, licensing,

financial, product and market regulation, reinsurance, corporate transactions, producers and holding company regulation. A national insurer would be subject to receivership under federal law. Subject to limited exceptions, a national insurer would not be subject to the application of state laws, including state insurance laws. The effect would create two parallel insurance regulatory systems – an insurer could remain in the state system and not be subject to federal regulation or an insurer could opt into the federal system and not be subject to

state regulation. Hence, the legislation has been referred to as an "optional federal charter" proposal. While there were many technical changes made to S.40 as compared to the National Insurance Act of 2006, which was introduced by Senators Sununu and Johnson in April 2006 and Representative Royce in September 2006, the essential features of the NIA remain unchanged. A detailed summary of the NIA is set forth in our July 30, 2007 Client Update, "U.S. Insurance Regulation Reform S.40 and H.R. 3200 – National Insurance Act of 2007".

Interpreting “Back-to-Back” Reinsurance Coverage: A View from Over the Pond

by Christopher Henley

“In every contract some terms are fundamental. In the case of a contract for the sale of land, such terms are the parties, the property, and the price. In a contract of carriage, they are the parties, the goods, the vessel, and the ports of loading and discharge. Such terms are both necessary and sufficient. They describe the main object and intention of the contract. If any of them are not agreed, there is no contract. If they are agreed, all else is detail”.¹

The devil, of course, is in the detail. With some prodding from the Financial Services Authority (“FSA”), the London insurance and reinsurance market has taken great steps over the last two years to minimise the likelihood of disputes arising out of the contract detail, or lack of it, under the watchword of “contract certainty”. Its aims have substantially been achieved – on 24 January 2007 the FSA agreed that sufficient progress had been made by the industry to obviate the need for regulatory intervention because 90% of the subscription market had achieved the benchmarks of certainty, with 88% of the non-subscription market also complying, a feature clearly to the benefit of all parties concerned. The old London market practice of delaying a decision about the inclusion or text of a term until after contract formation, and perhaps never actually agreeing to it at all before a claim arises, has now been substantially displaced. Nevertheless, whatever parameters for contract certainty may have been laid down generically by the market associations, it is still possible to leave terms outstanding for future agreement, of which the most notable is perhaps the rate of premium, which will be assessed by a court as a

“reasonable premium” if not agreed at the date of contract formation. However, there are certain terms that must be agreed in order to have a contract at all. The period of cover, for example, is fundamental. Interestingly, a contract of reinsurance need not contain a “follow the settlements” clause,² despite that apparently being the very purpose of such a contract. The presence of such a clause makes it easier to determine the parties’ obligations and is therefore commercially beneficial to both parties, yet it is not required. A recent case has thrown these two elements into sharp relief.

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In *WASA International Insurance Company Ltd. v. Lexington Insurance Company and AGF Insurance Limited v. Lexington Insurance Company* [2007],³ Lexington facultatively reinsured to WASA and AGF environmental clean-up costs incurred by its own insured, Alcoa. In the early 1990s, Alcoa had been ordered by the U.S. Environmental Protection Agency to clean up pollution at several manufacturing sites in the U.S. in respect of pollution that had occurred between 1942 and 1986. Alcoa sought to recover its inwards claims and costs from Lexington. Lexington’s insurance of Alcoa ran for a 3-year period from 1 July 1977 to 1 July 1980. The contract included a standard U.S. “service of suit” clause which provided that, at Alcoa’s request, Lexington would submit to the jurisdiction of any competent U.S. court for the resolution of any claim dispute, but contained no governing law clause. The ensuing dispute reached the Washington State Supreme Court, which, applying Pennsylvanian law to the underlying policy, held that Lexington was jointly and severally liable for the whole of Alcoa’s clean-up costs, despite the fact that Lexington had only been at risk for 3 of the 44 years during which the pollution had occurred. Lexington then settled Alcoa’s claims in a deal spanning all 44 years of the remedial costs before claiming against its reinsurers. Significantly, the underlying argument between Lexington and Alcoa was not about the date on which the damage occurred. Lexington’s settlement was predicated on the basis that it was liable for the costs of remedying the damage which occurred outside its period of cover owing to the absence of an exclusion for loss that had started prior to that cover. WASA and AGF then applied to the

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Commercial Court in London for a declaration that it was not obliged to follow Lexington’s settlement because the loss did not fall within the scope of the reinsurance contract as a result of its express period clause, which clearly imposed a temporal limit on the cover in respect of which losses occurring outside that period simply would not be covered. The reinsurance contract (which was subject to English law) contained a “full reinsurance” clause and covered the identical period and same subject matter as the underlying insurance.

