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Burdensome Conditions to Regulatory Approvals: Lessons for Financial Institutions M&A from the Alliance Data Systems Dispute

by Michael D. Devins

On May 17, 2007, the Blackstone Group announced that its private equity fund, Blackstone Capital Partners V L.P., had agreed to acquire Alliance Data Systems Corp. ("ADS"), a publicly traded credit card service provider, for $7.8 billion, approximately a 30% premium over ADS's market capitalization at the time. The transaction was subject to customary closing conditions, including approval of ADS's shareholders and applicable regulatory authorities. The deal was expected to close by the end of the year.

On August 8, 2007, ADS's shareholders overwhelmingly voted in favor of the transaction, and on August 31, ADS permitted Blackstone to immediately acquire 5% of ADS's stock. Soon, however, the financial markets became more turbulent and private equity buyouts became more difficult to finance. Rumors began circulating that the deal was in trouble. ADS took the somewhat unusual step of issuing a press release on November 29, 2007, addressing the rumors and announcing that the deal was still on track and that no renegotiations with Blackstone had taken place. Nonetheless, the end of the year came and went, and the acquisition was not consummated.

ADS reported on January 28, 2008 that Blackstone had notified the company three days earlier that while it remained committed to attempting to complete its acquisition of ADS, due to "unprecedented and unacceptable" conditions that the U.S. Office of the Comptroller of the Currency (the "OCC") had placed on its approval of the transaction, Blackstone did not believe the conditions to the closing of the transaction could be met. On January 30, ADS sued Blackstone, claiming that in breach of its merger agreement with ADS, it had failed to exercise "reasonable best efforts" to consummate the transaction and seeking specific performance of those obligations.

Among ADS's subsidiaries is a credit card bank, World Financial Network National Bank, over which the OCC has regulatory authority. It is customary for the OCC to seek a guarantee from a credit card bank's parent of the bank's obligations, and as a condition to its approval of the acquisition by Blackstone, the OCC insisted on such a guarantee from the Blackstone Capital Partners V fund of $400 million. There is some dispute between the parties as to the exact nature of discussions among ADS, Blackstone and the OCC, but it is clear that Blackstone was not willing to offer a guarantee of more than $100 million, and that such a level was not acceptable to the OCC.

The merger agreement between ADS and the merger vehicles set up by Blackstone provides that each party is to use its reasonable best efforts to take the actions necessary to consummate the merger, including filing for, and taking other actions necessary to obtain, all required regulatory approvals (including the OCC approval). The receipt of such regulatory approvals is a condition to closing.

ADS dropped its lawsuit against Blackstone on February 8, 2008 to try to reach a negotiated compromise acceptable to both

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Letter from the Editor

Amid continuing uncertainty in the global credit and financial markets, much is happening in the financial services sector. Despite difficult market conditions, financial services firms continue to explore M&A and capital market transactions. In this issue, we present an article discussing issues associated with required regulatory approvals in acquisitions of regulated entities. We also present an article discussing surplus notes, a type of subordinated debt issued by insurers, and their uses in a variety of transactions. Surplus notes function like traditional debt, but are treated as "surplus" for U.S. statutory accounting purposes.

Meanwhile, regulators and industry worldwide continue to focus on the modernization of financial institutions regulation. In the U.S., reform proposals, at both the state and federal level, garner increasing attention. In late March, as reported in our Client Update dated April 1, 2008, U.S. Treasury Secretary Henry Paulson announced the release of the Department of the Treasury's *Blueprint for a Modernized Financial Regulatory Structure*, which includes comprehensive proposals for reforming the regulation of U.S. financial institutions, including depository institutions, securities firms, insurance companies, financial intermediaries and others. In this issue, we report on the Blueprint and recount the history of state-based regulation of insurance in the U.S. We also discuss recent efforts by state insurance regulators and the NAIC to reform the regulatory framework governing collateralization requirements in reinsurance transactions. In Europe, the European Commission and the U.K. Financial Services Authority published reports concerning anti-competitive practices in the business insurance sector and compensation of insurance brokers.

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

Wolcott B. Dunham, Jr.
Editor-in-Chief

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Placing Proposals for the Federal Regulation of Insurance in Context: A Brief History of Insurance Regulation in the United States

In light of the recent turmoil in the financial markets, regulators and other interested parties have increasingly devoted attention to the basic framework for the regulation of financial institutions in the United States. A significant amount of this attention has focused on the release, in late March, of the U.S. Department of the Treasury's *Blueprint for a Modernized Financial Regulatory Structure* (the "Blueprint"). The Blueprint is the product of a study of many months, and includes recommendations for both short-term targeted regulatory reform and a comprehensive long-term restructuring of the regulatory regime that governs financial institutions in the United States.

The Blueprint includes a number of recommendations that are of special interest to insurers operating in the United States. These recommendations include the establishment in the near-term of an Office of Insurance Oversight within the U.S. Department of the Treasury in order to improve the ability of the United States to speak with a single, official voice in international forums. The Blueprint also endorses the adoption, in the intermediate term, of an optional federal charter for insurers, which would allow insurers to be regulated either nationally or at the state level, much like modern commercial banks. Subject to limited exceptions, a federally chartered insurer would not be subject to state insurance regulation.

Proposals for the federal regulation of the insurance industry are not new. For example, in 1865, the U.S. Congress considered creating a National Chamber of Insurance. The bill to establish this entity died in the House Judiciary Committee. In 1905, Senator John F. Dryden of New Jersey, President of The Prudential Insurance Company of America, introduced a bill providing for national licensing of insurers. More recently, the National Insurance Act of 2007, which would authorize an optional federal charter for insurers, was introduced in the U.S. Senate and House of Representatives. The 2007 proposal, in turn, borrows from several earlier iterations. Each of these proposals includes a great deal of noteworthy detail that is beyond the scope of this article. Instead, we set forth below a brief summary of the history of insurance regulation in the United States, which we hope will provide useful context for considering recent proposals for reform.

The regulation of insurance by individual U.S. states has its origins in the eighteenth and nineteenth centuries. As the insurance industry developed, various U.S. states enacted statutes to govern the conduct of insurance business. Beginning in the 1850s, states began to establish administrative bodies to supervise insurance companies operating within their borders. This nascent system of state regulation overcame its first challenge in 1869, when the U.S. Supreme Court (the "Court") upheld state regulatory power over insurance in the seminal case of *Paul v. Virginia*, described below.

Paul v. Virginia

In *Paul v. Virginia*, the Court held, among other things, that the issuance of an insurance policy did not constitute the transaction of interstate commerce subject to regulation by the U.S. federal government.[1] Therefore, according to the Court, there was no constitutional basis under the commerce clause of the U.S. Constitution for the federal regulation of insurance, and regulation of the business of insurance was left to the individual states.

The second half of the nineteenth century was marked by intense competition in the insurance industry as well as increasingly stringent and varied state regulation. After *Paul v. Virginia*, state legislatures continued to develop their insurance regulatory regimes. In 1871, the National Association of Insurance Commissioners (the "NAIC") was created to help facilitate uniformity in state regulation. During this period, many regulatory concepts that still exist today came into being, including for example, reserving and solvency requirements. Not surprisingly, insurance regulatory regimes varied among the states and some states implemented more rigorous regulatory standards than others.

The Armstrong Committee

In 1905, State Senator William Armstrong of New York chaired a legislative committee (the "Armstrong Committee") to investigate the conduct of business by insurers domiciled in New York. The Armstrong Committee, led by its counsel Charles Evans Hughes, began as a reaction to a highly publicized fight for control of The Equitable Life Assurance Society. The investigation made a number of important recommendations for reform. The life insurance industry had grown quite large in the period leading up to the Armstrong Committee's review, in part because of the introduction of policies that did not require life insurers to reserve for dividends accumulated on premium payments until the end of a specified period. In an effort to boost sales, life insurers engaged in heavy

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rebating and used aggressive illustrations of future policy benefits to market these policies. The Armstrong Committee also identified instances of secret lobbying efforts, excessive executive compensation and the abuse of proxy voting to maintain control of insurers. The Armstrong Committee recommended sweeping changes to the regulation of insurance in New York, including restrictions on sales practices, more substantial disclosure of the activities of insurers and the disallowance of deferred dividends. Other states took notice of the results of the Armstrong Committee. In some cases, these states revised their own insurance regulatory regimes on the basis of the New York model. Other states that did not previously regulate insurers implemented new regulatory regimes.

U.S. v. South-Eastern Underwriters Association

In 1944, in the case of *United States v. South-Eastern Underwriters Association*, the Court reconsidered the permissibility of federal regulation of the business of insurance.[2] In this case, the court held that a group of fire insurers who banded together in order to fix prices violated federal antitrust laws. Since premiums were collected from insureds in many states and were pooled together to pay policy obligations arising under contracts issued in various states, the Court held that the business of insurance constituted interstate commerce, and involved "a continuous and indivisible stream of intercourse among the states." The insurance business was now potentially subject to federal regulation based on the commerce clause of the U.S. Constitution, leaving the insurance industry uncertain as to the laws that would apply to them.

McCarran-Ferguson

In 1945, the U.S. Congress responded to the Court's holding in *United States v. South-Eastern Underwriters Association* by passing the McCarran-Ferguson Act ("McCarran-Ferguson").[3] McCarran-Ferguson generally reserves regulation of the business of insurance for the states. Under McCarran-Ferguson, a federal law does not preempt state law relating to the insurance industry unless the federal law specifically relates to the "business of insurance." To a limited extent, McCarran-Ferguson also makes the business of insurance subject to federal antitrust laws.

Beginning in the 1850s, states began to establish administrative bodies to supervise insurance companies operating within their borders.

Recent Developments

In the years since the enactment of McCarran-Ferguson, the U.S. government has taken a number of affirmative steps to exert control over or impose uniformity upon the regulation of insurance in the United States. For example, in 1974, the U.S. Congress enacted the Employee Retirement Income Security Act, which sets forth detailed requirements governing employer-sponsored retirement plans and related insurance benefits. Similarly, for many years, the U.S. government has played a significant role in sponsoring important insurance programs, including flood insurance, crop insurance, terrorism insurance, social security, deposit insurance and other forms of insurance.

In 1999, in connection with the Gramm-Leach-Bliley Financial Services Modernization Act (the "GLBA"), Congress reaffirmed the essential role of the states in regulating insurance. The GLBA repealed portions of the Glass-Steagall Act of 1933, which separated the banking and securities industries, and amended the Bank Holding Company Act of 1956, which prohibited affiliations between banks and insurance companies. Under the GLBA, the insurance activities of any financial holding company system are subject to state insurance regulation. However, the GLBA also exhibited a tendency toward federal insurance regulation, imposing a deadline for states to enact uniform insurance producer licensing laws or accept a federal insurance producer licensing system (a deadline states met).

Since enacting the GLBA, Congress has continued to exert influence over certain aspects of insurance regulation. For example, in 2006, Congress enacted the Military Personnel Financial Services Protection Act (the "Military Protection Act"), in essence asking the states to collaborate "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 Military Protection Act resulted in the adoption by the NAIC of its Military Sales Model Regulation at its June 2007 meeting. ■

[1] *75 U.S. 168 (1869)*
[2] *322 U.S. 533 (1944).*
[3] *15 U.S.C. §§ 1011-1015 (1945).*

The Department of the Treasury *Blueprint for a Modernized Financial Regulatory Structure*

In addition to proposing insurance regulatory reforms, the U.S. Department of the Treasury's *Blueprint for a Modernized Financial Regulatory Structure* (the "Blueprint") proposes sweeping reform of the regulation of financial institutions in the U.S. generally, including depository institutions, securities firms, financial intermediaries and others.

In the near-term, the Blueprint recommends certain immediate initiatives designed in part to improve coordination among regulators and strengthen market stability, including ongoing coordination by the President's Working Group on Financial Markets, the creation of a new federal Mortgage Origination Commission to evaluate, rate and report on the adequacy of state regulation of participants in the mortgage origination process, and a review of the role of the Federal Reserve in providing liquidity to the financial system. In the intermediate-term, the Blueprint recommends reforms designed to eliminate duplication in the existing regulatory structure and modernize regulation within the current framework. Intermediate-term recommendations include: phasing out the federal thrift charter and transitioning it to the national bank charter, with the Office of Thrift Supervision being closed; rationalizing federal supervision of state-chartered banks; creating a federal charter for important payment and settlement systems, overseen by the Federal Reserve; merging the Securities and Exchange Commission and the Commodity Futures Trading Commission; and creating an optional federal charter for insurance institutions and establishing a federal Office of Insurance Oversight within the Department of the Treasury.

The most expansive proposals in the Blueprint come in the form of long-term recommendations, which are framed as providing a conceptual model for an "optimal regulatory system." In contrast to the current functional regulatory system, in which different functional regulators oversee banking, insurance, securities and futures firms, the Blueprint proposes an objectives-based regulatory approach focused on achieving three overarching goals: (1) market stability regulation, addressing financial market stability; (2) prudential financial regulation, in particular addressing issues related to market discipline associated with government guarantees; and (3) business conduct regulation, addressing business conduct standards. A separate regulator would focus on each of these goals. Specifically, the Federal Reserve would assume the role of market stability regulator, a new prudential financial regulator would be created (and would assume the roles of current federal prudential regulators, such as the Office of the Comptroller of the Currency and the Office of Thrift Supervision), and a new conduct of business regulator would be created (and would assume business conduct responsibilities of various current regulators including regulators of insured depository institutions and insurers, the Securities and Exchange Commission, the Commodity Futures Trading Commission and the Federal Trade Commission). ■

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Basics of Surplus Notes

by Thomas M. Kelly, John Dembeck and Marilyn A. Lion

Surplus notes are subordinated notes issued by U.S. insurers that function like debt, but are treated as "surplus," the insurance statutory accounting analogue to equity, for U.S. statutory accounting purposes. Due to the unique treatment of surplus notes under U.S. statutory accounting principles, surplus notes have been utilized by insurers in a variety of transactions including capitalization of non-stock insurers, capital infusions from parent companies (insurers and non-insurers) to insurer subsidiaries, private placement capital raisings, insurance securitizations and contingent capital facilities.