English case law presumes that facultative reinsurance is on a back-to-back basis with the underlying coverage so that a claim properly paid in accordance with the underlying insurance would be indemnified by the reinsurance. However, in this case, the contracts were not entirely back-to-back because they were ultimately governed by different applicable laws. Therefore, the presumption in favour of back-to-back contracts was rebutted because it was not possible at the time of formation of the reinsurance contract to ascertain the construction of the underlying policy. It was certainly accepted that a different construction would be placed on the underlying insurance in different U.S. jurisdictions, and therefore there was no way of predicting the construction that would be placed on the period clause at the time the reinsurance was placed because it was not known that either the Washington state courts would decide the claim or that Pennsylvania law would be applied. It is on any view correct that equivalent terms in two contracts should not be given the same legal definition if the parties could not have had in mind a legal definition taken from the relevant case law of the local system of law when forming the contract.

The period of cover in any insurance or reinsurance policy is of fundamental importance, and the reinsurers had clearly only agreed to reinsure Lexington “during the continuance of the policy”, i.e., for the relevant 3-year period as defined in the reinsurance policy. Although the insurance and reinsurance contracts were intended to be back-to-back, the court stated that reinsurance contracts were distinct and independent contracts and terms within the reinsurance should not be distorted or disregarded to make them more consistent with the original cover. The reinsurers had neither agreed that the period clause in the reinsurance should be determined by U.S. law nor that they would indemnify Lexington for any liability incurred by it under the underlying insurance.

This case is yet another refinement of the principles laid down in the modern grandfather of English reinsurance law, *Insurance Company of Africa v. SCOR [1985]*,⁴ which set out the two basic requirements for all “follow the settlements” clauses: the reinsurer must indemnify the reinsured if the loss falls within both (a) the scope of the cover of the insurance contract and (b) the scope of the cover of the reinsurance contract. To comply with the first proviso the reinsured need only show that it acted honestly and took all proper and businesslike steps in making the settlement, which Lexington was able to show, but the loss failed to meet the second requirement, because the “follow the settlements” clause and the back-to-back nature of the insurance and reinsurance contracts did not displace the importance of the fundamental term of the period of cover. The reinsurance simply could not indemnify the reinsured for claims paid outside the period of reinsurance because the reinsurer had not agreed to do so. Therefore, the court held that the claim recognised by Lexington fell outside the reinsurance contract as a matter of law.

English case law presumes that facultative reinsurance is on a back-to-back basis with the underlying coverage so that a claim properly paid in accordance with the underlying insurance would be indemnified by the reinsurance. However, in this case, the contracts were not entirely back-to-back because they were ultimately governed by different applicable laws.

Given the intention of the parties that the contracts should be back-to-back, this decision does not contribute to parties’ certainty that reinsurance will provide the coverage anticipated by the insurer at inception. However, permission to appeal has been granted in this case and the ultimate outcome is still unknown. One might ask why the reinsurance could not mirror the “floating” meaning in the underlying insurance, on the presumption that the contracts’ coverage were intended to be congruent. However, the key feature of the case is the argument that if there is an

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unpredictable outcome at the level of the insurance, there is no back-to-back cover. Where the underlying insurance contract does not specify the governing law and the insured can select any competent U.S. court for suit, there is an argument that the back-to-back presumption has been ousted. U.S. insurers will have to consider ways of

protecting themselves, the obvious candidate being a more specific service of suit clause, if that is possible. ■

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¹ *Homburg Houtimport B.V. v. Agrosin Private Ltd. and others (The Starsin)*, [2003] 1 Lloyd's Rep. 571.

² A “follow the settlements” clause typically provides that claims settlements made by the reinsured are binding upon the reinsurer as long as such settlements are within the terms and conditions of the underlying policies and are within the terms and conditions of the reinsurance.

³ [2007] EWHC 896 (Com).