U.S. Statutory Accounting Considerations

U.S. Statutory Accounting Treatment for Surplus Note Issuers

The principal advantage to issuing surplus notes as opposed to traditional debt securities is that such notes receive equity treatment for U.S. statutory accounting purposes. In order for a security to qualify for treatment as a surplus note, it must comply with any applicable state insurance law requirements as well as the criteria set forth in Statement of Statutory Accounting Principles No. 41 ("SSAP 41") in the *Accounting Practices and Procedures Manual* adopted by the National Association of Insurance Commissioners (the "NAIC"). As a preliminary matter, SSAP 41 requires that the surplus note issuer's domiciliary state insurance regulator approve the form and content of the surplus note. In addition to domestic insurance regulatory approval as to content, SSAP 41 permits notes to be reported as surplus only if the notes explicitly provide for the following:

- subordination to policyholders;
- subordination to claimant and beneficiary claims;
- subordination to all other classes of creditors other than surplus note holders; and
- prior approval of the insurer's domestic state insurance regulator for payment of interest and repayment of principal on the notes.

SSAP 41 also requires that that the proceeds received from the issuance of surplus notes be in the form of cash or other admitted assets with a readily determinable value and liquidity acceptable to the issuer's domestic state insurance regulator.

If a surplus note issuance meets these conditions, the note may be reported as surplus on the issuer's statutory balance sheet. This means that the proceeds received from the surplus note issuance (less the costs of issuance) are included as admitted assets of the issuing insurer, but the note is not reported as a liability on the insurer's statutory financial statements unless regulatory approval for a particular payment of interest or principal has been received, and, in that case, only to the extent interest or principal is currently due. If domestic state insurance regulatory approval is not obtained for a particular payment of interest or repayment of principal, no interest will accrue on such amount.

In addition to reporting the notes as surplus on its statutory balance sheet, under SSAP 41 an issuer of surplus notes must provide detailed disclosure regarding the terms of the securities in the notes to its statutory financial statements. The issuer must also identify in the notes to its statutory financial statements any affiliates that hold its surplus notes, as well as any holders of more than 10% of the outstanding amount of any surplus notes the issuer has registered under the Securities Act of 1933 (the "Securities Act") or sold in a private placement transaction pursuant to Rule 144A under the Securities Act.

U.S. Statutory Accounting Treatment for Insurers Purchasing Surplus Notes

SSAP 41 also provides detailed guidance on statutory accounting for U.S. insurers that have purchased surplus notes issued by other insurers. Surplus notes are admitted assets on the statutory financial statements of the purchaser if the notes conform to the requirements of SSAP 41. Surplus notes are accounted for in accordance with the statutory accounting principles promulgated by the NAIC with respect to bonds, and interest on surplus notes is accrued as income only to the extent approved by the issuer's domestic state insurance regulator. SSAP 41 also provides specific rules for valuation of an investment in surplus notes based on the rating of the notes and, for lower rated and non-rated surplus notes, the capital and surplus of the issuer.

Statutory Requirements

A surplus note issuer should bear in mind the provisions of the surplus note authorizing law in its domestic state, as well as the requirements of any state, such as Texas, that imposes its surplus notes law on foreign licensed insurer issuers or risk losing the favorable statutory accounting treatment described above. While surplus notes were originally a means for non-stock insurers to raise capital in many states, a majority of U.S. states and territories now have enacted statutes that expressly authorize the issuance of surplus notes by both stock and mutual domestic insurers. To the extent that an insurer's state of domicile does not have a surplus note authorizing law, the insurance regulator in that state may informally authorize the issuance of surplus notes by domestic insurers consistent with SSAP 41.

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Treatment in Insolvency

In addition to the express contractual subordination provisions required to be contained in surplus notes under SSAP 41, surplus notes are also statutorily subordinated under state insurance insolvency laws. State insurance insolvency laws that establish the priority of distribution of a domestic insurer's assets in the event of liquidation afford most other creditors of a domestic insurer the right to be paid in full before surplus note holders may receive payments. While the precise treatment of surplus notes in insolvency differs by state, under the Insurance Receivership Model Act adopted by the NAIC, surplus notes constitute "Class 11" claims out of thirteen possible classes of claims, senior only to interest on the allowed claims of other creditors and claims of shareholders or other owners.

Surplus Note Transactions

Though not extensively used, surplus notes have been issued in the following types of transactions:

- *Capitalization of non-stock insurers.* Surplus notes are the only effective means of capitalizing non-stock insurers, such as mutual insurers, reciprocal insurers and non-profits insurers, and therefore can be used to initially capitalize such non-stock insurers or bolster the surplus of existing non-stock insurers.
- *Capitalization of stock insurers.* Surplus notes provide an alternative method of capitalizing a stock insurer subsidiary. In lieu of a capital contribution, the parent (insurer or non-insurer) of a stock insurer may purchase surplus notes from its insurer subsidiary and receive a return through payments of interest and principal on the surplus notes rather than dividends on stock. Payments to the parent on a surplus note are subject to prior regulatory approval of the domestic state insurance regulator of the subsidiary insurer, while ordinary insurance company dividends are not. However, ordinary dividends may only be declared by an insurer up to statutorily prescribed amounts and, like payments on surplus notes, any extraordinary dividends above these statutory limits will also require domestic state insurance regulatory approval. Additionally, in some states an insurer may pay shareholder dividends only out of earned surplus. Surplus note authorizing laws, in contrast, do not generally include such a limitation on the source of funds available to pay interest and principal. Therefore, surplus notes may provide an alternative for an insurer without sufficient earned surplus to support dividend payments to its parent.

The principal advantage to issuing surplus notes as opposed to traditional debt securities is that such notes receive equity treatment for U.S. statutory accounting purposes.

- *Rule 144A/Regulation S Issuances.* Surplus notes have been used by U.S. insurers to access the capital markets through private placement transactions pursuant to Rule 144A and Regulation S under the Securities Act since 1993. The risk-based capital requirements for U.S. insurers first introduced in the early 1990s, and the views of rating agencies, prompted growth in surplus note utilization as a way for mutual insurers, which cannot issue stock, to raise a significant amount of capital. More recently, stock insurers also have issued surplus notes in private placement transactions.
- *Securitization Transactions.* Insurer structured financings including a surplus note component are a fairly recent development. In the basic type of surplus note securitization transaction, which may be aimed at funding statutory reserve requirements or monetizing the cash flows associated with a closed block of business, an insurer sets up a captive reinsurer and cedes the block of business to be securitized to the captive. The captive then issues surplus notes to a special purpose vehicle, and, in turn, the vehicle issues notes to capital markets investors in a private placement transaction. The cash flows from the securitized block fund payments of interest and principal on the surplus notes, which in turn service the debt of the special purpose vehicle issued to investors. There are no constraints on payment of interest and principal on the notes issued to capital markets investors, but payments of interest and principal on the surplus notes issued by the captive are subject to prior domestic state insurance regulatory approval.
- *Contingent surplus note facilities.* As an alternative to catastrophe bonds or traditional reinsurance or where reinsurance coverage is not available, property-casualty insurers have entered into "surplus note facilities" in order to protect against catastrophic losses. In one type of surplus note facility structure,

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an investor in the facility is obligated to purchase surplus notes from the insurer upon the occurrence of certain specified catastrophic events and in return receives a specified fee. The surplus notes are not issued unless and until the catastrophic event occurs. At the inception of the transaction, the insurer's domestic state insurance regulator may approve the form of the surplus note to be issued in the event specified contingencies occur. If surplus notes are issued under such a facility, payments of principal and interest require separate domestic state insurance regulatory approval.