⁴ [1985] 1 Lloyd's 312 (CA).

Reinsurance

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used by solvent selling insurers, assumption reinsurance continues to be used in acquiring life and annuity blocks of business from life insurers that are placed in receivership. In this case, the assumption reinsurance is approved by the receivership court. While policyholder consent may still be required as a matter of law to release the selling insurer from liability, if the selling insurer goes out of business (or is liquidated) and the acquiring insurer fails, there is, as a practical matter, no selling insurer for a policyholder to hold liable.

Today, direct life and annuity blocks of business (long term liability lines of business) are typically “acquired” from solvent life insurers by the acquiring insurer entering into a 100% coinsurance agreement with the selling insurer. The acquiring insurer will also enter into an administrative services agreement with the selling insurer to administer the acquired block of business until all obligations are satisfied (e.g., policy servicing, collecting premiums and settling claims). The administrative services agreement is very important since it protects the acquirer's role as ultimate claims payer with the acquirer also playing the role of claims decision maker.

Today, direct life and annuity blocks of business (long term liability lines of business) are typically “acquired” from solvent life insurers by the acquiring insurer entering into a 100% coinsurance agreement with the selling insurer.

Acquisition of Life or Property/Casualty Block of Assumed Reinsurance Business

The sale of a block of assumed reinsurance business, whether life and annuity or property/casualty, presents the same kind of issues as does a block of direct life or annuity business – the outstanding liabilities may be long term and assumption reinsurance does not relieve the selling insurer from liability

without the consent of the original ceding insurer. Consequently, acquisitions of a block of assumed reinsurance business will also be usually done using indemnity reinsurance – 100% coinsurance (retrocession) for assumed life and annuity business and 100% quota share reinsurance (retrocession) for assumed property/casualty business. The acquiring insurer will also enter into an administrative services agreement under which it will agree to service the acquired block of business. If the assumed block of business involves few original ceding insurers, it may be possible to obtain the consent of the original ceding insurers to the transfer of obligations to the acquiring insurer, assuming that the acquiring insurer were creditworthy. This may be problematic for a large block of business with dozens or hundreds of original ceding insurers.

Acquisition of Direct Property/Casualty Block of Business

While it is possible to acquire a block of direct property/casualty business by 100% quota share reinsurance, since direct property/casualty insurance policies typically have a policy period of 12 months (6 months in the case of some personal automobile insurance policies), the acquiring insurer may

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just be interested in a “renewal rights” transaction. Under such a transaction, the acquiring insurer purchases from the selling insurer an exclusive right to seek renewal of policies originally issued by the selling insurer. The renewal policies would be issued by the acquiring insurer. If the acquiring insurer is also interested in acquiring the in-force business, the “renewal rights” transaction can be coupled with 100% quota share reinsurance of the in-force business (either all outstanding liabilities or only new liabilities after a designated date).

Some states have laws that provide that, unless the insurer issues a nonrenewal notice in a timely fashion, the insurer must offer to renew a policy on expiration. If the selling insurer is exiting a line of business and is seeking to monetize the value of its customer relationships in a “renewal rights” transaction, then the selling insurer should probably give the required nonrenewal notices at the same time the acquiring insurer makes an offer to renew. This kind of transaction may be more quickly implemented for commercial lines property/casualty insurance policies than personal line property/casualty insurance policies since (i) personal line property/casualty insurance policies may be subject to protective laws that bar the selling insurer from non-renewing in-force policies for extended periods, and (ii) exiting personal lines business may require a state insurance regulatory notice or consent for a “block” cancellation or nonrenewal.

Acquisition of Property/Casualty Insurers – Adverse Development Reinsurance

In a U.S. stock purchase transaction for a property/casualty insurer, it is not uncommon for an adverse development reinsurance agreement to be used as a substitute or supplement to seller indemnification. The purpose of such a reinsurance agreement is to protect an acquirer against the risk that the

reserves for the property/casualty business are inadequate. A stop-loss (or aggregate excess of loss) reinsurance agreement requires the seller (or its insurer affiliate) to enter into, a moment before closing, a reinsurance agreement with the acquired insurer. The agreement generally provides that, with respect to the acquired insurer’s in-force business (i.e., business written at or prior to the closing), if the paid losses that emerge over time exceed a stated retention, then the excess over the retention will be borne by the seller or its insurer affiliate. In effect, this reinsurance agreement shifts the risk of under-reserving back to the seller or its insurer affiliate. In some cases, the seller may be unwilling to retain any tail liability, and the buyer might purchase stop loss coverage from a third-party reinsurer.

The quota share ceded under the reinsurance agreement may be 100% or less and the aggregate amount that the reinsurer will pay may be capped at a stated aggregate limit or unlimited. Furthermore, the retention can be a fixed dollar amount or a floating amount that takes into account closing date reserves, investment income on the assets supporting the reserves, paid losses and premiums paid to and losses paid by other third-party reinsurers.

Acquisition of an Insurer – Disposition of Unwanted Business

If the buyer is faced with an opportunity to acquire an insurer or a block of business but the acquisition includes a block of business that the buyer does not want, the unwanted business can be eliminated by reinsuring it, either with an affiliate of the seller or with an unaffiliated third party reinsurer. The reinsurance typically takes the form of 100% coinsurance (life and annuity business) or 100% quota share reinsurance (property/casualty business), often coupled with some form of assurance as to reserves at closing. The ability to reinsure the unwanted

business out of the acquired insurer or business permits significant flexibility in structuring privately negotiated insurance acquisitions. The disposition of the unwanted business will probably be best achieved if it is done contemporaneously with the main acquisition.

While it is possible to acquire a block of direct property/casualty business by 100% quota share reinsurance, since direct property/casualty insurance policies typically have a policy period of 12 months (6 months in the case of some personal automobile insurance policies), the acquiring insurer may just be interested in a “renewal rights” transaction.

Reinsurance in Insurance-Linked Securities

The 1990s saw the development of an entirely new class of securities called “insurance-linked securities.” Reinsurance is a key element of creating insurance-linked securities – transforming insurance risk into securities risk. The following are some key

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kinds of insurance-linked securities that have been developed which use reinsurance as a key component.

Catastrophe Bonds

Catastrophe losses by property/casualty insurers have grown greatly since the 1980s, major losses being incurred due to hurricanes, earthquakes and other natural disasters. This risk was traditionally shared with other insurers through reinsurance. Catastrophe bonds were developed to share this risk with the capital markets.

In a typical catastrophe bond structure, a property/casualty insurer forms a special purpose vehicle and cedes catastrophe risk to the special purpose vehicle (paying a premium) under a reinsurance agreement. The special purpose vehicle will usually be an unauthorized insurer. (Such a transaction can also be done through reinsurance ceded to a protected cell of a reinsurer whose domestic law authorizes protected cell companies.) The special purpose vehicle issues notes to investors – payment of principal and/or

interest (at LIBOR plus a spread) is catastrophe event contingent. Reinsurance premiums and note proceeds are invested. The special purpose vehicle may enter into a swap with a counterparty to swap investment earnings for LIBOR plus or minus a spread.

Regulation XXX Structured Transactions

The NAIC Valuation of Life Insurance Model Regulation (so-called “Regulation XXX”) requires increased reserves for term life insurance policies with long term premium guarantees. If the liability is ceded under a reinsurance agreement to an unauthorized insurer, the entire liability must be secured using qualifying letters of credit or other qualifying collateral. The Regulation XXX structured transaction replaces the need for a letter of credit with collateral funded by investors (and deposited into a single beneficiary reinsurance trust) through debt issued by a special purpose vehicle. A detailed description of this kind of transaction is contained in “U.S. Life Insurance Securitizations: Capital Market Strategies for Funding ‘Excess’ Reserves,” Debevoise & Plimpton Financial Institutions Report, Spring 2007, Vol. 1, No. 1, Page 5.

Embedded Value Transactions

Life insurers with mature blocks of business must, in the ordinary course, wait for profits to be realized over an extended period of time. Non-recourse notes can be issued to the capital markets by a special purpose vehicle backed by the emerging surplus of the block of business, thereby bringing in current cash to the life insurer in exchange for future profits on the block of business.