Although navigation of the technical accounting and regulatory aspects of surplus notes can be complex, surplus notes have been used in a range of transactions and may be an attractive alternative for an insurer looking to raise capital or further other strategic objectives without increasing the liabilities reported on its U.S. statutory financial statements. ■

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Modernization of U.S. Reinsurance Regulation

by Nicholas F. Potter, Elizabeth K. Brill, Michael K. McDonnell and Alexander R. Cochran

For some time, the National Association of Insurance Commissioners (the "NAIC"), state insurance regulators and others have been considering dramatic changes to the long-standing U.S. reinsurance regulatory framework governing collateralization requirements in reinsurance transactions. Under the existing framework, credit for reinsurance is available to a ceding insurer only if the assuming reinsurer is authorized or accredited in the ceding insurer's state of domicile (or, in some states, in at least one U.S. state) or the assuming reinsurer posts collateral equal to 100% of the reinsurance obligations assumed. Although a ceding insurer may enter into a reinsurance transaction that does not comply with these requirements, the ceding insurer would not be allowed to take credit on its statutory financial statements for liabilities ceded pursuant to such a transaction. Under the existing regime, full reinsurance credit is permitted for reinsurance ceded to authorized or accredited reinsurers without collateral whereas an unauthorized reinsurer must post 100% collateral in order for full reinsurance credit to be permitted to the ceding insurer, regardless of how highly-rated or well-capitalized the reinsurer may be. In recent months and years, this seemingly arbitrary distinction, coupled with the extraterritorial application of certain states' credit for reinsurance rules, has generated increasing criticism from both regulators and interested parties.

In response, in early 2006, the NAIC directed its Reinsurance Task Force to begin developing alternatives to the existing regulatory framework. Additionally, both New York and Florida have started to review alternatives to their existing regulatory framework for reinsurance credit. The U.S. Congress has also recently taken up legislation targeting the extraterritorial application of state rules governing reinsurance.

Recent NAIC Developments

The NAIC, through its Reinsurance Task Force, has been considering potential reforms to the current reinsurance regulatory framework governing collateralization requirements. In particular, the Reinsurance Task Force has been instructed to consider approaches that take into account a reinsurer's financial strength regardless of its domicile, to identify and consider variations in state reinsurance law and regulation and to consult with international regulators in addition to other interested parties in developing a proposal for reinsurance regulatory reform. In 2006 and 2007, the Reinsurance Task Force developed and discussed specific proposals focusing on risk-based collateralization requirements and a mutual recognition framework permitting U.S.-licensed reinsurers and non-U.S. reinsurers to provide reinsurance throughout the United States on the basis of compliance with risk-based collateral requirements and other regulations prescribed by a single "home state" or "port-of-entry" regulator. These proposals generated significant discussion among regulators and voluminous comments from interested parties.

The Framework Memorandum

In November 2007, the Reinsurance Task Force began drafting a framework memorandum to address certain fundamental aspects of the regulatory

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modernization. The Framework Memorandum, which was unanimously adopted by the Reinsurance Task Force and its parent, the Financial Condition (E) Committee, in December 2007 and by the NAIC plenary in March 2008, identifies the broad goals of the reinsurance modernization framework and recognizes certain outstanding issues that require further discussion and consideration. The Framework Memorandum describes the following three principal goals:

1. *Mutual Recognition.* A new NAIC entity, the Reinsurance Supervision Review Department (the "RSRD"), would be established. The RSRD, under the supervision of the NAIC, would determine which non-U.S. jurisdictions are entitled to enter into mutual recognition agreements by assessing regulatory effectiveness through an "outcomes oriented" approach.
2. *Single State U.S. Regulator for U.S. Reinsurers.* U.S. reinsurers would submit to a single state insurance regulator in order to access the U.S. market, thereby addressing "inappropriate" extraterritorial regulation by other state regulators. Uniform minimum standards would be established for a reinsurer to qualify for certification and for a state to qualify as a recognized single state regulator.
3. *Single State U.S. Regulator for non-U.S. Reinsurers.* Non-U.S. reinsurers from RSRD-approved jurisdictions would be certified to access the U.S. market through a single U.S. jurisdiction (a "port of entry"). Uniform minimum standards would govern this process as well.

The Framework Memorandum also includes a lengthy and non-exhaustive list of outstanding issues, including: the establishment of appropriate required collateral levels (on a prospective basis); addressing uniformity among the states; preventing "inappropriate" extraterritorial application of state law; whether the proposal will apply to all affiliates of a group of reinsurers; whether the proposal will apply to reinsurers that are not professional reinsurers (primary insurers that also assume risk); the extent of regulatory authority retained by the ceding insurer's domestic state insurance regulator; requirements to achieve and maintain status as a "port of entry" state and a recognized single state insurance regulator for U.S. reinsurers; accounting reconciliation to GAAP or SAP; whether to establish or facilitate some sort of security, or guaranty, fund; and determination of how to negotiate, enforce and terminate mutual recognition agreements.

Since its adoption of the Framework Memorandum, the Reinsurance Task Force has discussed, and described in additional detail, the concept set forth in the Framework Memorandum of a single-state regulator for U.S. reinsurers. Among other things, the Reinsurance Task Force has highlighted the following aspects of its proposal:

- *National Reinsurers.* The RSRD would certify U.S. states as eligible to supervise a new class of reinsurers approved to write business across the U.S. known as "national reinsurers". A national reinsurer would be subject to the exclusive jurisdiction of one U.S. regulatory supervisor for all of its U.S. business. U.S. reinsurers that choose not to apply for a new license to operate as national reinsurers would continue to operate under the current reinsurance regulatory framework. RSRD certification of a state as eligible to supervise national reinsurers would be based on the state's resources, expertise and experience in the regulation of reinsurance.
- *Ceding Insurer's Domiciliary State.* A ceding insurer's state of domicile would retain authority regarding credit for reinsurance and would determine whether a reinsurance contract transfers risk. However, a ceding insurer's state of domicile would be required to grant "appropriate" credit for reinsurance ceded to a national reinsurer. A ceding insurer's domiciliary state would also have the ability to request additional information concerning a national reinsurer from its supervisory state for a "valid regulatory reason," such as a material financial concern or a concern about potential fraud, and in certain other circumstances. In addition, a ceding insurer's state of domicile would receive notification of any enforcement action against the national reinsurer by its supervisory state regulator.
- *Consultative Process.* In the event of disagreement among insurance regulators with respect to issues involving a national reinsurer, a supervisory review board of the RSRD consisting of state insurance regulators would engage in a consultative process to facilitate resolution of such disagreements. After the RSRD consultative process, regulatory decisions of a national reinsurer's supervisory state regulator with respect to the national reinsurer's financial condition would be final. Similarly, after discussion with the RSRD supervisory board, the ceding insurer's state of domicile retains the authority to make final regulatory decisions with respect to the amount of credit for liabilities reinsured or compliance with risk transfer requirements in a particular transaction.
- *Uniform Mandatory Contract Clauses.* The RSRD would establish standardized mandatory reinsurance contract clauses (including a parties to the agreement

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clause, a net retained lines clause, a premium clause, a reinsurance intermediary clause, a service of suit clause and an insolvency clause).

Although the Framework Memorandum sets forth certain fundamental aspects of the NAIC's proposed reinsurance regulatory reform framework, significant issues remain unresolved and much work remains to be done. In particular, as noted in the Framework Memorandum itself, the appropriate levels of required collateral remain to be determined. Previous Reinsurance Task Force proposals advocated a risk-based approach to collateral requirements whereby highly-rated reinsurers would be required to post little or no collateral whereas lower-rated reinsurers would face higher collateralization requirements. It remains to be seen whether the Reinsurance Task Force will continue to support a risk-based approach in one form or another.

State Developments

Concurrently with the work of the NAIC Reinsurance Task Force, both Florida and New York have taken steps to update their reinsurance credit rules.

New York

In a proposed amendment to the New York Insurance Department (the "NYID") Regulation 20, dated October 18, 2007, the NYID proposed significant changes to its credit for reinsurance rules. Among the changes proposed by the NYID are (1) the addition of provisions permitting alternative credit for reinsurance ceded by a New York licensed or accredited reinsurer (life or non-life) to an unauthorized reinsurer (reinsurers that are not licensed (or admitted) in New York) that ties the amount of collateral required to secure reinsurance recoverables to the rating of the unauthorized reinsurer; (2) as part of a principles-based approach to regulation, the addition of new principles of prudent reinsurance credit risk management applicable to all authorized ceding insurers; and (3) the addition of new reporting requirements for New York domestic ceding insurers.

Like the earlier Reinsurance Task Force proposals, the NYID proposal embraces a risk-based approach. Under the NYID alternative credit proposal, a ceding insurer may take full credit for reinsurance ceded to a highly rated unauthorized reinsurer without the reinsurer having to post collateral. As an unauthorized reinsurer's rating decreases, the amount of collateral that a reinsurer would be required to post would increase. In addition, in order for a ceding insurer to take credit, it must maintain "satisfactory evidence" that the unauthorized reinsurer (1) meets the standards of solvency, including standards for capital adequacy, established by its domestic regulator; (2) is authorized in its domiciliary jurisdiction to assume the kinds of reinsurance ceded by the ceding insurer; and (3) maintains a policyholder's surplus or equivalent in excess of $250 million. Furthermore, for an unauthorized non-U.S. reinsurer, in order for a ceding insurer to take the credit, (1) the New York Superintendent of Insurance (the "Superintendent") and the domiciliary regulator of the reinsurer must enter into a memorandum of understanding that addresses information sharing and considers regulatory equivalence, enforceability of judgments and any other matters the Superintendent deems relevant, and (2) the domiciliary jurisdiction of the reinsurer must allow U.S. reinsurers access to its market on terms and conditions that are at least as favorable as those provided by New York law and regulations for unauthorized non-U.S. reinsurers. Certain specific contract provisions would also be required.

The New York alternative credit proposal differs structurally from the NAIC Framework Memorandum in that the proposed amendment also contains principles pertaining to authorized ceding insurers managing their reinsurance credit risk. Under the proposed principles, an authorized ceding insurer must act with "financial prudence" when entering into any reinsurance transaction and must consider and account for all risks associated with the reinsurance agreement, including (1) compliance with all applicable legal and regulatory requirements; (2) the net risk to be retained; (3) concentration of risk on a net and gross basis; (4) projections as to reasonable future availability and affordability of adequate levels of reinsurance support for the ceding insurer's ongoing operations; (5) the degree to which future reinsurance proceeds for existing and future ceded reserves are likely to be recoverable based upon best available current information; (6) the way a reinsurer will be selected, including how to assess its security; (7) how the reinsurance program will be monitored (i.e., the reporting and internal control systems); and (8) that the terms of agreements with any affiliated reinsurer are fair and equitable. In addition, a ceding insurer must take steps to manage its reinsurance recoverables in proportion to its book of business and diversify its reinsurance program.

Lastly, under the proposed amendment, a New York domestic ceding insurer would have to notify the Superintendent within 30 days if a reinsurance recoverable from any single reinsurer, or group of affiliated reinsurers, exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders or the domestic ceding insurer cedes more than 20% of the domestic ceding insurer's gross written premium in the prior calendar year to any single reinsurer or

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group of affiliated reinsurers. The notification must demonstrate that the exposure, in each case, is safely managed by the domestic ceding insurer.

Florida

In early 2007, the Florida legislature enacted revisions to the Florida insurance law that authorize the Florida Commissioner of the Office of Insurance Regulation (the "Commissioner") to permit full or partial credit for reinsurance ceded by a Florida-licensed ceding insurer to an unaccredited reinsurer, without posting collateral, if the reinsurer holds surplus in excess of $100 million and has a secure financial strength rating from at least two nationally recognized statistical rating organizations deemed acceptable by the Commissioner. In determining whether credit is allowed, the Commissioner must consider: (1) the domiciliary regulatory jurisdiction of the assuming insurer; (2) the structure and authority of the reinsurer's domiciliary regulator with respect to solvency regulation requirements and financial surveillance; (3) the substance of financial and operating standards for reinsurers in the domiciliary jurisdiction; (4) the form and substance of financial reports required to be filed in the domiciliary jurisdiction or other public financial statements; (5) the domiciliary regulator's willingness to cooperate with United States regulators and the Florida Office of Insurance Regulation; (6) the history of performance by reinsurers in the domiciliary jurisdiction; (7) documented evidence of substantial problems with the enforcement of valid U.S. judgments in the domiciliary jurisdiction; and (8) any other matters deemed relevant by the Commissioner. Additionally, the Commissioner must give appropriate consideration to insurer group ratings that may have been issued.