In a typical embedded value transaction, to segregate the in-force block of business from the other business of the life insurer, the block is reinsured in a special purpose vehicle pursuant to a reinsurance agreement. The special purpose vehicle will usually be an unauthorized insurer. The embedded value

of a life insurer is the present value of all future surpluses for the insurer, taking into account reserve releases. The insurer’s net asset value is added to this total. A number of non-U.S. life insurers disclose their embedded value in their annual reports.

Key Corporate and Insurance Regulatory Issues

The kinds of reinsurance transactions mentioned in this article give rise to many corporate and insurance regulatory issues. Among the key issues are those described below.

Risk Transfer Rules

In order for reinsurance transactions to be afforded reinsurance accounting (as opposed to deposit accounting) treatment, the reinsurance must satisfy “risk transfer” rules. Compared to deposit accounting, reinsurance accounting permits a ceding company to report lower liabilities and losses.

The U.S. life statutory risk transfer rules provide that the reinsurance agreement must transfer all of the significant risk inherent in the business being reinsured. These risks may include mortality, morbidity, lapse, credit quality, reinvestment and disintermediation, depending on the product being reinsured. The U.S. property/casualty risk transfer rules provide that the reinsurance agreement must transfer insurance risk which involves uncertainties about both (i) the ultimate amount of cash flows from premiums, commissions, claims, and claim settlement expenses (underwriting risk), and (ii) the timing of the receipt and payment of those cash flows (timing risk).

In contrast, the U.S. GAAP risk transfer rules focus largely on the permanence of transfer to the reinsurer. Generally, the GAAP rules for long-duration contracts (including most types of life insurance) require that it must be reasonably possible that the reinsurer could

The 1990s saw the development of an entirely new class of securities called “insurance-linked securities.” Reinsurance is a key element of creating insurance-linked securities – transforming insurance risk into securities risk.

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Key Reinsurance Provisions

The following are certain key provisions included in reinsurance agreements involving a U.S. ceding insurer:

Entire Contract. Provides that the agreement constitutes the entire contract between the parties. Basically a statement that there are no undisclosed side agreements. Required for statutory reinsurance credit for U.S. life and non-life ceding insurers.

Insolvency. Provides that reinsurance will be payable by the reinsurer on the basis of liability of the ceding company under the contracts reinsured without diminution because of the ceding insurer's insolvency. Required for statutory reinsurance credit for U.S. life and non-life ceding insurers.

Setoff. Provides that the ceding insurer and the reinsurer may set off any amounts due from one to the other, whether on account of premiums, claims or losses, loss expenses or salvage. May allow setoff among multiple contracts between the same parties. Generally subject to state insurance insolvency law rules on setoff following the insolvency of a party.

Service of Suit. A provision under which an unauthorized reinsurer agrees to submit to the jurisdiction of a court of competent jurisdiction within the U.S. and to abide by the final decision of the court or any appellate court, the reinsurer designates a person as its agent located in the U.S. for service of process and the reinsurer designates applicable state insurance regulators as its attorney for service of process in an action brought by the ceding insurer. In agreements with an arbitration clause, the service of suit clause would pertain to actions to compel arbitration and enforcement of an arbitral award.

Settlements. Requires that settlements under the reinsurance agreement occur no less frequently than quarterly. Required for statutory reinsurance credit for U.S. life and non-life ceding insurers.

Credit for Reinsurance (Unauthorized Reinsurer). Provides that an unauthorized reinsurer post permitted collateral at least equal to the amount of reserves ceded. Permitted forms of collateral are funds withheld, letters of credit and single beneficiary reinsurance trust agreements under which the reinsurer deposits funds for the benefit of the ceding insurer. Required for statutory reinsurance credit for U.S. life and non-life ceding insurers.

realize a significant loss. The GAAP rules for short-duration contracts (including most property and casualty policies and certain term life policies) generally require that (i) the reinsurer must assume significant insurance risk under the reinsured portions of the underlying insurance contracts and (ii) it must be reasonably possible that the reinsurer could realize a significant loss.