In response to this revision to the Florida insurance law, the Commissioner proposed a draft rule, which, like the NYID's alternative credit proposal, would allow ceding insurers full credit for reinsurance ceded to a highly-rated unauthorized reinsurer without the reinsurer having to post collateral. As with the NYID proposal, as an unauthorized reinsurer's rating decreases, the amount of collateral that a reinsurer would be required to post would increase. Additionally, in order for a ceding insurer to take credit, (1) the unauthorized reinsurer must be approved as an "eligible reinsurer" by the Commissioner; (2) the ceding insurer must maintain satisfactory evidence that the reinsurer meets the standards of solvency, including standards for capital adequacy, established by its domestic regulator; and (3) all reinsurance contracts between the ceding insurer and the reinsurer must include certain required contractual provisions.

In order to be approved as an "eligible reinsurer," a reinsurer must hold surplus in excess of $100 million, be authorized in its domiciliary jurisdiction to assume the kinds of reinsurance that will be ceded to it and be domiciled in an "eligible jurisdiction," as determined by the Commissioner. If the Commissioner determines, based on an application and any other relevant information, that it is in the best interests of market stability and the solvency of ceding insurers, he will find, by order, that the reinsurer is an eligible reinsurer and may establish a required collateral level lower than that otherwise specified in the proposed rule. An eligible reinsurer must make certain annual filings with the Florida Office of Insurance Regulation and immediately advise the Florida Office of Insurance Regulation of any changes in ratings, domiciliary license status or directors and officers. In order to be approved as an "eligible jurisdiction," at a minimum, a jurisdiction must (1) agree to provide information requested by the Florida Office of Insurance Regulation regarding its domestic reinsurers; (2) have a satisfactory structure and authority with regard to solvency regulation, acceptable financial and operating standards for its domestic reinsurers, acceptable transparent financial reports filed in accordance with generally accepted accounting principles and verifiable evidence of prompt enforcement of valid U.S. judgments; (3) have a history of performance by its domestic reinsurers such that the insuring public will be served by a finding of eligibility; and (4) if the jurisdiction is a non-U.S. jurisdiction, allow U.S. reinsurers access to its market on terms and conditions that are at least as favorable as those provided in Florida law and regulations for unaccredited non-U.S. assuming reinsurers. Additionally, there can be no documented information that a determination of eligibility would not serve the best interest of the insuring public and the solvency of ceding insurers. If, in the future, the NAIC issues findings that certain jurisdictions should be considered eligible jurisdictions, and if doing so would serve the best interests of the insuring public and the solvency of ceding insurers, the Commissioner shall make a determination that such jurisdictions constitute "eligible jurisdictions" under Florida law.

The Commissioner would exercise broad discretion under the proposed rule. In addition to the discretion inherent in determining the status of eligible reinsurers and eligible jursisdictions, the Commissioner, for example, would be able to disallow or reduce, by order, any credit otherwise permitted pursuant to the proposed rule if it appears that granting credit would not be in the public interest or serve the best interests

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of the ceding insurer's solvency. Additionally, the Commissioner must, by order, withdraw a determination that a jurisdiction is an "eligible jurisdiction" if the Commissioner determines it would be in the best interests of market stability and the solvency of ceding insurers.

Finally, analogous to the notification requirements in the NYID proposal, the proposed Florida rule requires a ceding insurer to notify the Office of Insurance Regulation, and increase reserves as necessary, if the obligations of an eligible reinsurer are more than 90 days past due (and are not in dispute) or if there is any indication that an eligible reinsurer, with which the ceding insurer has a contract, does not substantially comply with solvency requirements in Florida or its domiciliary jurisdiction.

Federal Legislation

Concerns raised with respect to the current regulatory framework governing credit for reinsurance stem in part from the lack of uniformity in requirements among the various U.S. states. This is potentially problematic from the perspective of non-U.S. reinsurers that reinsure business from ceding insurers domiciled and licensed in multiple states. Additionally, because certain states apply their reinsurance credit rules extraterritorially to ceding insurers domiciled in other states, a single ceding insurer may be subject to reinsurance credit requirements imposed by multiple states if it wishes to take credit for reinsurance on its statutory financial statements filed in each such state. One way to ensure uniformity is through federal legislation. The U.S. Congress is currently considering legislation that generally would require deference to a ceding insurer's domiciliary state insurance regulator on questions of reinsurance credit and deference to a reinsurer's domiciliary regulator regarding the reinsurer's financial solvency. Additionally, in its *Blueprint for a Modernized Financial Regulatory Structure*, released in March 2008, the U.S. Department of the Treasury suggests that Congress create a national Office of Insurance Oversight within the Department of the Treasury to, among other things, "deal with international regulatory issues, such as reinsurance collateral."

On June 25, 2007, the U.S. House of Representatives passed a bill titled the Nonadmitted and Reinsurance Reform Act of 2007 that, if enacted into law, would, among other things (1) prohibit other states from denying a ceding insurer credit for reinsurance that was allowed by that ceding insurer's domiciliary state (provided the domiciliary state is NAIC-accredited or has financial solvency requirements substantially similar to the requirements necessary for NAIC accreditation); (2) preempt states, other than the domiciliary state of a ceding insurer, from applying laws or restrictions governing the reinsurance arrangements of that ceding insurer (subject to certain limited exceptions); and (3) require that the domiciliary state of a reinsurer be solely responsible for supervising that reinsurer's financial solvency (provided the domiciliary state is NAIC-accredited or has financial solvency requirements substantially similar to the requirements necessary for NAIC accreditation). After passing the House, a similar version of the Nonadmitted and Reinsurance Reform Act of 2007 was introduced in the Senate as S. 929 and is currently pending.

Conclusion

As the NAIC, certain individual states and the U.S. Congress continue to work to modernize the regulatory framework governing reinsurance collateralization requirements, a consensus appears to be forming that some change is necessary. It should be noted that a similar consensus has been forming in the European Union (the "EU") as well, as evidenced by recent EU efforts to adopt uniform regulations with respect to collateralization requirements for reinsurance across the EU market. Though non-U.S. reinsurers have raised concerns to the NAIC and others about aspects of the reinsurance modernization proposals discussed above, the efforts by the NAIC and others have the potential not only to streamline reinsurance regulation in the United States, but could also potentially lead to a more consistent system of regulation for cross-border reinsurance transactions. ■

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European Commission Final Report on Business Insurance

by Christopher Henley

One of the consequences of the recent investigations into broker compensation practices in the U.S. was a scrutiny of practices carried on in London by those insurers and brokers with transatlantic operations. The European Commission (the "Commission") engaged in frenetic activity in 2004 and 2005 which was followed by a lull, but scrutiny intensified firstly with the publication of the Commission's Interim Report on Business Insurance in January 2007 and more recently with the publication in September 2007 of its Final Report (the "Report"). See "Contingent Commissions: Interim Report on Business Insurance from the European Commission" in the *Debevoise & Plimpton Financial Institutions Report*, Volume 1, Number 1, for a discussion of the Interim Report.

The Report's main conclusion is that a range of potentially anti-competitive practices exist, which include the use of "best terms and conditions" clauses, and most controversially the use of the subscription market generally. It also reviews the offering of inducements by insurers to brokers to affect the flow of business and the lack of transparency giving rise to the inability of clients to make fully informed choices.