Reinsurance Credit

In order for reinsurance to be effective from a statutory accounting standpoint, a U.S. ceding insurer must obtain full credit for the reinsurance ceded – that is, its liabilities must be reduced by an amount equal to the full amount of liabilities assumed by the reinsurer. Under state laws, a ceding insurer will be allowed reinsurance credit if the

reinsurer is licensed or accredited as a reinsurer. This will usually be satisfied in the insurance M&A transactions described in this article since the reinsurer will typically be licensed in all or nearly all states. A state of special concern for life and annuity reinsurance transactions is New York since New York applies its reinsurance credit rules to both domestic and foreign licensed ceding insurers (which means that reinsurance credit will be allowed for the ceding insurer in New York only if the reinsurer is licensed or accredited in New York) and not all insurers that will reinsure a direct block of life or annuity business are licensed or accredited in New York. This concept of reinsurance credit is for U.S. statutory accounting practices only. Under U.S. GAAP rules, the ceding company's

reserves are not reduced by reinsurance. Instead, an asset is established offsetting the reserve liability.

In insurance-linked securities transactions risk is often ceded to offshore reinsurers – reinsurers that are “unauthorized” under U.S. state reinsurance credit laws. The U.S. state reinsurance credit laws provide that a ceding insurer will be allowed credit for reinsurance ceded to an unauthorized reinsurer only if the reinsurer posts permitted collateral at least equal to the amount of reserves ceded – 100% collateralization is required. Permitted forms of collateral are funds withheld, letters of credit and single beneficiary reinsurance trust agreements under which the reinsurer deposits funds for the benefit of the ceding insurer. There is a developing proposal in the U.S. to tie the amount of collateral required

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to the creditworthiness of the reinsurer, thereby requiring less than 100% collateralization where the reinsurer meets certain credit standards. See “U.S. Credit for Reinsurance: REO Proposal,” Debevoise & Plimpton Financial Institutions Report, Spring 2007, Vol. 1, No. 1, Page 7.

General Credit Issues

Even if the ceding insurer is allowed credit for reinsurance ceded under all applicable U.S. state reinsurance credit rules, both the ceding insurer and the reinsurer may be concerned about the continuing creditworthiness of their counterparty, especially when long-term life or annuity risks are reinsured. If either party fails, then its counterparty becomes a creditor in the failed insurer’s receivership proceeding governed by the state insurance insolvency law of the domiciliary state of the failed insurer.

A ceding insurer ceding life and annuity risks might seek to protect itself from the effects of a failure of the reinsurer by including in the reinsurance agreement either or both of the following: (i) the ceding insurer may elect to require that the reinsurer post collateral supporting its obligations to the ceding insurer following the occurrence of a trigger event; or (ii) the ceding insurer may elect to recapture the ceded business following the occurrence of a trigger event. Among the designated kinds of trigger events may be the following – rating downgrade, failure to maintain a designated risk-based capital ratio, commencement of an insolvency proceeding or a change of control of the reinsurer.

U.S. state reinsurance credit rules require that a reinsurance agreement include an insolvency clause as a condition to the ceding insurer being allowed credit for the ceded reinsurance. Under this clause, if the

ceding insurer fails, the reinsurer agrees to pay reinsurance proceeds under the reinsurance agreement whether or not the ceding insurer actually pays the underlying insurance policy claim to the policyholder. Furthermore, under U.S. state insurance insolvency laws, all claims against the failed ceding insurer for direct policy obligations must be satisfied in full before the failed ceding insurer will be able to pay any claim to an unsecured general creditor (which includes a reinsurer if the obligations owed it by the ceding insurer, such as premium payments, are unsecured). In this case, the reinsurer can protect itself, in part, by reliance on a contractual right to set off obligations it owes the ceding insurer (e.g., reinsurance proceeds, ceding commission, expense allowance) against obligations the ceding insurer owes it (e.g., reinsurance premiums).

Third Party Administrator Licensing (Exceptions)

If the acquired block of life or annuity business consists of policies issued in many states and the acquiring insurer will administer business written by the ceding insurer in these states, it is important that the acquiring insurer either be licensed as a third-party administrator, or exempt from such licensing requirements, in each of these states. Although many states require licensing of third party administrators, most states exempt from such licensing an authorized insurer. There are, however, a few states – Alaska, Kentucky, Nevada, New York and Texas – that do not follow this general rule.

State Insurance Regulatory Consents

Certain reinsurance agreements must either be filed with or approved by one or more state insurance regulators. Therefore, reinsurance transactions are often subject to

making the required filings or obtaining the required consents. Bulk reinsurance and affiliate transaction laws are among the kinds of laws that may be implicated.