"Best Terms and Conditions" Clauses and the Subscription Market

A "best terms and conditions" ("BTC") clause, appearing in reinsurance or coninsurance contracts, is intended to permit an insurer to benefit from the best terms available to other participating insurers, without specifically quoting those terms. The use of BTC clauses may result in a higher premium for insurance than would otherwise occur under fully competitive conditions because they negate the impact of the original differences in terms (manifested as premiums and conditions) that result from differences in solvency, strength and rating or from differences in insurers' underwriting policies. They are imposed by an underwriter who wishes to benefit from a harder stance adopted by a later underwriter (who in any event cannot himself offer a lower premium than that already set), and their only redeeming feature is that one policy wording can be produced, containing one set of identical terms and one rate. However, it is argued that the use of a BTC clause might amount to a restriction of competition within the meaning of Article 81 of the Treaty of Rome, which governs agreements that distort competition. In fact, given that alignment occurs even without the use of BTC clauses, their use is no longer as prevalent as it was, and so the Commission has looked at the alignment of premiums and conditions of cover independently of such clauses.

Some insurers have argued that such uniformity of terms is advantageous for the insured in the event of a claim, that smaller insurers can participate because they would benefit from the terms that the larger insurers impose on the market and that the subscription market generally increases market capacity. The Commission is less worried about the broker revealing the price set by the leading insurer to the following market, and aligning the terms of cover, provided these do not impact the rate of premium later set. The Commission has accepted that a shared wording arising out of such horizontal cooperation would deliver a benefit to the insured, which will no doubt come as a relief to those participants who have spent considerable time and effort to reach "contract certainty," but that the broker (as agent of the insured) should seek price competition within any layer. This might make some sense in the event of oversubscription if an insured were only interested in obtaining the most competitive price, rather than say the highest quality insurer with an exemplary record of paying claims. However, subordinating the insured's interests to the alleged greater benefit of the market was not a concept ever likely to be upheld. Justification based on improved efficiency of the market, increased capacity (because a following underwriter with no sector experience can rely on an experienced leader) and better spreading of the risk and administrative benefits, is not sufficient to uphold the alignment of premiums, particularly given the obvious possibility of collusive behavior. The Report states that, "it should normally be possible for the risk to be priced individually by each of the participants, as it depends on the terms and assessment of the risks which are specific to every insurer." One obvious effect would be that any program would be more patchworked than it is now, and that to achieve this non-homogenous result the broker would have to work considerably harder.

What the Report does not take comment on is the fact that the London market is in fact highly competitive and presents an efficient vehicle for spreading risk (one of the main rationales for insurance), and more importantly that a detailed assessment of the risk by every coinsurer would inevitably slow the subscription process considerably, which might itself force upwards the premium per risk.

Transparency

As a matter of English agency law an intermediary must disclose his remuneration when asked to do so by a commercial client. The Financial Services Authority (the "FSA")

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has enshrined this principle within its rules. The FSA is not currently mandating additional guidelines in addition to its more general rules, partly because the common law is clear – that a broker must disclose his remuneration to a commercial client when asked, and that he must not make a secret profit – and partly because those FSA rules are already clear enough.

The Commission previously commented that the lack of transparency reduces the potential for price competition in mediation services, but has now gone further in the Report, suggesting that the broker may be induced to direct business to specific insurers, rather than on more traditional considerations such as price or quality. It then states that it is questionable whether disclosure of remuneration would provide sufficient protection because it is not always clear, complete and understandable to the client, or in respect of those types of remuneration that specifically aim at aligning the interests of brokers and insurers. Although the Report does not make any recommendation, the Commission does not appear to be convinced that remuneration by commission is the appropriate solution, leaving fees agreed between the insured and broker as its apparently preferred answer. The Commission plans to revisit this area in its review of the Insurance Mediation Directive in 2008 and 2009.

In December 2007 the FSA published an independent report from CRA International, a global consulting firm, that considers whether disclosure of commissions earned by commercial insurance intermediaries should be made mandatory. The report finds that intermediary disclosure by itself is not justified on cost/benefit grounds, with estimated direct compliance costs initially of £86 million, and £34 million each year thereafter. Following the Commission's Report, the FSA released a further discussion paper in March 2008 entitled "Transparency, disclosure and conflicts of interest in the commercial insurance market," which examines the importance of buyers having access to clear and comparable information about the role of the intermediary, its services and the way it is paid. The paper also looks at managing conflicts of interests arising out of the intermediary's dual roles as adviser to his clients and as distributor to insurers.

The FSA's paper outlines three possible solutions:

- more rigorous enforcement of existing rules through a combination of further guidance and additional reporting requirements;
- an enhanced regime to improve quality of disclosure of commission (on request by the customer), services and status; and
- mandatory automatic disclosure of commission.

Dan Waters, Director of Retail Policy and Themes at the FSA, said, "It is important that insurance buyers know what they're paying for when they use an intermediary. We remain concerned that for some buyers of commercial insurance this is not the case. Our discussion paper offers some potential regulatory solutions, but the door also remains open for an industry-led response." These solutions are not mutually exclusive and each would require improved conflict management processes. The closing date for comments on the discussion paper is 25 June 2008. Whilst mandatory disclosure may not ultimately be required, mounting evidence of detriment for customers suggests that change will be unavoidable. It is hard to disagree with a regime promoting transparency of remuneration, which can only benefit all parties. Achieving this state may be somewhat harder but an industry led solution must clearly be the optimum solution for the market.

The Block Exemption

Finally, the Block Exemption Regulation (2003) (the "BER") enables insurers to share certain data, including the joint calculations of risks and joint studies on future risks, the establishment of non-binding standard policy conditions, the establishment and management of insurance pools, and the testing and acceptance of security equipment. The Commission takes the view that even if cooperation agreements were desirable and competitive, there is no need for the legal instrument of a block exemption. Insurers are capable of individually assessing the legality of their actions and do not need the luxury of a tailored exemption. The current BER expires on 31 March 2010 and the Commission sees no compelling reason to prolong it. In fact, there may be some forms of cooperation which are inadvertently exempted but have undesirable anticompetitive effects.

The Commission has invited the parties concerned with the various issues to engage in a dialogue to clarify whether the practices are compatible with competition law and propose appropriate action, and will itself be looking at specific areas within its review of the Insurance Mediation Directive and the BER. ■

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Income Tax-Related Issues Associated with Proposed Changes to Life Insurance and Annuity Valuation Requirements: IRS Notice 2008-18

In early 2008, the U.S. Internal Revenue Service (the "IRS") issued Notice 2008-18 (the "Notice"), alerting life insurance companies to potential U.S. federal income tax issues associated with the adoption of proposed actuarial guideline VACARVM, a new actuarial guideline setting forth the commissioner's annuity reserve valuation method for variable annuities and other contracts involving similar guaranteed benefits ("Proposed AG VACARVM"), and/or a proposed principles-based approach for calculating statutory life insurance reserves ("Proposed Life PBR"). Both proposals are currently under consideration by the American Academy of Actuaries and the NAIC.

The Notice identifies eight potential federal tax issues relating to Proposed AG VACARVM and Proposed Life PBR. These include: (1) whether reserves determined under Proposed AG VACARVM or Proposed Life PBR would qualify as "life reserves" under section 816 of the Internal Revenue Code (the "Code"); (2) whether the adoption of Proposed Life PBR would affect the qualification of contracts as "life insurance contracts" under Code provisions (found in Section 7702) that contemplate mortality charges specified in "the commissioners' standard mortality tables;" (3) whether aggregate reserves that are not determined on a contract-by-contract basis, based on uniform interest-rate and mortality factors, would qualify as deductible life insurance reserves under the Code; (4) how the absence of a prevailing state assumed interest rate would affect the calculation of life insurance reserves under the Code; and (5) whether stochastically determined reserves can meet the Code's requirement that life insurance reserves be determined based on prevailing mortality tables.

The Notice also states that it is anticipated that for federal income tax purposes Proposed AG VACARVM and Proposed Life PBR would only apply to contracts that are issued after the date of adoption, regardless of the applicability of the new rules to in-force contracts for regulatory purposes. In addition, the IRS and Treasury do not anticipate changes to existing guidance that require that tax principles override statutory accounting in appropriate circumstances. Lastly, the Notice expresses concern that the degree of discretion companies will have to determine CTE amounts (under Proposed AG VACARVM) or the stochastic reserve (under Proposed Life PBR) could make those amounts difficult or impossible for the IRS to audit, and suggests that this concern may support recognizing only the standard scenario amount (in the case of Proposed AG VACARVM) or the deterministic reserve (in the case of Proposed Life PBR) for purposes of making federal income tax calculations.

The Notice describes this list as "preliminary and nonexclusive," and invites comments on these issues and any other federal tax issues that taxpayers and their advisors believe should be addressed if Proposed AG VACARVM or Proposed Life PBR are adopted by one or more states. ■

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Blackstone and the OCC in order to secure the closing of the merger. However, on March 17, ADS delivered a notice to Blackstone, again claiming a breach of the merger agreement. On April 18, 2008, each of Blackstone and ADS delivered to the other a notice of termination of the merger agreement, and ADS once again filed suit against Blackstone, seeking payment of a reverse breakup fee of $170 million and reimbursement of certain of its transaction expenses. ADS claimed that Blackstone did not make a real effort to come to a resolution of the OCC approval issue. ADS claimed that it even proposed reducing the price to be paid by Blackstone by $400 million and using the savings to fund the OCC's backstop requirements, but that Blackstone refused.

The specifics of the ADS transaction actually made ADS's specific performance demand somewhat difficult. Its contractual counterparties are, in fact, shell acquisition vehicles, not the Blackstone fund itself. Although the fund guarantees certain of the buyers' merger agreement obligations, the fund is not under a direct contractual obligation to use reasonable best efforts to obtain regulatory approvals; that is an obligation of the buyer entities, which have no power to force the Blackstone fund to provide the backstop that the OCC requires. In addition, the contract actually provides for specific performance only of certain cov-

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enants, which do not include the obligation to use reasonable best efforts to obtain regulatory approvals. Putting these considerations aside, however (and also putting aside ADS's contention that Blackstone is using the OCC's demands as a pretext to escape from the deal because market conditions have deteriorated and financing is more expensive), this dispute provides some interesting lessons for buyers in mergers and acquisitions in the financial services industry, where regulatory approvals are almost always an important consideration.

With respect to the insurance industry, for example, regulators are often empowered to impose conditions or restrictions on their approvals of acquisitions of insurance companies or other regulated entities in the insurance industry. A regulator could require a buyer to contribute additional capital to the company it is buying or to covenant to contribute capital in the future in order to maintain a specified level of net worth, reserves or capital and surplus of the company. A regulator could also impose restrictions on the operations of the company or its parent beyond the limitations already imposed by statute or regulation, such as limiting the amount of dividends that can be paid or the ability of the acquirer to take on debt or pledge its interest in the company to creditors. If a regulator is concerned about the potential for jobs leaving the state of domicile of the acquired company, it could impose restrictions on the ability of the acquirer to move the company's operations out of state. A regulator may be more likely to impose conditions on its approval of a sale to a private equity firm or runoff operator, or any other buyer that is not a "repeat player" with other operations over which the regulator has authority, because such buyers may be less susceptible to the regulator's moral suasion to keep the company well capitalized in the future.

It is not always easy to predict, however, when a regulator may impose conditions on an approval. Indeed, in the ADS merger agreement, certain regulatory approvals, such as those of the Federal Deposit Insurance Corporation and the federal antitrust authorities are addressed in some detail. According to press reports, the parties did not similarly address the OCC approval because they assumed it would be uncontroversial and easily obtained. That is why a buyer of a heavily-regulated entity should make sure to protect itself in an acquisition agreement against the possibility that a regulator will impose burdensome conditions on its approval of the deal.

The protection should be in the form of both an exception to the buyer's covenant to use its efforts (whatever the efforts standard) to obtain regulatory approvals if the regulator imposes materially burdensome conditions, and a further condition to closing that not only must all required approvals be obtained, but that such approvals not be subject to materially burdensome conditions. The wording of this exception and condition can take various forms, and is often subject to heavy negotiation. Sometimes the phrase "materially burdensome condition" is used. Often it is defined in some way, but sometimes those words are used without further definition. A buyer may ask for a more subjective standard such as "any conditions that would materially impair the benefit of the transaction expected to be enjoyed by the buyer" and a seller may push for a higher standard such as "a condition that would cause a material adverse effect on the buyer." Of course, if a buyer is concerned about specific conditions that it is unwilling to satisfy, it should try to expressly include those in the covenant exception and closing condition rather than rely on general language.

Beyond the exception for burdensome conditions that it should try to negotiate into the acquisition agreement, a buyer should also pay close attention to its covenant with respect to regulatory approvals more generally. The points of negotiation with respect to this covenant may involve whether the buyer must share all materials and correspondence submitted to the regulator with the seller or allow the seller to participate in (or at least receive notification of) all discussions with the regulator. Particularly with private equity buyers, there may be an attempt to limit the information about the buyer that must be provided to the regulator.

Finally, there may be negotiation of the level of efforts that the buyer is required to exercise to obtain regulatory approval. The Blackstone entities are required by the ADS merger agreement to expend "reasonable best efforts" to obtain regulatory approval. The other common candidates are "commercially reasonable efforts," thought to be a lower standard than reasonable best efforts, and "best efforts," thought to be a higher standard. The truth is there is very little, if any, case law interpreting the meaning of these phrases relative to one another, so a buyer should not take much comfort from a supposedly lower form of efforts standard. However, it is a good idea to be consistent throughout an agreement in the use of an efforts standard unless varying levels of efforts are actually intended. If both "commercially reasonable efforts" and "best efforts," for example, are used in different covenants in the same agreement, a court might very well interpret that to mean a higher level of effort is required in the latter case. On the other hand, there is no guarantee that a court will take that position. ■

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