Even if the ceding insurer is allowed credit for reinsurance ceded under all applicable U.S. state reinsurance credit rules, both the ceding insurer and the reinsurer may be concerned about the continuing creditworthiness of their counterparty, especially when long-term life or annuity risks are reinsured.

Bulk reinsurance laws. A state insurance regulatory consent may be required for a ceding insurer to reinsure all or substantially all of its insurance business in force, or all or substantially all of a major class thereof. For example, if a ceding insurer proposes to cede its entire block of direct individual life insurance to another insurer, such a transaction may be subject to this kind of regulatory consent.

REINSURANCE CONTINUES ON NEXT PAGE

Reinsurance

(CONTINUED FROM PREVIOUS PAGE)

Affiliate transaction laws. Where an insurance-linked securities transaction calls for reinsurance to be ceded by a U.S. ceding insurer to an affiliated special purpose reinsurer, then the reinsurance, if material, will be subject to prior notice to the ceding insurer's domestic state insurance regulator

under the ceding insurer's domestic state insurance holding company law. Under these laws, the transaction must be fair and reasonable and may be disapproved by the regulator if the transaction fails to meet that standard or the transaction may adversely affect the interests of policyholders. ■

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Reinsurance Terminology

Coinsurance. Proportional (pro-rata) reinsurance for life and annuity risks. Reinsurance is ceded on an individual policy in the same form as that of the direct policy. The ceding insurer pays the ceding company a proportionate share of the gross policy premiums and the reinsurer reimburses the ceding company for a proportionate share of commissions and other expenses (an expense allowance). Assets backing reserves as well as the risk are transferred to the reinsurer.

Excess of Loss Reinsurance. Non-proportional reinsurance under which, subject to a specified limit, the reinsurer indemnifies the ceding insurer against all or a portion of the amount of loss in excess of the ceding insurer's specified loss retention. May be per risk excess (or per policy), per occurrence excess (property catastrophe or casualty clash) or annual aggregate excess. Term is usually used in non-life reinsurance.

Funds Withheld. Assets that would usually be paid to the reinsurer are withheld by the ceding insurer and are used to satisfy payment of the reinsurer's obligations to the ceding insurer. Funds withheld assets are held by the ceding insurer at book value. One of three permitted forms of collateral that may be posted by an unauthorized reinsurer.

Letter of Credit (for Unauthorized Reinsurance). A bank guaranty obtained by the reinsurer in favor of the ceding insurer as beneficiary. Letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified U.S. financial institution. One of three permitted forms of collateral that may be posted by an unauthorized reinsurer.

Quota Share Reinsurance. Proportional (pro-rata) reinsurance for non-life risks. The reinsurer assumes an agreed percentage of each insurance policy being reinsured and shares all premiums and losses with the ceding insurer applying that agreed percentage. The reinsurer pays a ceding commission to the ceding insurer to cover commissions, expenses and profit.

Reinsurance Credit. Provision of U.S. insurance laws and statutory accounting practices under which a U.S. ceding insurer is allowed to treat reinsurance ceded to a reinsurer as a reduction from liability. Conditions to reinsurance credit include the status of the reinsurer (licensed, accredited, unauthorized) and the inclusion (or exclusion) of certain reinsurance agreement provisions.

Single Beneficiary Reinsurance Trust. Trust agreement entered into between the ceding insurer (beneficiary), the reinsurer

(grantor) and a qualified United States financial institution (trustee) for the sole benefit of the beneficiary which creates a trust account into which assets are deposited by the grantor. Trust agreement provides that the beneficiary has the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee (subject to no other statement or document or any other condition or qualification outside of the trust agreement). Trust assets are held at market value. One of three permitted forms of collateral that may be posted by an unauthorized reinsurer.

Yearly Renewal Term Reinsurance. Form of non-proportional life reinsurance under which the risks, but not the assets backing permanent plan reserves, are transferred to the reinsurer. Premium varies each year based on the amount at risk and the age of the insureds under the underlying policies. The ceding insurer reinsures the mortality or morbidity risk only – only the net amount at risk (death benefit less policy reserves) is reinsured. The reinsurer does not participate in the payment of surrender values, dividends, commissions or expenses. ■

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